Sustaining Technical and Analytic Resources (STAR) Project's Capacity Landscape Analysis

Submitted to the Public Health Institute by the Consortium of Universities for Global Health

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The Sustaining Technical and Analytic Resources (STAR) project, funded by the United States Agency for International Development (USAID, undertook this landscape analysis to inform STAR's Collaboration Laboratory, a one-year grants program to study academic partnerships between US-Based and LMIC based institutions, and better understand what makes them successful and mutually beneficial. During the first year of the STAR project, the Academic Partnerships team conducted this thorough analysis in order to inform STAR's overall understanding of formalized academic partnerships as well as partnerships with NGOs and the public and private sectors. This Landscape Analysis was conducted from July 15-July 28, 2019 and focused the capacity needs of US and LMIC academic institutions engaged in global health. Through this study, STAR sought to identify current gaps, constraints, and opportunities that will inform both USAID's and STAR's understanding of existing needs, as well as STAR's Collaboration Laboratory.

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ACKNOWLEDGEMENTS

Sustaining Technical and Analytic Resources (STAR) is a project of the Public Health Institute implemented in partnership with Johns Hopkins University, the Consortium of Universities for Global Health, and University of California at San Francisco.

ACRONYM LIST

AP   Academic Partnerships (STAR's)
CUGH   Consortium of Universities for Global Health
CAE   Central Asia & Europe
EAP   East Asia & Pacific
GH   Global Health
HIC   High Income Countries
IEC   Institutional Ethical Committee
IRB   Institutional Review Board
LMIC   Low- and Middle-Income Countries
NGO   Non-Governmental Organization
PH/CH   Public Health/Community Health
REC   Research Ethics Committee
SA   South Asia
SSA   Sub-Saharan Africa
STAR   Sustaining Technical and Analytic Resources
US   United States
USA   United States of America
USAID   United States Agency for International Development
USG   United States Government

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EXECUTIVE SUMMARY

Background

The Sustaining Technical and Analytic Resources (STAR) Project, a United States Agency for International Development (USAID)-funded project, undertook a Capacity Landscape Analysis survey in order to better understand the United States (US) and low- and-middle-income country (LMIC)-based academic institutions' capacity needs (e.g., workforce, structures, skills, tools) with respect to effective global health engagement. In partnership with the Consortium of Universities for Global Health (CUGH), the STAR Academic Partnerships Team (AP) aims to increase the capacity of individuals and academic institutions around the world to improve global health practice. The survey was conducted in English from July 15-July 28, 2019, and the results will be used to inform STAR programming.

Survey Participants

Among 117 total respondents, 64% were from the US, 28% from Sub-Saharan Africa, and 8% from Asia. Sixty-one% were from public institutions and 36% from private institutions with equal representation from Medical disciplines (which is inclusive of all physician disciplines) and Public/Community Health [PH/CH] (39% each). Most of the respondents worked in research (93%) and education (85%), with about half (54%) engaged in clinical and community/outreach programs (44% in clinical service, and 39% in advocacy); 41% were educators, with 31% at the Director, Dean or Executive level, and 20% were programmatic staff. In both the US (56%) and LMICs (31%), only a few respondents were engaged in Global Health (GH) activities, though more in LMIC (39%) than US (28%).

Priorities for Strengthening Global Health Programs/Activities

To strengthen GH programs/activities, the overall top four priority areas are education (especially for LMIC respondents), partnerships/collaboration, funding, and research. The highest priority areas reported by medical respondents are funding (20%), partnerships/collaboration (19%) and education (17%); PH/CH respondent's highest priority areas are partnerships/collaboration (17%), education (15%), funding (13%), and GH technical areas (13%), with a considerable list of topic-based areas that require resources.

Constraints to Addressing Identified Priorities

US respondents were four times as likely as LMIC respondents to cite funding (including protected time) as a deficiency, reflecting universal constraints on the support of GH activities, as well as a complex array of opportunities and expectations. The responses suggest the existence of collaborative learning opportunities for low-cost, creative solutions that build on existing shareable resources. The need for funded travel was cited as a particularly onerous burden; however, wide-spread communication technologies can save considerable time, travel costs, and greenhouse emissions from travel (https://academicflyingblog.wordpress.com/). Unhelpful bureaucracies were also noted to be especially crippling for GH activities, particularly in US private and LMIC public institutions.

Institutional Needs for Enhancing Capacity

Regarding methods for improving institutional capacity to apply for US government development funds, 65% of US respondents reported a need for additional time, 52% needed financial resources, and 51% wanted institutional prioritization of this work. In contrast, LMIC respondents primarily (74%) sought technical skill enhancement to explore, apply for, and manage grants, along with having access to partnering organizations (57%), and general financial resources (55%). Despite these differences, it was clear that even GH interested/experienced individuals from US institutions may feel daunted about the grant application process.

Way Forward

Education was among the top three capacity building priorities for both LMIC and US respondents, whereas training (29%) and workforce development (26%) were identified as the top LMIC needs. One ready solution for funding barriers, is the use of free, accredited trainings that are available globally online. As LMIC academic institutions develop partnerships with US institutions, it is important identify education and learning opportunities (either remotely or in person via trainee exchange programs). In contrast, research was cited as a low priority (8%) by this cohort of respondents. This is interesting as, while some clinical and basic science innovations may have difficulty crossing borders, it is critical that we continue to learn with the intention of promoting global health effectively.

Partners in GH activities, particularly those from high income countries (HIC) should engage in opportunities that strengthen and sustain learning and research capacity in LMIC institutions. This includes providing trainers, equal opportunities in the HIC institution, and access to educational products, journals and libraries.

INTRODUCTION TO STAR'S CAPACITY LANDSCAPE ANALYSIS

Background

STAR's Academic Partnerships (AP) team conducted a qualitative study on the capacity needs of US and LMIC academic institutions engaged in GH. Through this study, referred to as the "Landscape Analysis," the AP team sought to identify current gaps, constraints, and opportunities that will inform both USAID's and STAR's understanding of existing needs, as well as a mechanism in which STAR may be leveraged to strengthen capacity efforts. The findings also provide important information about academic capacity needs for other interested parties, such as GH funders, organizations, and academic institutions involved in capacity strengthening activities.

Additional questions guiding the sub-analysis included:
- What are the unique capacity needs of US and LMIC academic institutions, and how do they differ?
- What are the main constraints to addressing the capacity needs?
- What can both USAID and STAR learn about these capacity needs?
- How might STAR be leveraged to support capacity strengthening efforts?

Survey Methods

The landscape analysis consisted of an online survey developed by STAR's AP team and the STAR Committee, comprised of global health academics and professionals affiliated with the CUGH network., administered on SurveyMonkey in English from July 15 - July 28, 2019. The survey population included US and LMIC-based academic administrators, faculty, and staff, engaged in GH, global public health, and/or global partnerships for health, hereinafter referred to as "Global Health". A total of 188 responses were received. Incomplete responses (those that had only answered the consent and/or demographic questions) were removed from the data set, as well as responses from individuals who did not meet eligibility requirements for the survey. After this data clean-up process, 117 responses were eligible for the analysis.

A copy of the survey is available in Annex 1.

Ethical Approval and Consent Process

The landscape analysis protocol was granted Institutional Review Board (IRB) exemption by the Public Health Institute (PHI). Respondents were informed that participation in the survey was voluntary, that all questions were optional, and that they could exit the survey at any time without penalty. All responses were confidential, and no identifying data was shared outside of the STAR research team. The STAR committee was granted temporary data access to assist with the analysis and only aggregate data was shared externally (with no IP address information collected). The survey answers were initially sent to a SurveyMonkey.com link where data was stored in a password-protected electronic format, and that at the study's completion, data was removed and stored offline securely. Data will be accessible only by the APs team until the end of the STAR Project (expected September 2023) for use by STAR researchers. The primary potential risk associated with study was the minimal risk of information-related harms, as information provided by participants, if disclosed and identifiable, could potentially cause embarrassment, loss of privacy, or reputational damage to programs named by participants. These risks were

mitigated through data security safeguards and standard, and rigorous academic efforts, including the de-identification of the data for the purpose of disseminating study findings. The participants received no direct benefits from participating in the research study. However, their responses may inform the programming of STAR, USAID, and other GH actors involved in capacity strengthening at academic institutions. Finally, respondents were given STAR and IRB contact information (email, phone, and physical address) in case they had any questions about the study.

Strengths of Survey

This survey collected responses from individuals representing various geographical regions, professional disciplines, career stages, and expertise levels. Open-ended questions enabled the study team to identify specific global health priorities and constraints relevant to certain geographical and professional disciplines.

Limitations of Survey

This study has several limitations. Firstly, the survey tool was active for only two weeks. Additional responses could have been collected if the survey duration were extended. Secondly, relatively fewer responses were received from LMICs in Asia, and none from the Middle East, so the data captured in this survey may not represent the needs of individuals/institutions in those regions. This limitation could be related to geographic variation in internet access, or limited survey advertisement in certain regions. Thirdly, analysis themes were generated separately by individual STAR committee members for each open ended question; these themes or codes could have been more robust if two or more individuals analyzed the results for each question and worked collaboratively to agree on a single list of themes.

Use of Survey Results

This survey supports one of the long-term strategic goals outlined in STAR's AP Strategy— systematically building the capacity of LMIC and US academic institutions to engage in GH development work. By identifying institutional capacity needs STAR now has a baseline understanding of how knowledge sharing efforts and support of mutually beneficial partnerships can be targeted to address capacity building needs.

RESULTS

Characteristics of Survey Respondents

Findings by Region

Out of 117 valid responses, 75 (64%) came from the United States (US), 33 (28%) from Sub-Saharan Africa (SSA), and 9 (8%) from Asia-- 6 from South Asia (SA), 2 from East Asia & Pacific (EAP), and 1 from Central Asia & Europe (CAE). Figure 1.

Figure 1: Distribution of Respondents, by Region
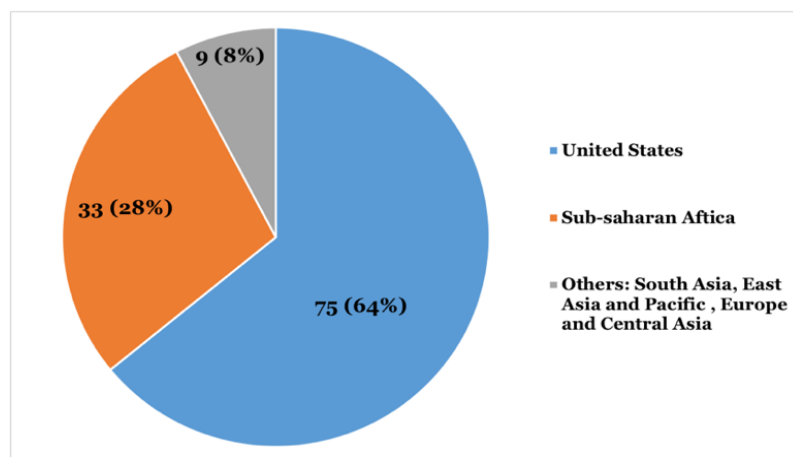
Findings by Institution Type

Respondents reported their affiliated institution as public, private, private-public mix (1), military (1), statuary (1), non-profit mission (1), private institution owned by an academic university (1), and non-governmental organization (NGO)-run institution (1). For the ease of the analysis, military and statutory institutions were grouped into public; private institution owned by academic university into private; and mission owned and NGO-run institutions as non-profit/NGO. Thus, respondents belonged to 72 public (61%), 42 private (36%), 1 public-private mix (1%), and 2 non-profit/NGO institutions (2%). Half of the US respondents belonged to public (55%) and the rest to private (44%) institutions. The majority (79%) of the respondents from SSA were affiliated with public institutions. Figure 2.

