GLOBAL HEALTH

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SOCIAL DETERMINANTS OF HEALTH (SDH):

Why SDH ?

▪Because we have sufficient evidence from cumulative research Studies state that when we work on the underlying causes of health, we end the illness, particularly those that lead to social differences in ill health.

▶ In this way our work would be much more better than focusing only the traditional causes of health like biological processes and germs as determinants of health

(this approach is not just traditional, it also became unacceptable, it is an extremely limited approach), instead we should consider the underlying social determinants of health and disease (social, economic, political, legal and material factors that affect health), which is the definition of SDH.

▶So, we don't focus only on the disease itself, instead we also try to consider the factors surrounding the individual that may affect the patient's health state.

▪Special kind of social determinants of health called social determinants of health equity, focuses on social differences that are considered avoidable. (The concept of health equity) => recall that we want to achieve equity not equality.

Conceptual frameworks for understanding SDH:

It is a theoretical framework followed by models (diagrams), that clarify the nature of relationships between the major concepts in any model or theory.

(There has been significant improvement on how this concept (SDH) is being used and applied in global health field)

▶One of these conceptual frameworks apply social determinants of (Turrell model):

Upstream, Midstream and Downstream

Upstream: (Macro-level): factors like international influences, government policies, social physical economic and environmental determinants.

Midstream: psycho-social factors, health related factors and most importantly health care system.

Downstream: (microlevel): physiologic and biologic functions. (This approach of considering only physiologic and biologic factors is no longer effective (as we said) because it iS not just about biological processes, we have other social determinants that have a huge effect on health and illness and prognosis and patient's response.

▶ **Another framework (rainbow model):according to that model, we put the human at the core, and with the human we put the fixed factors (age, sex and hereditary factors => not of SDH), then we add layers related to life style and social and community networks and on macro level we have environmental and cultural factors.**