Figure 2: Distribution of Respondents, by Institution Type
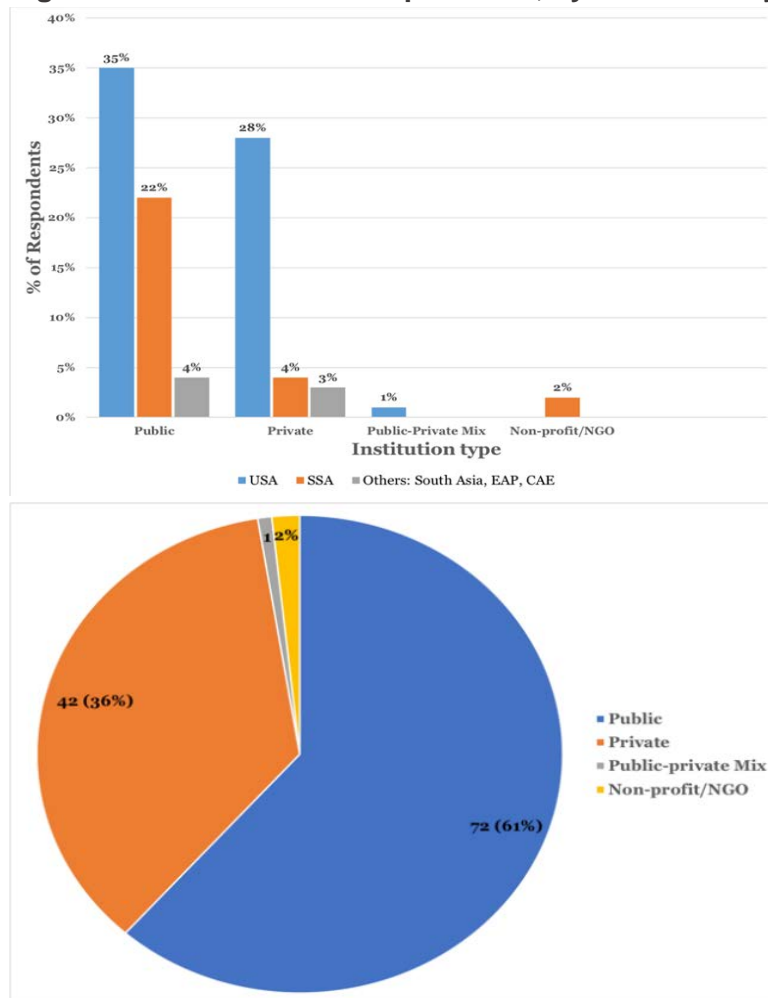
Findings by discipline

Respondents have equal representation from the Medicine and Public Health/Community Health (PH/CH) disciplines with 46 (39%) each. Eight (7%) respondents represented Nursing, and 3 (3%) Pharmacy, whereas 11 (9%) represented other faculties (dental, humanities, interdisciplinary). Among the 75 US respondents, 44% represented the medical discipline, 35% PH/CH, 7% Nursing, and 4% Pharmacy. Out of 33 SSA respondents, 50% were PH/CH, 29% Medicine, and 11% Nursing. Most Asian region respondents were from PH/CH (38%) and Medicine (38%).

Figure 3: Distribution of Respondents, by Discipline
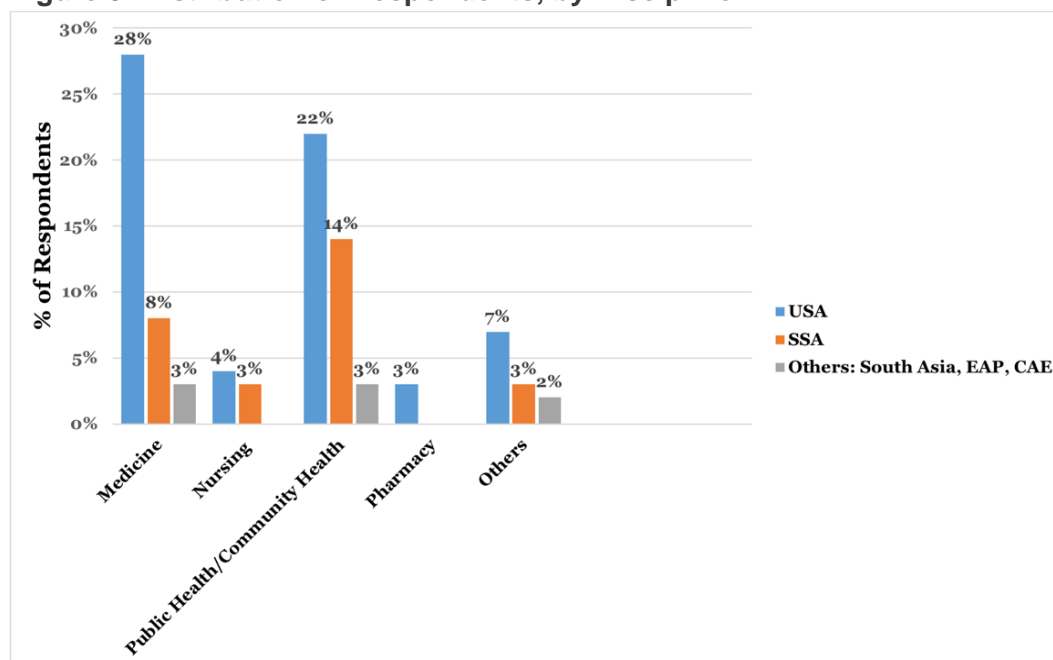
Findings by title or position

Of all respondents, 48 (41%) were educators (Faculty, Professor, Associate & Assistant Professor, lecturer, and teachers), 36 (31%) were administrators at the Director, Dean or Executive level, 24 (20%) were programmatic staff (including researchers), and 9 (8%) identified as others. The US respondents included 40% educators, 38% Director, Dean or Executive, and 18% at programmatic staff. In SSA, 48% were educators, 18% were Director, Dean or Executive, 24% programmatic staff, and 9% were in the "other" category. In Asia, most of the respondents were educators (33%), programmatic staff (33%), or administrators at the Director, Dean or Executive level (22%).

Table 1: Distribution of Respondents by Title/Position (n=117)

Title/Position	United States	Sub-Saharan Africa	Others (SA, EAP, CAE)
Educators (Faculty/Professor/Associate& Assistant Professor/Lecturer /Teacher)	29 (39%)	16 (48%)	3 (33%)
Director, Dean and Executive	28 (37%)	6 (18%)	2 (22%)
Programmatic staff (including researchers)	13 (17%)	8 (24%)	3 (33%)
Others	5 (7%)	3 (9%)	1 (11%)

Types of Global Health Activities

Overall findings

Of the 117 respondents (US and LMICs together), the majority reported being engaged in research(93%) and in education(85%). More than half of the respondents (54%) were engaged in community/outreach programs. Engagement in clinical service and advocacy constituted 52 (44%) and 46 (39%) respondents, respectively. Taken together, other activities such as policy, operations, Institutional Review Board/Research Ethics Committee (IRB/REC), capacity building, collaboration and partnerships were reported by 15 (13%) of the respondents. Table 2.

Findings by US vs LMICs

Comparison between US and LMICs revealed a similar pattern: major GH activities include research, education, community/outreach programs followed by clinical service and advocacy. However, in LMICs, engagement in research and education were less as compared to the US.

Table 2: Distribution of Respondents by the Type of Global Health Activities (n=117)

Type of Global Health Activities	US (n= 75)	LMICs (n=42)	Total (%)
Research	72 (96%)	37 (88%)	109 (93%)
Education	70 (93%)	29 (69%)	99 (85%)
Clinical Service	34(45%)	18(43%)	52(44%)
Advocacy	31 (41%)	15 (36%)	46 (39%)
Community/Outreach programs	39 (52%)	24 (57%)	63 (54%)
Others (Specify)	11 (15%) (one each in policy, operations, assessment, humanitarian, strategy, consulting, IRB/REC, GH, capacity building, partnership	4 (9.5%) (one each in policy, organization, teaching, and collaboration	15 (13%)

Findings by Region

Regional comparisons among respondents from the US and SSA show that research and education were the most common GH activities. It is difficult to comment on results from SA, EAP and CAE due to the very small number of respondents from these regions.

Table 3: Distribution of Respondents by Type of GH Activities, by Region (n=117)

Type of Global Health Activity	USA (n=75)	SSA (n=33)	SA (n=6)	EAP (n=2)	CAE (n=1)	Total (%)
Research	72 (96%)	29 (88%)	5 (83%)	2 (100%)	1 (100%)	109 (93%)
Education	70 (93%)	23 (70%)	4 (67%)	1 (50%)	1 (100%)	99 (85%)
Clinical Service	34 (45%)	17 (52%)	-	-	1 (100%)	52 (44%)
Advocacy	31 (41%)	11 (33%)	2 (33%)	1 (50%)	1 (100%)	46 (39%)
Community/Outreach programs	39 (52%)	19 (58%)	3 (50%)	1 (50%)	1 (100%)	63 (54%)
Others (specify)	11	3 (policy, organization, teaching)	1 (collab-oration)	-	-	15 (13%)

Departmental Engagement in Global Health Activities

Overall findings

Respondents were requested to describe the degree of GH engagement within their respective departments. Options provided in the survey were: only one person (the respondent) in the department is engaged in GH work, a few people in the department, about half, most people, or everyone in the department is engaged in GH activities. The results are presented in Figure 4 and Table 4.

Figure 4: Distribution of Departmental Staff Engaged in GH Activities (n=117)
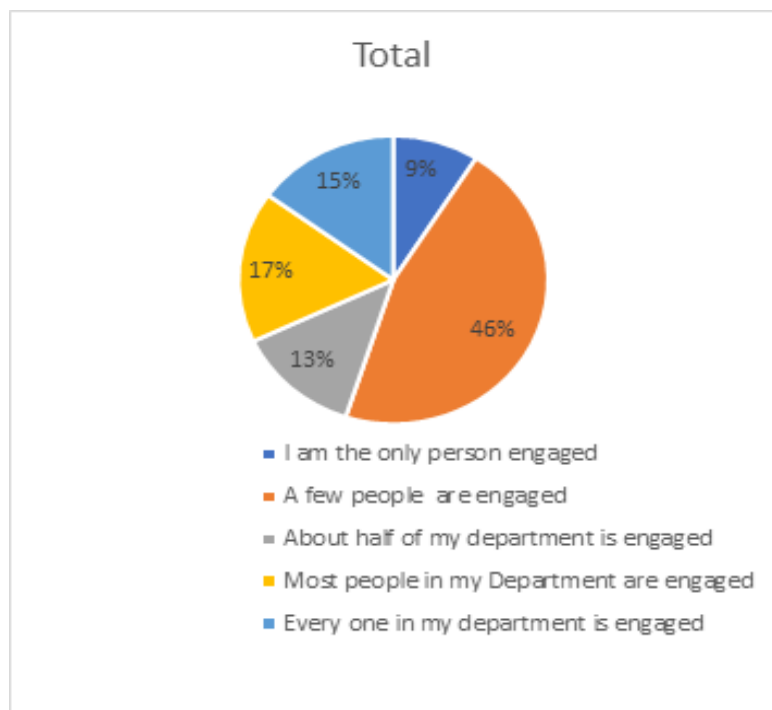
Findings by US vs. LMICs

Respondents from LMICs (14%) more commonly reported that they were the only person engaged in GH in their department, compared to respondents from the US (5%). Figure 5. Seventeen% of the US respondents reported GH engagement by everyone in their respective departments, as compared to 10% of LMIC respondents. More than half (56%) of the US respondents reported that their departments engage few people in GH activities, compared to a little less than one third (31%) in LMICs.

Figure 5: Departmental Staff Involvement in GH Activities, US vs. LMICs (US= 75; LMICs= 42)

USA

- I am the only person engaged
- A few people are engaged
- About half of my department is engaged
- Most people in my Department are engaged
- Every one in my department is engaged

LMICs

- I am the only person engaged
- A few people are engaged
- About half of my department is engaged
- Most people in my Department are engaged
- Every one in my department is engaged
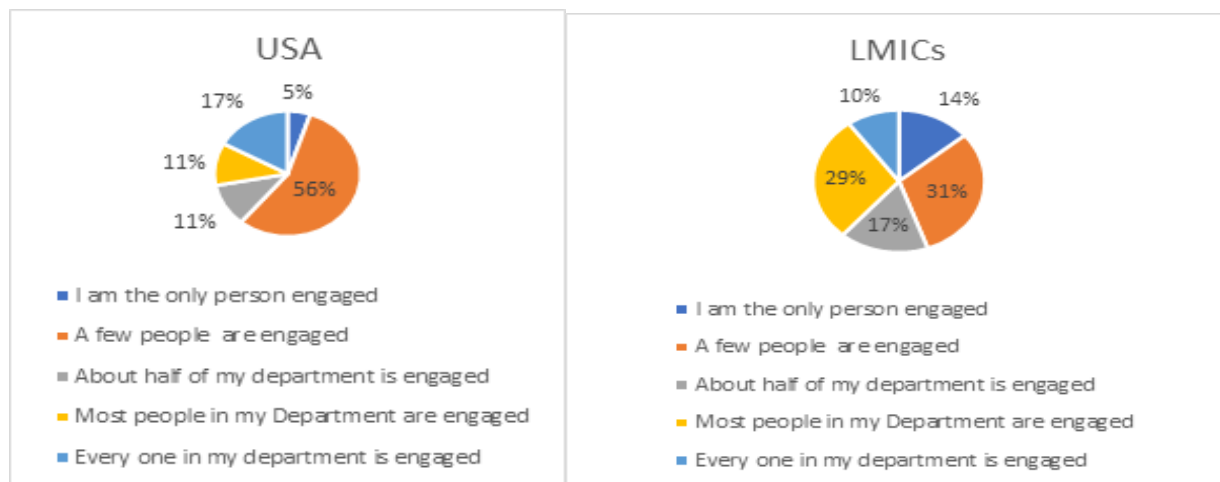
Findings by Region

The regional distribution of staff involvement in GH activities, as reported by respondents, is provided in Table 4.

Table 4: Distribution of Departmental Staff Involvement in GH, by Region (n=117)

Extent of Departmental Engagement in Global Health	USA	SSA	SA	EAP	CAE	Total (%)
Only one person in the Department engaged	4 (5%)	4 (12%)	1 (16%)	1 (50%)	-	10 (9%)
A few people in the Department engaged	42 (56%)	11 (33%)	2 (33%)	-	-	55 (47%)
About half in the Department engaged	8 (11%)	5 (15%)	1 (16%)	1 (50%)	-	15 (13%)
Most in the Department engaged	8 (11%)	10 (30%)	1 (16%)	-	1 (100%)	20 (17%)
Everyone in the Department engaged	13 (17%)	3 (9%)	1 (16%)	-	-	17 (15%)
Total	75 (100%)	33 (100%)	6 (100%)	2 (100%)	1 (100%)	117

Priority Areas for Strengthening Global Health Programs/Activities

Overall findings

The top four areas identified by all respondents as priorities for strengthening GH programs/activities are **education**, **partnerships/collaboration**, **funding**, and **research**. (Figure 6.) Respondents from PH/CH reported **GH technical areas** as priorities which included women's health, environmental health, mental health, maternal and child health, global health governance, policy analysis, nutrition, global health security, non-communicable disease, congenital anomalies, vaccinations, emergency management, malaria, tuberculosis, and other infectious diseases. Additional priority areas from US respondents include **governance** and **human resources**; governance is inclusive of leadership, institutional buy-in and institutional coordination, whereas human resources may indicate needs for dedicated staff and protected time.

Findings by Discipline

The top three priority areas in medical disciplines, are **funding** (20%), **partnerships/collaboration** (19%) and **education** (17%). Respondents from the field of Nursing reported **education** (25%) as the top priority area, whereas **GH technical areas**, **funding**, and **partnerships/collaboration** (13%, each) were tied for second place. Those from the PH/CH discipline reported **partnerships/collaboration** (17%), **education** (15%), and **funding** and **GH technical areas** (13%, each) as their top priority areas.

Figure 6: Key Priority Areas, by Discipline
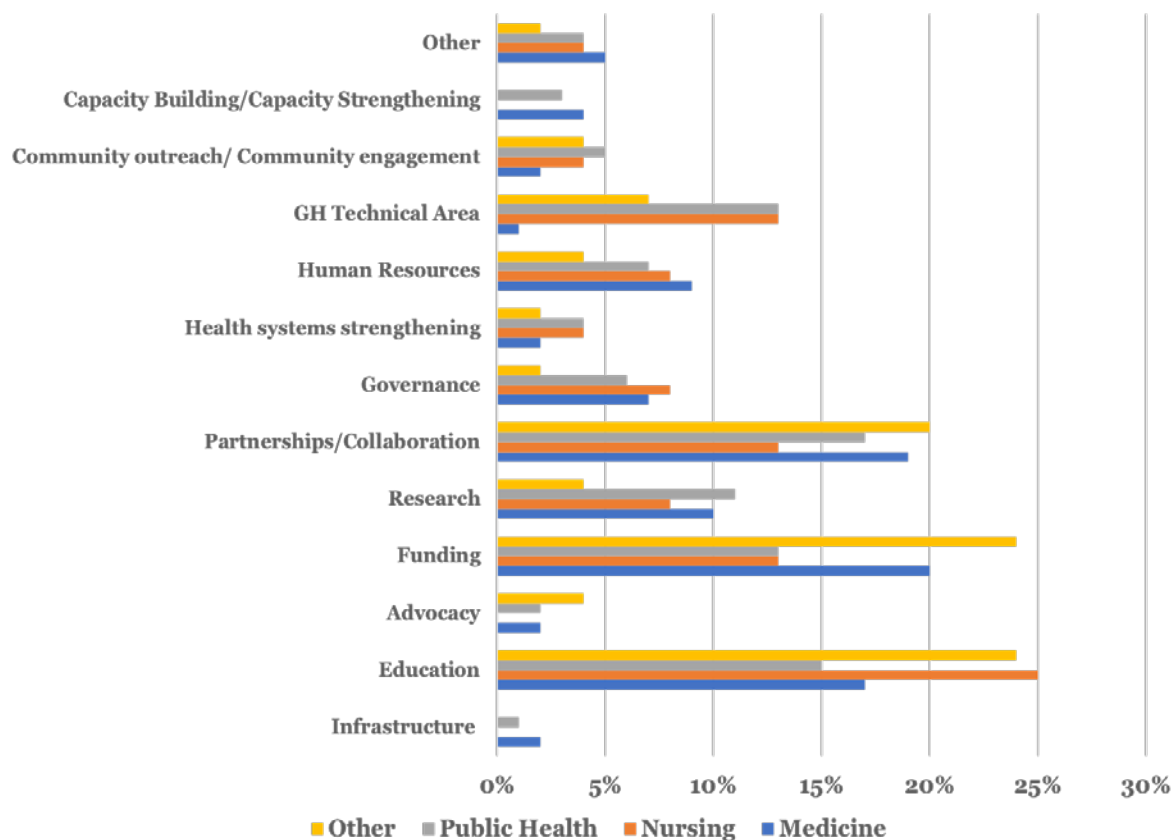
Findings by US vs LMICs

Top priority areas from US institutions are **funding** (24%), **partnerships/collaboration** (21%), and **education** (17%), followed by **governance** (9%), and **human resources** (9%). LMIC institutions reported **education** (20%), **research** (16%), and **partnerships/collaboration** (14%) as their top three priority areas, followed by **GH technical areas** (13%). **Infrastructure** and **advocacy** were reported as the two lowest priority areas for respondents from both the US and LMIC institutions. The comparison of key priority areas between the US and LMICs is presented in Figure 7.

Figure 7: Key Priority Areas, US vs. LMICs
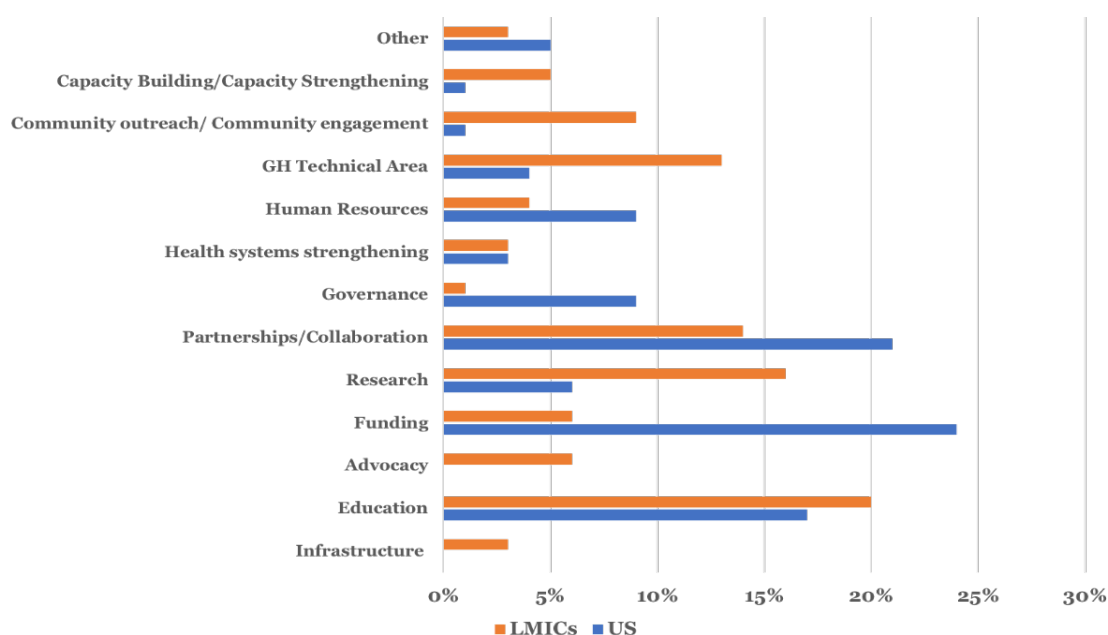
Findings by Region

Top three priority areas from SSA respondents are **education** (18%), **research** (16%), **partnerships/collaboration** (14%) followed by **community outreach/community engagement** (11%). The lowest priority areas from SSA are **capacity building/capacity strengthening**, **governance**, **health systems strengthening** and **infrastructure**. Top three priority areas for US respondents are **funding** (24%), **partnerships/collaboration** (21%) and e**ducation** (17%). Given that there were less than 10 respondents from SA, CAE and EAP combined, we are not able to comment about priority needs in those regions.

Figure 8: Key Priority Areas by Region, US vs. SSA
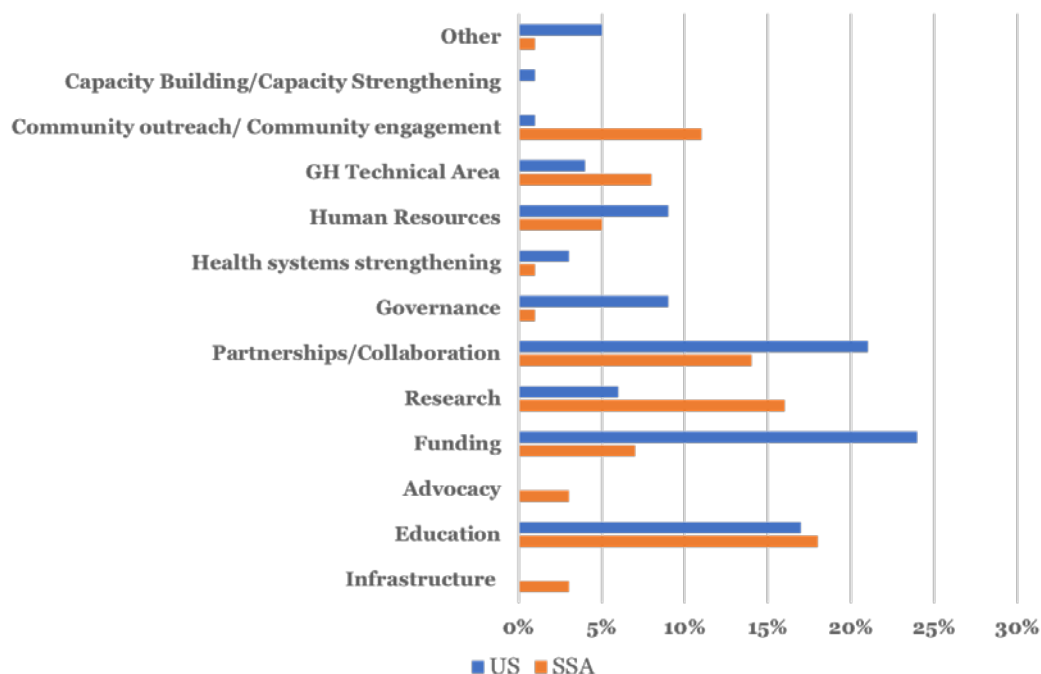
Findings by Institution Type (Public/Private)

Respondents from both US and LMIC private institutions reported their top priority capacity building needs were **education** and **partnerships/collaboration** (21%, each) and **funding** (20%). Whereas, respondents from both US and LMIC public institutions found **education**, **funding,** and **partnerships/collaboration** equally high priorities. (16% each). Figure 9.

Respondents from US private institutions reported **education** (22%) as their top priority and US public institutions reported **funding** (27%) as their top priority. Other priorities for US private institutions are **funding**, and **partnerships/collaboration** (21% each). Respondents from LMIC private institutions reported **partnerships/collaboration** (22%) as their first priority area, **education**, **funding** (17% each), and **advocacy** (11%) also priority areas. Figure 10.

The highest priority needs for respondents from LMIC and US public institutions are **education** (22%) and **funding** (27%). with other top priority areas being **research** (18%), **GH technical areas** (15%), and **partnerships/collaboration** (13%). Additional top priority areas for respondents from US public institutions were **partnerships/collaboration** (18%), as well as **education** and **governance** (13%, each).

Figure 9: Key Priority Areas, by Institution Type (Public/Private)
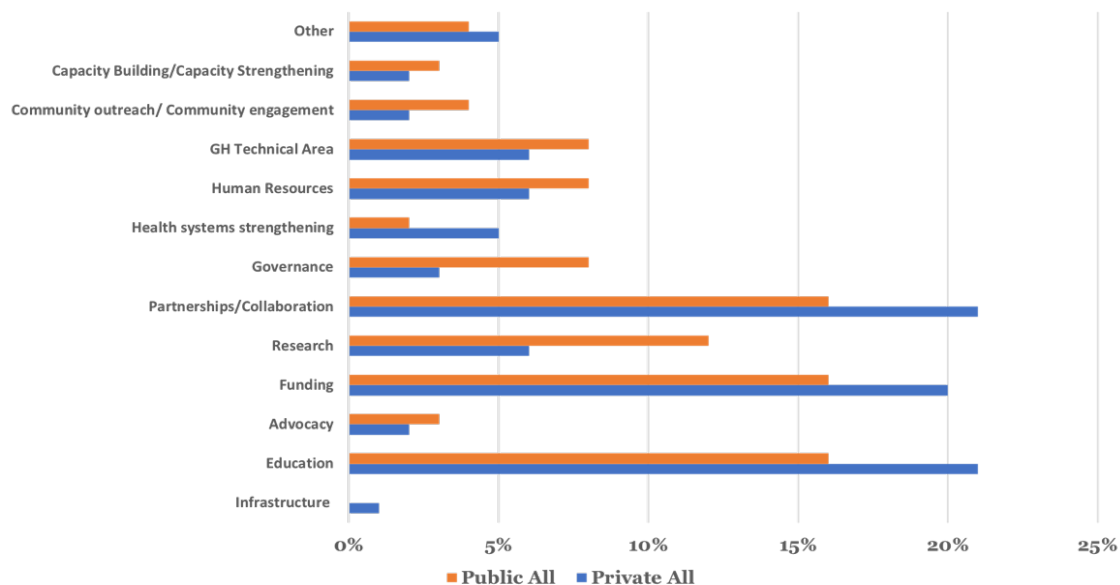
Figure 10: Comparison of Key Priority Areas, by Region and Institution Type

Priority areas, US/Private vs US/Public

■ US and Private   ■ US and Public

Priority areas, LMICs Private vs LMICs Public

■ All LMICs Private   ■ All LMICs Public
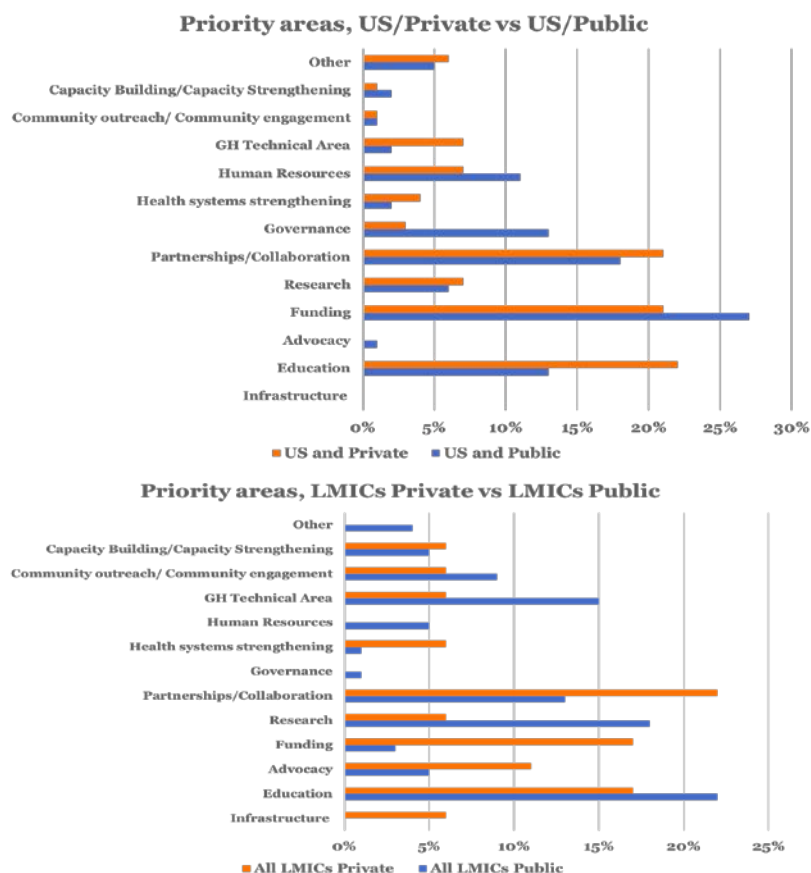
Individual Needs to Meet Identified Priorities for Strengthening Global Health Programs/Activities

Overall findings

The following findings refer to the open-ended responses and the analysis of the responses. The questions were: "If you could strengthen the global health program/activities you are engaged in, what would your top three priorities be (ranked in order of priority)?" and "For your identified priorities, what do you or your colleagues need? (For example, think in terms of resources, workforce, structures, skills, tools.)". When offered the opportunity to provide open ended responses, survey participants identified several areas of need that would help meet the respondents previously identified priorities for capacity building. These responses were categorized broadly into 11 themes (in descending order of percentages as reported). Table 5.

Table 5: Individual Needs to Meet Identified Priorities

Themes	Description
Funding (55%)	General funding and specific funding such as faculty seed grants for short-term projects, programmatic funding, travel grants, awards, personnel hire and salary, student scholarships, fellowships, sustainable funding for research and expansion of funding sources
Infrastructure (41%)	Material resources (such as buildings, equipment, logistics), space, internet access and other communication tools for partnership, toolkits, structures, guidelines and programs, and standards
Workforce (26%)	Healthcare providers, preceptors, administrative and support staff, additional faculty, researchers, and those skilled in research and database management
Partnerships (17%)	A range of collaboration practices from cross-disciplinary networking, joint grant applications and short consultations to student/professional exchanges and international collaboration for global health research and innovation
Training (15%)	Capacity building of existing and new cadres on grant writing, global health research and leadership, continuing professional development, etc.
Education (12%)	Teaching/learning platforms such as symposia, immersion opportunities, etc., as well as learning opportunities for students and faculties, overall academic systems, mentoring, curriculum development support, and support with Appointments, Promotion and Tenure (APT) related to global health scholarship, etc.

Leadership support (12%)	Institutional will and support for global health research, scholarship and teaching
Skills (12%)	General scientific and specific skill development such as grant/proposal writing skills, career development skills, networking/partnering skills, and lobbying skills
Protected time (10%)	Dedicated protected time away from clinical duties, and flexibility to develop global health as an academic specialty
Research (8%)	Collaborative research projects and IRBs, access to non-OA resources, conference visibility, and research capacity enhancement
Miscellaneous (4%)	Marketing, endorsement, political will, etc.

Findings by US vs LMICs

The respondents from US institutions identified **funding** (68%), **infrastructure** (35%), **workforce** (25%), and **leadership support** (17%) and LMIC respondents identified **infrastructure** (52%), **funding** (31%), **training** (29%), and **workforce** (26%) as priorities for support. Additionally, areas in which US respondents require support are identified as **leadership support** and **marketing** whereas **training** and **skills development** are predominantly identified by LMIC respondents. Figure 11.

Figure 11: Individual Needs, US vs. LMICs
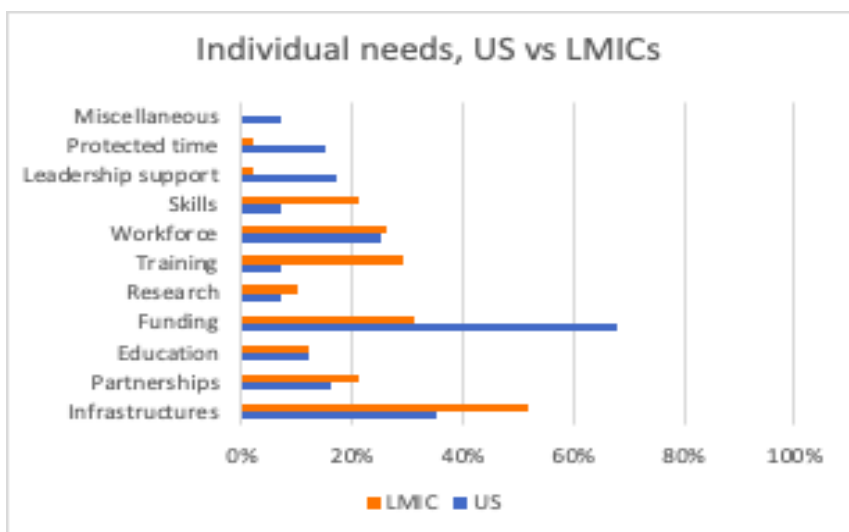
Findings by Region

The top three needs identified by respondents from US institutions are **funding** (68%), **infrastructure** (35%), and **workforce** (25%). For respondents from SSA, the top needs identified are **funding** (58%), **infrastructure** (58%), and **workforce** (30%). As noted previously, there were less than 10 respondents in total from SA, CAE and EAP; thus, the figure presents only the data based on US and SSA respondents.[1] Figure 12.

Figure 12: Individual Needs, US vs. SSA
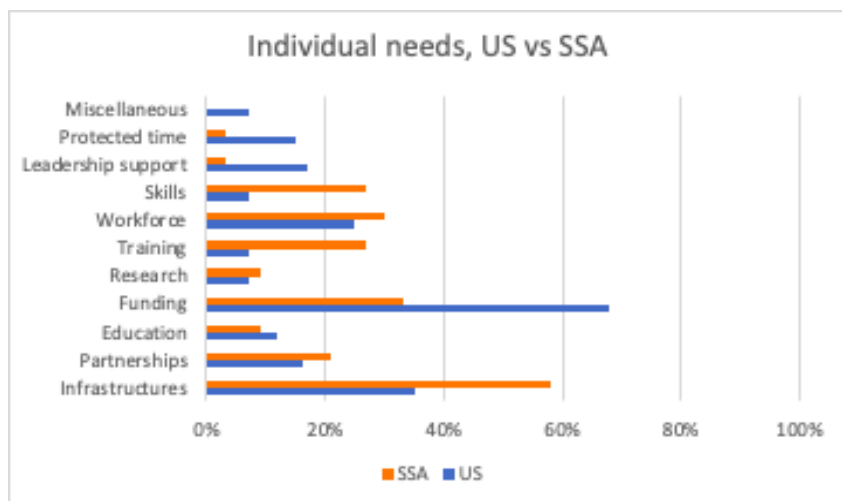
Findings by Institution Type (Public/Private)

Top three priorities identified by individuals from public institutions were **infrastructure** (47%), **funding** (46%), and **workforce** (29%), and from private institutions were **funding** (71%), and **infrastructure** and **partnerships** were tied for second place (29%, each). Figure 13. As there were less than 5 responses combined from individuals affiliated with non-profit institutions and public-private partnership institutions, these data are not presented in the figure. [2] While **funding**, **partnerships**, and **research** were predominantly identified as needs by individuals from private institutions, **infrastructure** and **skills development** were predominantly identified as the priority needs by individuals from public institutions.

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[1] For the 6 respondents from SA, the identified priority areas are **funding**, **infrastructure**, **training**, **partnerships**, and **education**. Amongst the 2 respondents from EAP, the top priority areas were **infrastructure**, **partnerships**, and **education**. And for the 1 respondent from CAE, the top priority areas were **training** and **research**.

[2] Although not presented in the figure, the two respondents from LMIC non-profit institutions identified key needs in the areas of: partnerships, funding, infrastructure, training, education and research. With respect to the one individual who identified that they were from an LMIC public-private mix institution, the priority needs are infrastructure, education and protected time.

Figure 13: Individual needs, by Institution Type (Public/Private)

Individual needs, public vs private
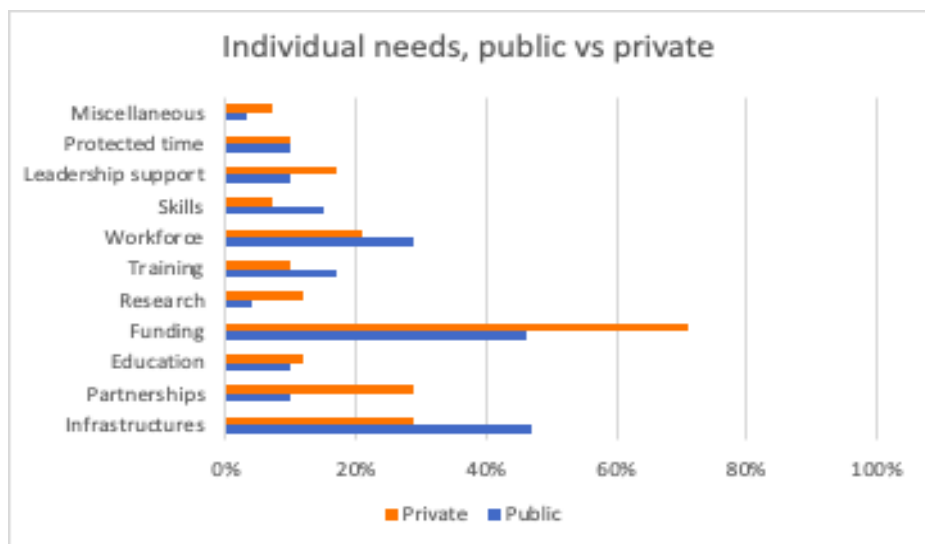
Findings by Discipline

The top three areas of need identified by respondents in the medical disciplines included **funding** (51%), **infrastructure** (40%), and **workforce** (26%). Those involved in the PH/CH field also identified **funding** (64%), **infrastructure** (48%), and **workforce** (28%), as their top three areas of need, as did those in the combined group of other disciplines: **funding** (53%), **infrastructure** (38%), and **workforce** (24%). While skills development was identified as a need predominantly in PH/CH, protected time was identified as important from both PH/CH and the medical disciplines.

Figure 14: Individual needs, by Discipline

Individual needs, by discipline
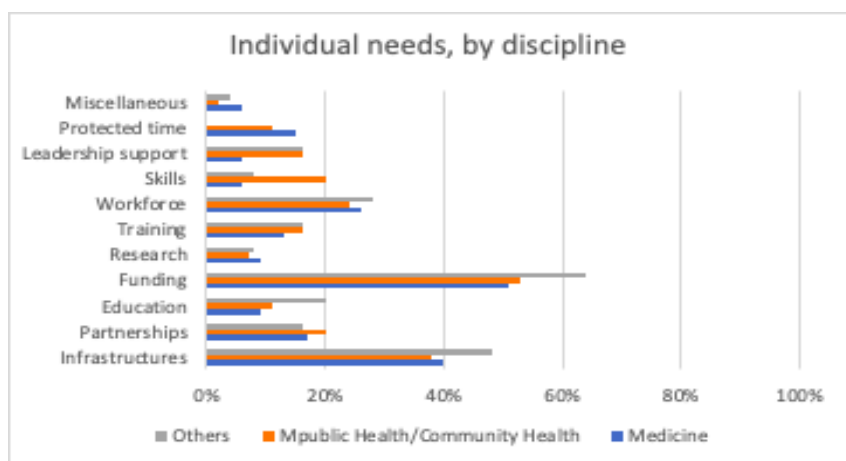
Main Constraints to Meet the Identified Priorities/Needs for Strengthening Global Health Programs/Activities

Overall findings

The following findings refer to the open-ended responses in the survey and the analysis of responses to the question: "From your perspective, what have been the main constraints to address the three priorities/needs [that you] identified above? (For example, lack of funding opportunities, time, etc.)." These responses were categorized broadly into 11 themes (presented in Figure 15). The majority (75%) of respondents reported **lack of funding opportunities** as the chief constraint, followed by **lack of dedicated time for GH activities** (25%), and **unsatisfactory institutional leadership** (13%). Some respondents reported the **lack of administrative skills and support** (7%), **inadequate opportunities for capacity building** (6%), and the **lack of standard models or tool kits for partnership development** (5%). Figure 15.

Other constraints (17%) included: bureaucratic obstacles and the lack of political will (particularly noted by respondents from US institutions), poor governance in LMICs, lack of partnering organizations, lack of knowledge exchange, lack of incentives for GH actors, lack of donor interest in non-communicable diseases, tough IRB/accreditation rules, and technical issues such as poor internet and GH travel-related visa issues (especially noted by LMIC respondents). Nearly one-tenth of respondents reported the lack of recognition of GH programs, lack of collaborative attitude among key stakeholders within their own institutions, and the lack of staff who are trained in GH.

Figure 15: Constraints to Meet the Identified Priorities
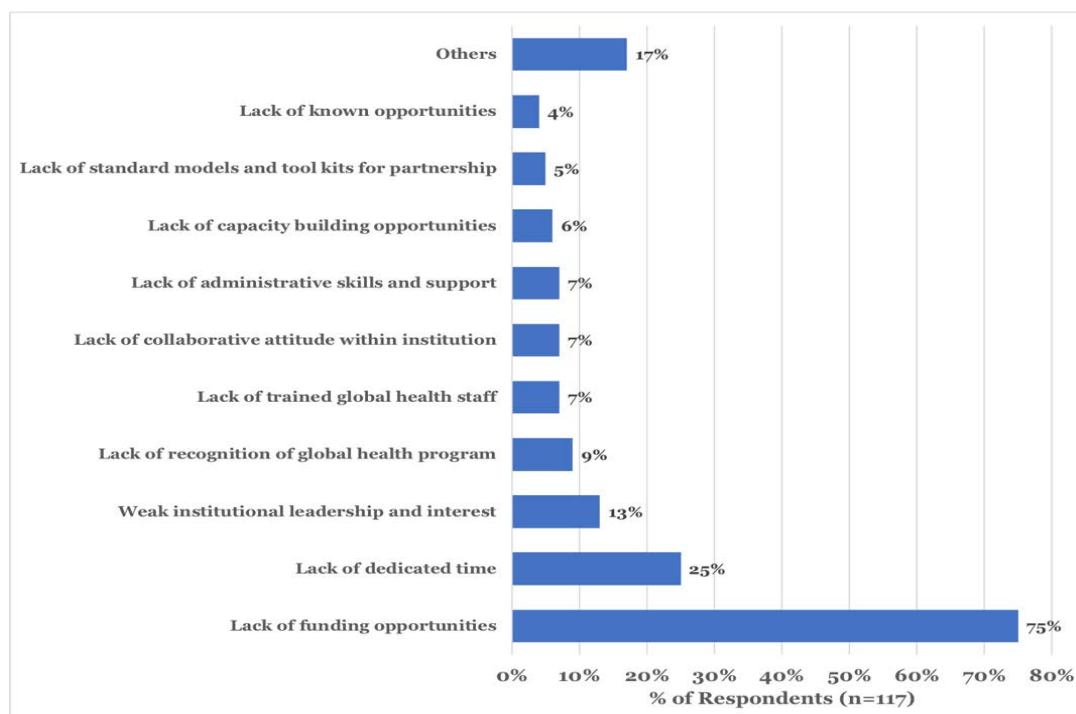
Findings by Region

The four most common constraints to meet GH strengthening priorities, as reported by respondents from US institutions, were **lack of funding opportunities** (69%), followed by the **lack of dedicated time** (32%), **lack of recognition of global health activities** (13%), and **weak institutional leadership** (12%). Figure 16. Hindrances specific to the US institutions included tough bureaucracy, lack of political will, and issues with program uptake or sustainability of partnership with LMICs. The obstacles reported by respondents from LMIC institutions included the lack of **funding opportunities** (86%), **weak institutional leadership and interest** (14%), and **lack of dedicated time** (12%). Concerns related to "brain drain", technical issues (such as poor internet connectivity) and lack of capacity building opportunities, were noted to be LMIC-specific.

Figure 16: Constraints to Meet the Identified Priorities, by Region
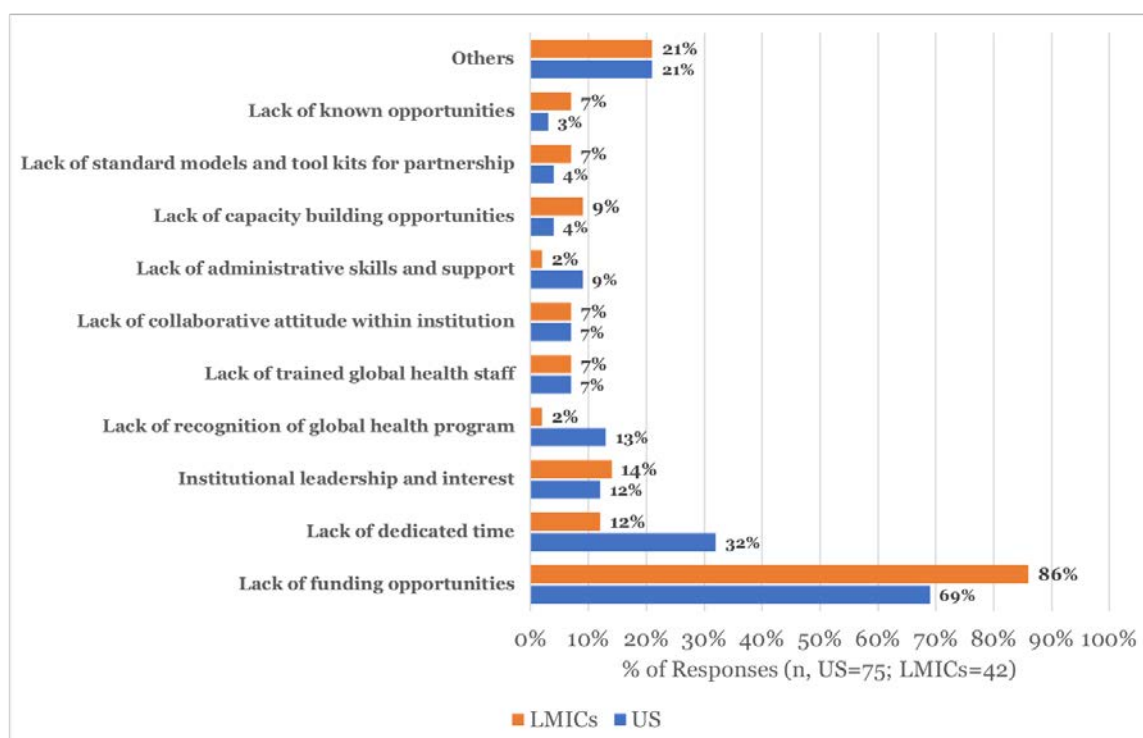
Findings by Institution Type (Public/Private)

Respondents from both private and public institutions (US and LMIC combined) identified that **the lack of funding opportunities** was a significant constraint (reported by 74% and 72%, respectively). Individuals from both types of institutions reported similar concerns about the **lack of dedicated time for GH activities** (24% and 21%, respectively), and the **lack of institutional leadership and interest** (12% each). Figure 17. Respondents from public institutions identified constraints related to the **lack of collaborative attitudes within the institution** (9%), in addition to **inadequate GH staff** (8%). The individuals from private institutions faced a **lack of program recognition** more than those from the public institutions (9% vs. 5%).

Figure 17: Constraints to Meet the Identified Priorities, by Institution type
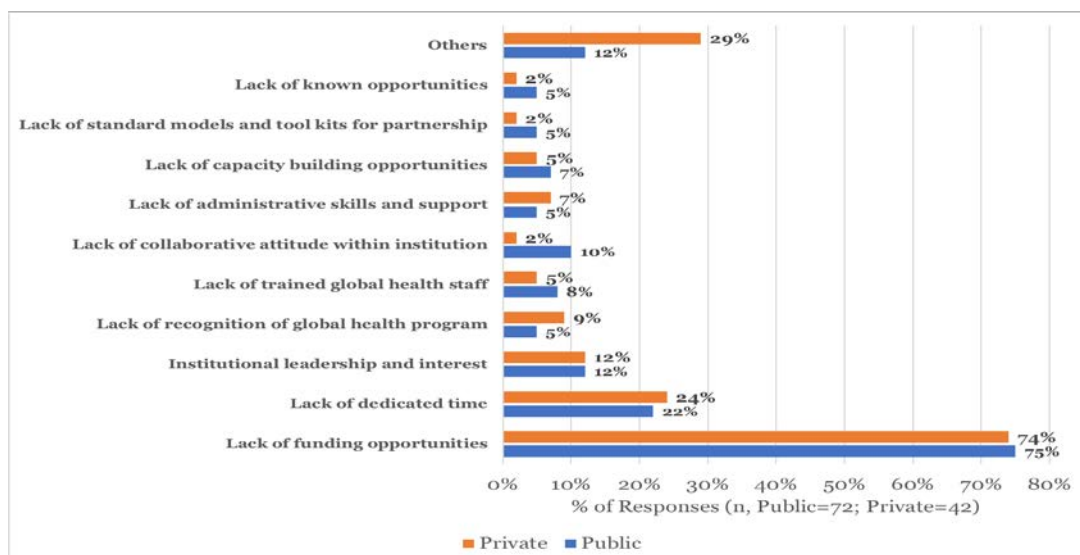
Institutional Needs for Enhancing Capacity to Access US Government Funding Opportunities in Global Health

Respondents were invited to answer the question: "What would be most helpful to your program to enhance its capacity to access U.S. Government development funding opportunities? (For example, USAID.) Select up to three." The answer choices were from the following list:

> **A.** Stronger technical skills to explore, apply to, and manage grant funding opportunities
> **B.** Stronger administrative skills to explore, apply to, and manage grant opportunities
> **C.** Increased number of employees
> **D.** Dedicated time to apply to grant funding opportunities
> **E.** Institutional leadership prioritizing this work
> **F.** Financial resources
> **G.** Needed infrastructure and/or technological resources, for example, reliable Internet
> **H.** A partnering organization
> **I.** Others

Overall findings

The top three areas were **strong technical skills to explore, apply for, and manage grants** (52%), **financial resources** (51%), and **dedicated time to apply for grants** (50%). The least important areas were related to **needed infrastructure and/or technical resources** (19%) and **increased number of employees** (16%).

Figure 18: Institutional Needs for Enhancing Capacity to Access USG Funds
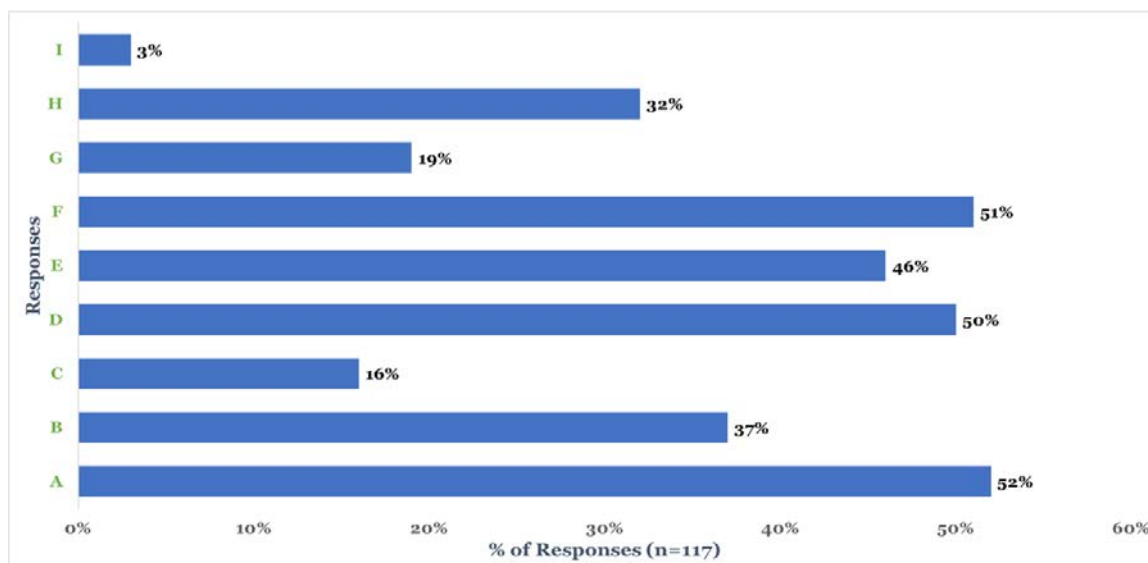
Findings by US vs LMICs

The majority (65%) of respondents from US institutions indicated that they would need **dedicated time to apply for grants** to access USG funds; 52% reported that they would need **financial resources**, and 51% would need **institutional leadership prioritizing this work**. In contrast, the majority (74%) of individuals from LMIC institutions indicated needs for **developing strong technical skills to explore, apply for and manage grants** (74%), and a **partnering organization** (57%), in addition to **financial resources** (55%).

Figure 19: Institutional Needs for Enhancing Capacity to Access USG Funds, by US vs. LMICs
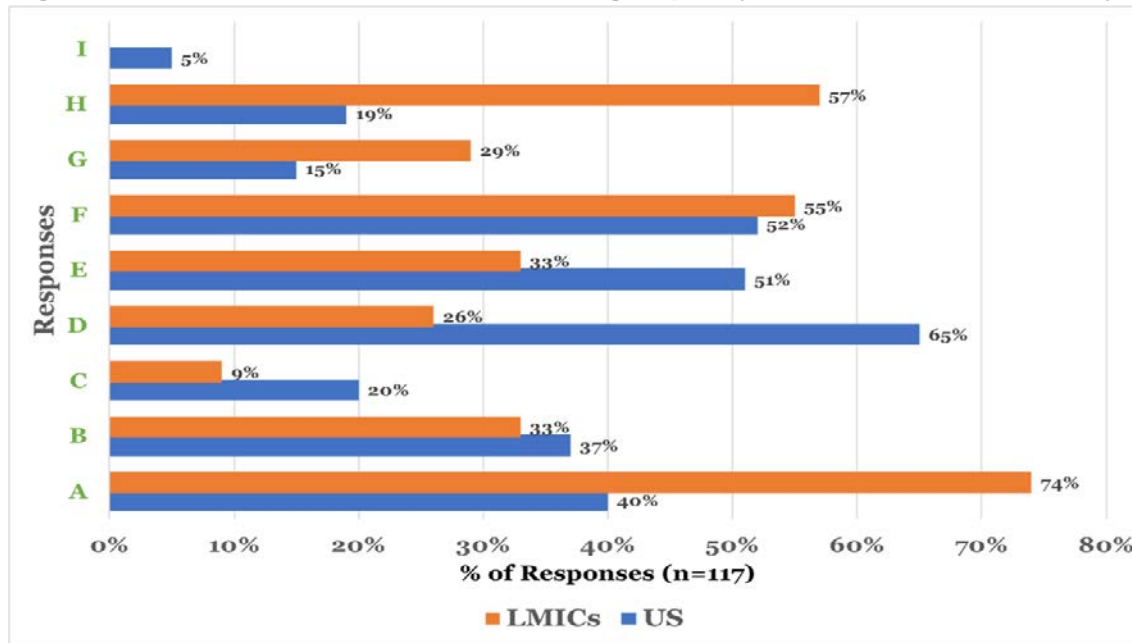
Findings by LMIC regions

The majority of the 33 respondents from SSA (76%) and the 9 respondents from Asian institutions (67%) highlighted the need for **stronger technical skills to explore, apply to, and manage grant funding opportunities** related to USG development funds. Respondents from both SSA and Asian institutions mentioned the need for **financial resources** (58% and 44% respectively) to enhance their fund accessing capacities. On the other hand, only half of respondents from African institutions (51%) vs. most respondents from Asian institutions (78%) felt the need to **partner with other organizations** to access USG funds.

Findings by Public vs. Private

Respondents from the majority of public (53%) and private (55%) institutions (US and LMIC combined) indicated that they would need **stronger technical skills to explore, apply to, and manage grant funding opportunities.** Half of the respondents from public as well as private institutions would need **financial resources** and **dedicated time to apply for grant funding opportunities**.

Figure 20: Institutional Needs for Enhancing Capacity to Access USG Funds, Institution type
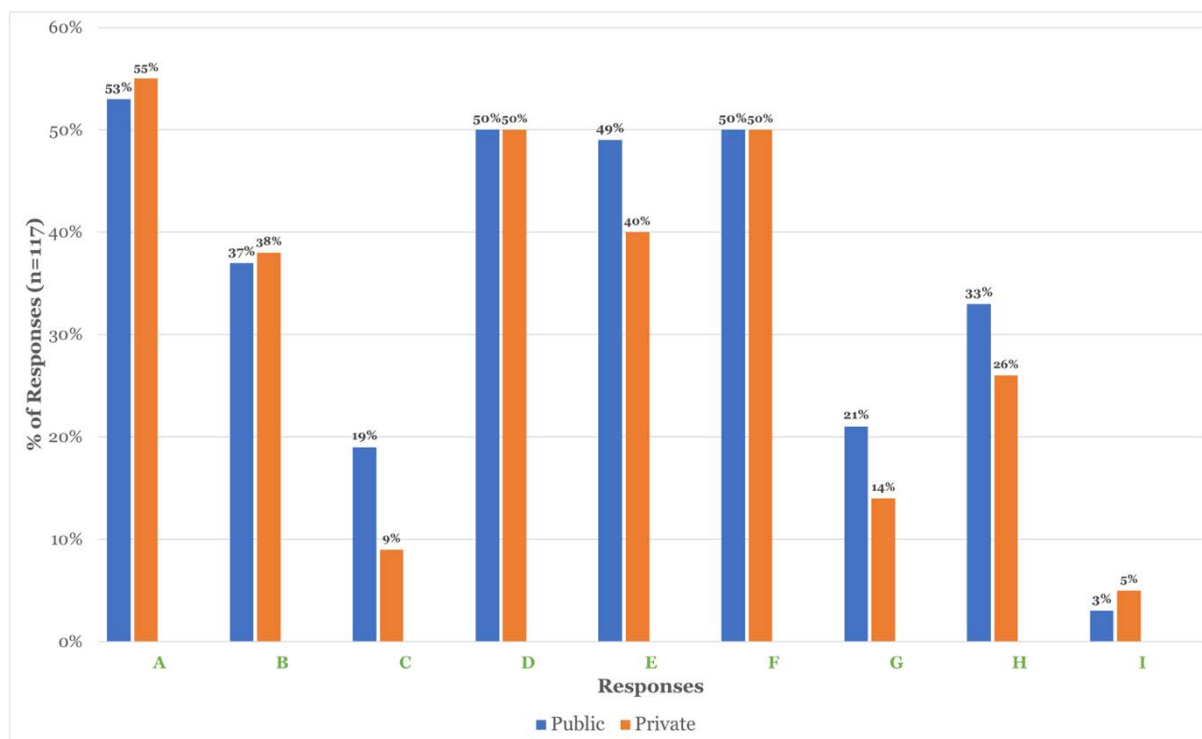
Institutional Needs for Enhancing Capacity to Exchange Knowledge with Other Institutions or Global Health Actors

Respondents were asked: "What would be most helpful to your program to enhance its capacity to exchange knowledge with other institutions/global health actors, regarding global health education and research? (Select up to three)." The answer choices were from the following list:

- **A.** Institutional leadership prioritizing this work
- **B.** Needed infrastructure and/or technological resources
- **C.** Better understanding of best practices for knowledge exchange
- **D.** Information about what spaces exist for open knowledge exchange
- **E.** Dedicated time to engage in knowledge exchange
- **F.** Dedicated staff to make/design products for knowledge exchange
- **G.** Others

Overall findings

The respondents indicated that the three most common requirements would be: **dedicated time to engage in knowledge exchange activity** (60%), **institutional leadership prioritizing this work** (58%), and **dedicated staff to design knowledge exchange tools** (53%). Figure 21.

Figure 21: Institutional Needs for Enhancing Capacity to Exchange Knowledge with Others
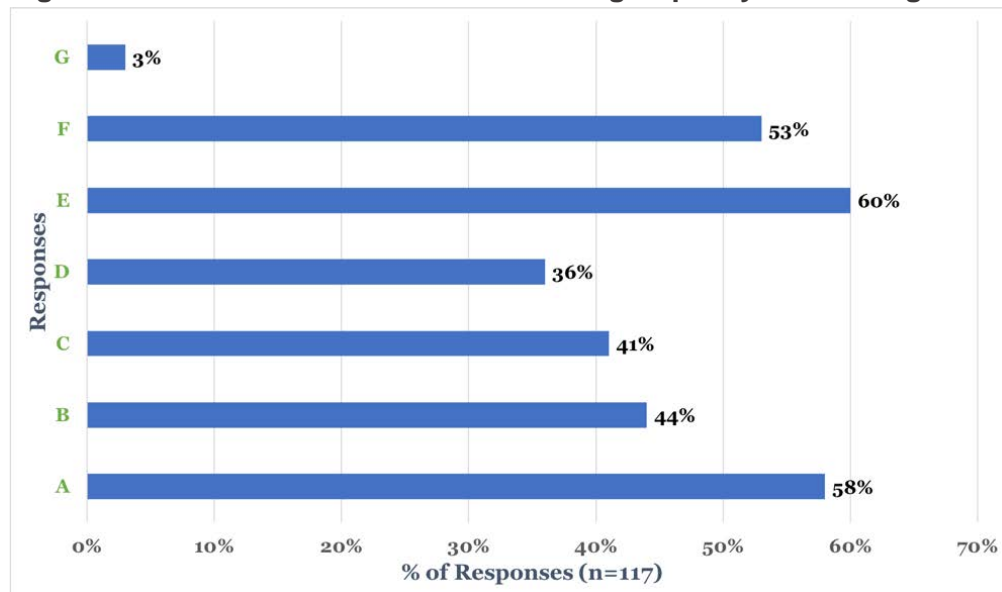
Findings by US vs. LMICs

The most common responses from US institutions were **dedicated time for engagement** (68%), **focused institutional leadership** (67%), and **dedicated staff to make/design products for knowledge exchange** (47%). Respondents from LMIC institutions more frequently prioritized having **dedicated staff to make/design products for knowledge exchange** (59%), **focused institutional leadership** (57%), **better infrastructures and resources** (52%), and **better understanding of knowledge exchange practices** (45%). Figure 22.

Figure 22: Institutional Needs for Enhancing Capacity to Exchange Knowledge, by US vs. LMICs
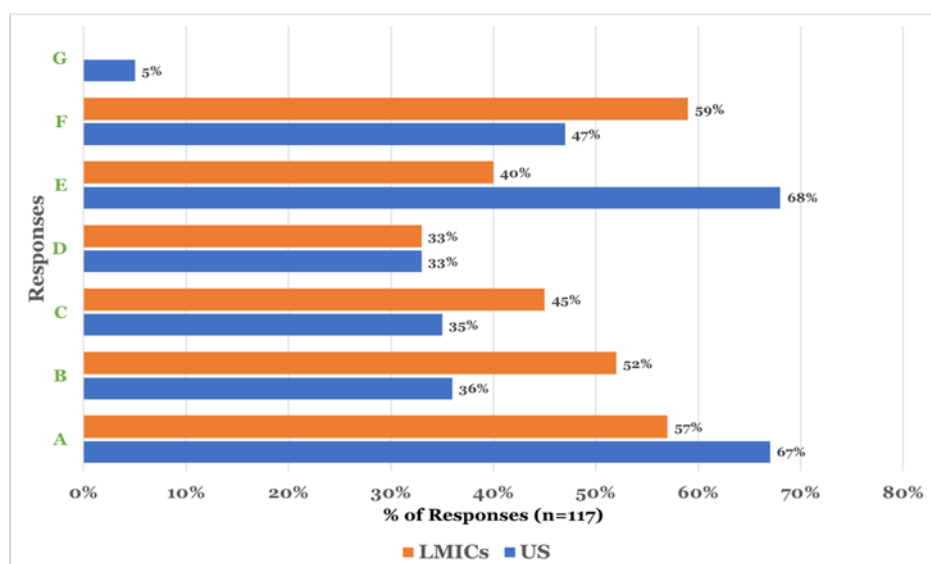
Findings by LMIC regions

Respondents from both SSA and Asian institutions prioritized having **dedicated staff to make/design products for knowledge exchange** (61% vs. 55%, respectively) and **infrastructure or/and technical resources** (51 vs. 55%). As compared to individuals from SSA institutions, respondents from Asian institutions were more likely to prioritize the development of **institutional leadership focused on this work** (54% vs. 67%).

Findings by Private vs. Public

Most respondents from public institutions (US and LMIC combined) prioritized the development of **institutional leadership focused on this work** (64%), **dedicated staff to make/design products for knowledge exchange** (57%), and **dedicated time to engage in knowledge exchange** (47%). For individuals from private institutions, the top priority capacity enhancers **were dedicated time to engage in knowledge exchange** (57%), **institutional leadership prioritizing this work** (50%), **dedicated staff to make/design products for knowledge exchange** (45%), and a **better understanding of best practices for knowledge** exchange (45%). Figure 23.

Figure 23: Institutional Needs for Enhancing Capacity to Exchange Knowledge, by Institution type

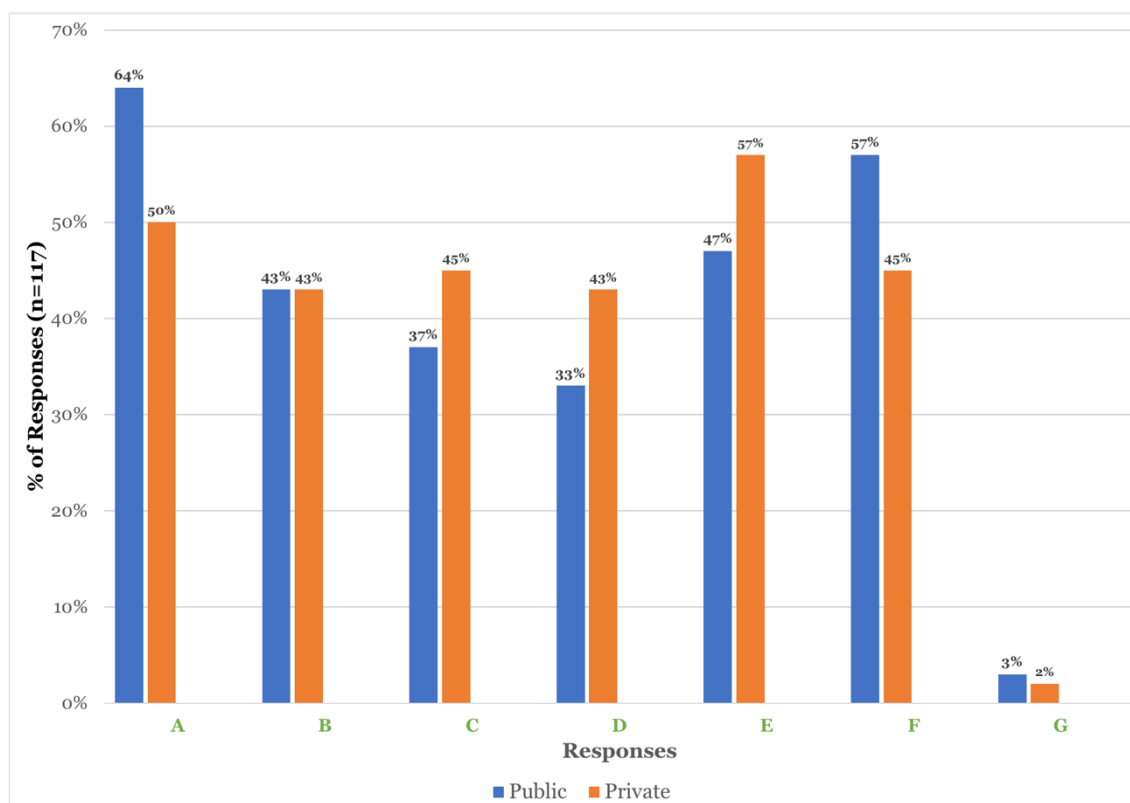# Institutional Needs for Enhancing Capacity to Partner with Other Institutions for Global Health Activities

Respondents were asked: "What would be most helpful to your program to enhance its capacity to partner with other academic institutions? (Select up to three)." The answer choices were from the following list:

      A. Institutional leadership prioritizing this work
      B. Needed infrastructure and/or technological resources
      C. Online networking opportunities to meet potential partners
      D. Funding to attend conferences, workshops, and other in-person networking events
      E. Dedicated time to search for partnership opportunities
      F. Resources to strengthen the technical and administrative skills to support a partnership
      G. Guidelines on best practices for engaging in a global health partnership
      H. Others

Overall findings

The majority (67%) of respondents reported the need for **funding to attend conferences, workshops, and other in-person networking events**. Other respondents prioritized the development of **resources to strengthen technical and administrative skills for supporting partnership** (56%), and **institutional leadership that would prioritize partnership building** (53%). Very few (17%) prioritized the development of **guidelines on best practices for engaging in a global health partnership**. These findings are presented in Figure 24.

Figure 24: Institutional Needs for Enhancing Capacity to Partner with Others
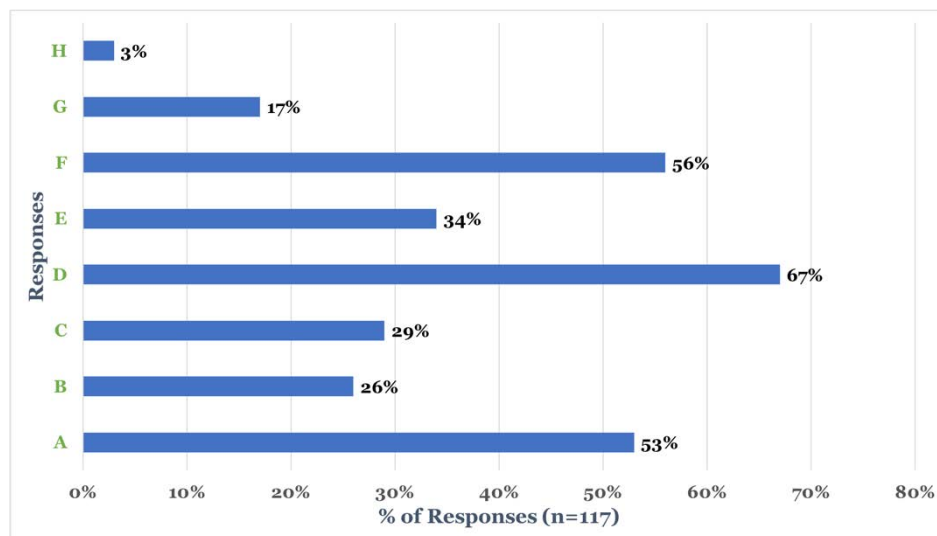
Findings by US vs. LMICs

Funding to attend conferences, workshops, and other in-person networking events was identified as the top priority area that respondents from both US and LMIC institutions would find the most helpful (64% each). Respondents from both regions (53% each) similarly prioritized the development of **resources to strengthen the technical and administrative skills to support a partnership**. Lastly, respondents from US institutions were more likely than those fro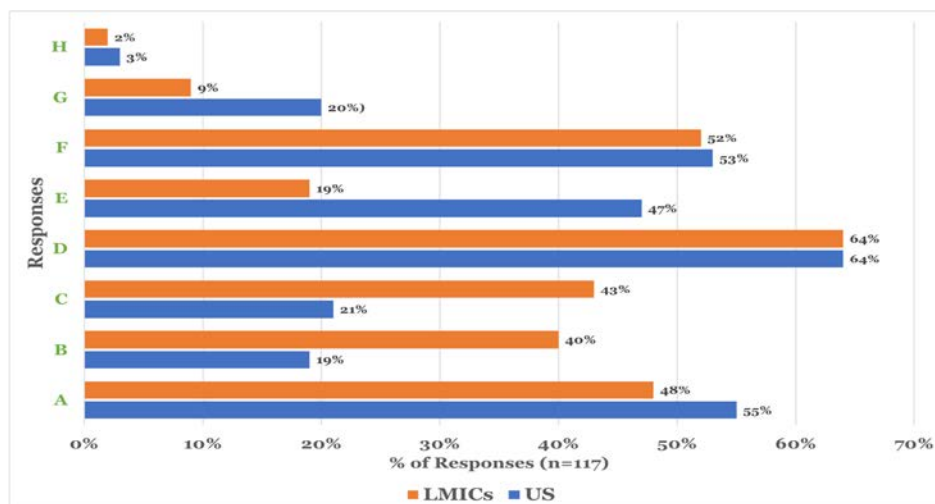m LMIC institutions to prioritize the development of **institutional leadership prioritizing this work** (55% vs. 48%). The findings are presented in Figure 25.

Figure 25: Institutional Needs for Enhancing Capacity to Partner with Others, by US vs. LMICs

Findings by LMIC regions

The majority (70%) of the 33 respondents from SSA institutions identified **funding to attend conferences, workshops, and other in-person networking events** as a top priority to enhance their partnership development capabilities. The second most common priority was **resources to strengthen the technical and administrative skills to support a partnership** (54%), and the development of **institutional leadership prioritizing this work** (51%). Among the 9 respondents from Asian institutions, 44% prioritized **funding to attend conferences, workshops, and other in-person networking events.**

Findings by Private vs. Public

Respondents from public and private institutions reported on the importance of **funding to attend conferences, workshops, and other in-person networking events** (69% vs. 64%). Many respondents identified **institutional leadership that prioritizes this work** (57% vs. 50%), and **resources to strengthen technical and administrative skills to support partnership** (55% vs. 57%).

Figure 26: Institutional Needs for Enhancing Capacity to Partner with Others, by Institution type
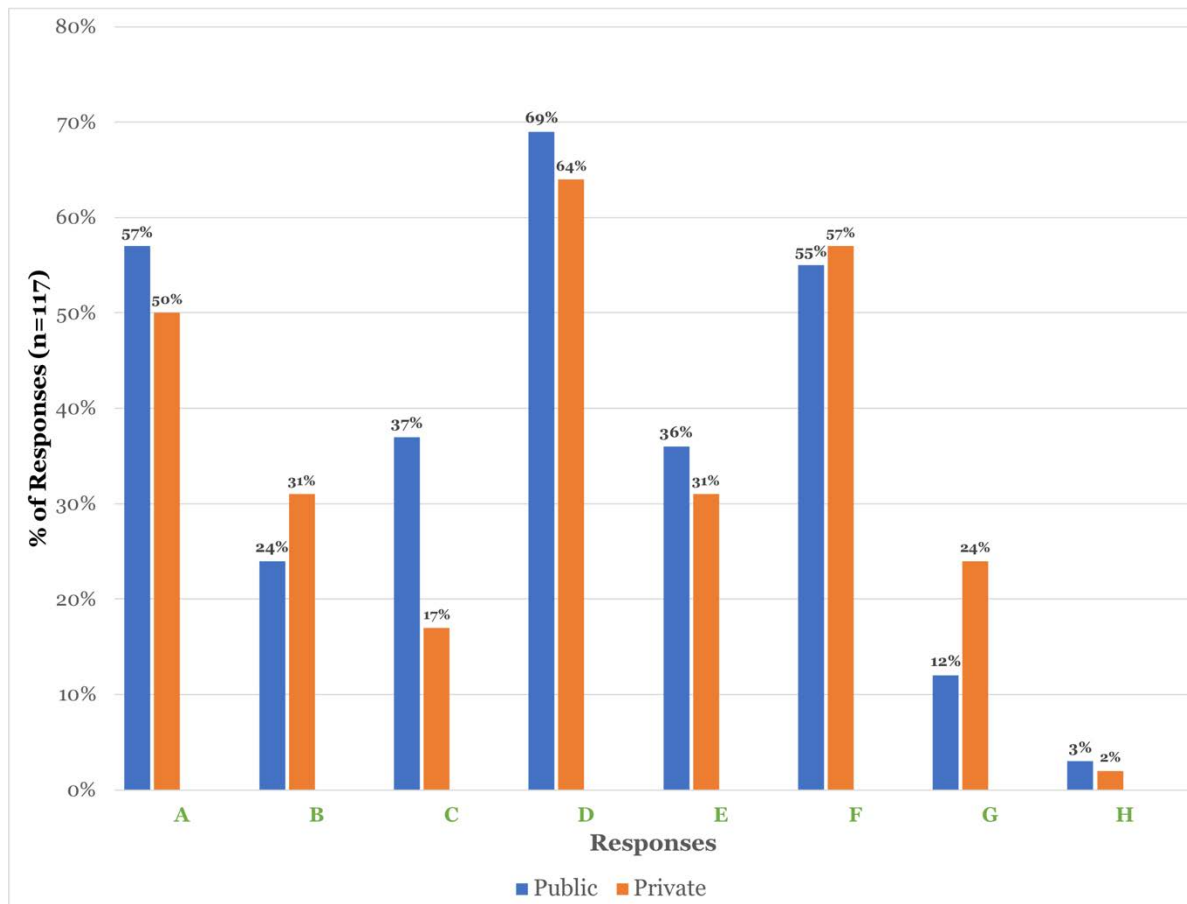
CONCLUSIONS

The survey respondents (n=117) included US academic institutions (64%), LMIC academic institutions in Sub-Saharan Africa (28%), Asia (8%), with 61% from public and 36% from private institutions. There was equal representation from medical disciplines (inclusive of all physician disciplines) and Public Health/Community Health respondents (39% each). Among the respondents, 41% self-identified as educators, 31% identified as administrators at the Director, Dean or Executive level, and 20% identified as programmatic staff.

Q1 -- Among both US and LMIC respondents, most worked in the research (93%) and education (85%) sectors. About half (54%) engaged in clinical and community/outreach programs, 44% in clinical service, and 39% in advocacy.

Q2 -- In both the US (56%) and LMICs (31%), it was more typical for only a few people in the respondents' department to be engaged in Global Health activities, though more LMIC (39%) than US departments (28%) had most people or everyone engaged, a finding that may be reflected in the resiliency expressed by LMIC respondents in later questions.

Q3 -- For strengthening global health programs/activities, respondents' top four priority areas were education (especially for those from LMICs), partnerships/collaboration, funding, and research. Governance and human resources were also identified as high priorities by respondents from US institutions. The highest priority areas reported by respondents in medicine were funding (20%), partnerships/collaboration (19%) and education (17%); PH/CH respondents reported their highest priority areas to be partnerships/collaboration (17%), education (15%), funding (13%), and GH technical areas (13%), with a considerable list of topic-based technical areas identified that need assistance.

U.S. respondents were four times as likely as LMIC respondents to cite funding as a deficiency. The reason for this difference is unclear and would require dedicated qualitative research to further evaluate. One possibility – though not specifically arising from this survey data - is that individuals from LMIC may have less opportunities for access to domestic or international funds to support their global health work, and that they may be more accustomed to doing the work without financial support. This interpretation would suggest an opportunity for individuals from LMIC institutions to teach U.S. respondents to engage in global health initiatives without dedicated funding (or specific funding for each component). In relatively resource rich places like the US, where there are often grants available for global health work, one positive result is the creation of many outstanding programs, and much excellent research. But it may also create a culture where only funded/monetized initiatives are likely to happen. Likewise, Public/Community Health respondents (who may be less well funded than those in the Medicine disciplines) were 1/3rd less likely (13% vs 20%) to cite funding as a priority; those in medicine deemed funding to be their highest priority.

Education was among the top three priorities for both LMIC and U.S. respondents. This finding provides a ready model for those discovering funding to be a barrier, through the availability of free, accredited online training in global health.

Q4 – The open-ended responses to the question of needs for support in GH were varied and considerable, with the following themes cited most frequently: funding (55%), infrastructure (41%), education and training (27%), workforce (26%), partnerships (17%), leadership support and skills (12% each), protected time (10%), and research (8%). It is noteworthy that assistance with research capacity is cited as such a low priority by this cohort of respondents; while some clinical and basic science research may have difficulty crossing borders, it is critical that we study and report on the interventions that we create in the name of promoting global health, so that these efforts may proceed with maximum efficacy and beneficence. This may simply reflect some factor related to the professional orientation of the survey respondents, that has not been captured in this survey.

Amongst respondents from both public and private institutions (U.S. and LMIC combined) the two most frequently cited priority areas were infrastructure (47% and 46%, respectively) and funding (29% and 71% respectively). Infrastructure and institutional needs are systemic and transnational, encouraging outcomes research and publications so that each site's interventions can best inform others attempting similar improvements.

As noted from the multiple choice data in Q3, LMIC respondents were less than half as likely as US respondents (31% vs. 68%) to identify funding as a top priority; similarly, training (29%) and workforce development (26%) were identified as the top LMIC needs.

Q5 -- Respondents were asked to report the main constraints to addressing the identified top priorities for strengthening global health programs and activities; most (75%) reported a lack of funding opportunities as among the top three constraints. This is an area where agencies like USAID may play an important role, in providing opportunities to financially support innovative programming in academic. Additionally, the lack of dedicated time for global health activities was reported as the second most common priority area (25%). This issue of protected time is directly related to previous mention of funding concerns, as academic faculty time is accounted for by grant funding, as well as other teaching and institutional service activities; if more opportunities are available for financially supporting academic faculty to engage in global health work, they typically can negotiate to have less time required for engagement in these other activities.

Q6-8 – For these last questions, respondents selected up to 3 priority needs for enhancing their institutional capacity for: access US government development funding opportunities, engaging in knowledge exchange with other institutions and global health actors, and developing partnerships with other institutions.

In question 6 (enhancing institutional capacity to apply for U.S. government development funding opportunities), 65% of U.S. respondents prioritized protected time, 52% prioritized financial resources, and 51% reported that they would benefit from institutional prioritization of this work. In contrast, respondents in LMICs most commonly (74%) sought technical skill enhancement to explore, apply for, and manage grants, along with having access to partnering organizations (57%), and general financial resources (55%).

For question 7 (enhancing institutional capacity for knowledge exchange), the most common needs were dedicated time to engage in knowledge exchange (60% [68% US respondents vs 40% LMIC respondents]), institutional leadership prioritizing this work (58% [US respondents 67% vs LMIC respondents 57%]), and dedicated staff to design knowledge exchange tools (53% [US respondents 47% vs LMIC respondents 59%). The institutional leadership piece, in particular, may be an area in which USAID may be able to engage in advocacy with academic

institutions and work to enhance the understanding and status of global health activities within the administrative leadership.

And finally, regarding question 8, two-thirds (67%) of respondents expressed a particular desire for funds to attend conferences, workshops and other in-person networking events, with more than half also reporting the need for resources to strengthen technical and administrative partnership skills (56%), and institutional prioritization of partnerships (53%). There was little discussion of the desire for alternatives to travel, such as better use of videoconferencing, now being promoted by growing numbers of academicians concerned about the enormous cost, time, and carbon emission consequences of international travel. This presents an opportunity for potential partners and funders to solve part of this problem by transporting people's ideas, typically a more financially, personally, and environmentally sustainable approach than transporting people.

IMPLICATIONS FOR STAR

Through this survey, STAR identified current gaps, constraints, and opportunities that can inform both USAID's and STAR's learning about academic institutions' capacity needs in regards to their global health programming. This information suggests how STAR may be leveraged to strengthen capacity efforts. The results may also be useful to other interested parties, such as global health funders including USAID, non-governmental organizations, and academic institutions involved in capacity strengthening activities.

ANNEX 1: CAPACITY LANDSCAPE SURVEY

Survey Description & Consent

Survey Purpose: Sustaining Technical and Analytic Resources (STAR), a United States Agency for International Development (USAID)-funded project, wants to better understand the capacity needs (for example, workforce, structures, skills, tools) of U.S. and low- and lower-middle-income country (LMIC)-based academic institutions' capacity needs to engage in global health. STAR's Academic Partnerships Team, in partnership with the Consortium of Universities for Global Health (CUGH), aims to increase the capacity of individuals and academic institutions around the world to improve global health practice. The results of this survey will be used to inform STAR programming. The survey should take about 10 to 20 minutes to complete.

Please contact academicpartnerships@ghstar.org if you have any questions to learn more about STAR's Academic Partnerships.

Eligibility Criteria for Survey Respondents: You work for a department, division, or unit engaged in *global health, global public health, and/or global partnerships for health, hereinafter referred to as "global health,"* at an academic institution in the U.S. or a LMIC (low-income and lower-middle-income economies as determined by the World Bank).

Participation: Your participation in this survey is voluntary. All questions are optional, and you may refuse to take part in the research or exit the survey at any time without penalty.

Confidentiality: Your responses will be confidential, and no identifying data will be shared outside the STAR research team, composed of the STAR Academic Partnerships team. Select STAR Committee members, who are affiliated with the CUGH network and will assist with the study analysis, will have temporary access to the data. Only aggregate data will be shared externally through a study and reporting to USAID. No IP address information will be collected.

Your survey answers will be sent to a link at SurveyMonkey.com where data will be stored in a password protected electronic format. At the close of the study, data will be removed from SurveyMonkey and stored offline and securely, accessible only by the Academic Partnerships team, until the end of the STAR Project (expected September 30, 2023) for use by STAR research.

Risk: The study involves minimal risk of informational harms. Information provided by participants, if disclosed and identifiable, could potentially cause reputational damage to programs named by participants, embarrassment, and loss of privacy. These risks are mitigated through data security and rigorous efforts then the planned de-identification of study data in expressing study findings and conclusions.

Benefits: Participants will receive no direct benefits from participating in this research study, but their responses may inform the programming of STAR, USAID, and other global health actors involved in capacity strengthening at academic institutions.

Contact: If you have questions at any time about the study or the procedures, you may contact Ms. Arisa Koyama, STAR Academic Partnerships Specialist, at academicpartnerships@ghstar.org.

For concerns about study administration, please contact Dr. Robert McLaughlin, Institutional Review Board (IRB) Administrator, Public Health Institute, 555 12th St., 10th Floor, Oakland, CA 94607. Phone: (510) 285-5500.

* 1. I have read the above information, meet the participation criteria, and would like to proceed.

◯ Yes

◯ No

STAR Project | Capacity Landscape Survey

Demographic Information

As a reminder, the use of "global health" in this survey also includes activities related to global public health, and/or global partnerships for health.

2. Your academic institution's location.

[▲▼]

3. How would you best describe your institution?

◯ Public

◯ Private

◯ Other (please specify)

[   ]

4. Which of the following best describes the discipline that your global health program/activities fall under:

◯ Medicine   ◯ Veterinary Science

◯ Nursing   ◯ Law

◯ Public Health/Community Health   ◯ Humanities

◯ Other (please specify)

[   ]

5. Your position/title

[   ]

As a reminder, the use of "global health" in this survey also includes activities related to global public health, and/or global partnerships for health.

6. Please describe the global health activities that you are involved in at your academic institution. (Check all that apply)

☐ Research   ☐ Advocacy

☐ Education   ☐ Community/Outreach programs

☐ Clinical service

☐ Other (please specify)

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[                                    ]
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7. How would you best describe your department's engagement in global health?

○ I am the only person in my department engaged in global health activities.

○ Most people in my department are engaged in global health activities.

○ A few people in my department are engaged in global health activities.

○ Everyone in my department is engaged in global health activities.

○ About half of my department is engaged in global health activities.

8. If you could strengthen the global health program/activities you are engaged in, what would your top three priorities be (ranked in order of priority)?

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[                                    ]
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9. For your identified priorities, what do you or your colleagues need? (For example, think in terms of resources, workforce, structures, skills, tools.)

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[                                    ]
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10. From your perspective, what have been the main constraints to address the three priorities/needs identified above? (For example, lack of funding opportunities, time, etc.)

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[                                    ]
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11. What would be most helpful to your program to enhance its capacity to access U.S. Government development funding opportunities? (For example, USAID.) Select up to three.

- [ ] Stronger technical skills to explore, apply to, and manage grant funding opportunities
- [ ] Stronger administrative skills to explore, apply to, and manage grant funding opportunities
- [ ] Increased number of employees
- [ ] Dedicated time to apply to grant funding opportunities
- [ ] Other (please specify)

- [ ] Institutional leadership prioritizing this work
- [ ] Financial resources
- [ ] Needed infrastructure and/or technological resources, for example, reliable Internet
- [ ] A partnering organization

12. What would be most helpful to your program to enhance its capacity to exchange knowledge with other institutions/global health actors, regarding global health education and research? (Select up to three)

- [ ] Institutional leadership prioritizing this work
- [ ] Needed infrastructure and/or technological resources
- [ ] Better understanding of best practices for knowledge exchange
- [ ] Other (please specify)

- [ ] Information about what spaces exist for open knowledge exchange
- [ ] Dedicated time to engage in knowledge exchange
- [ ] Dedicated staff to make/design products for knowledge exchange

13. What would be most helpful to your program to enhance its capacity to partner with other academic institutions? (Select up to three)

- [ ] Institutional leadership prioritizing this work
- [ ] Needed infrastructure and/or technological resources
- [ ] Online networking opportunities to meet potential partners
- [ ] Funding to attend conferences, workshops, and other in-person networking events
- [ ] Other (please specify)

- [ ] Dedicated time to search for partnership opportunities
- [ ] Resources to strengthen the technical and administrative skills to support a partnership
- [ ] Guidelines on best practices for engaging in a global health partnership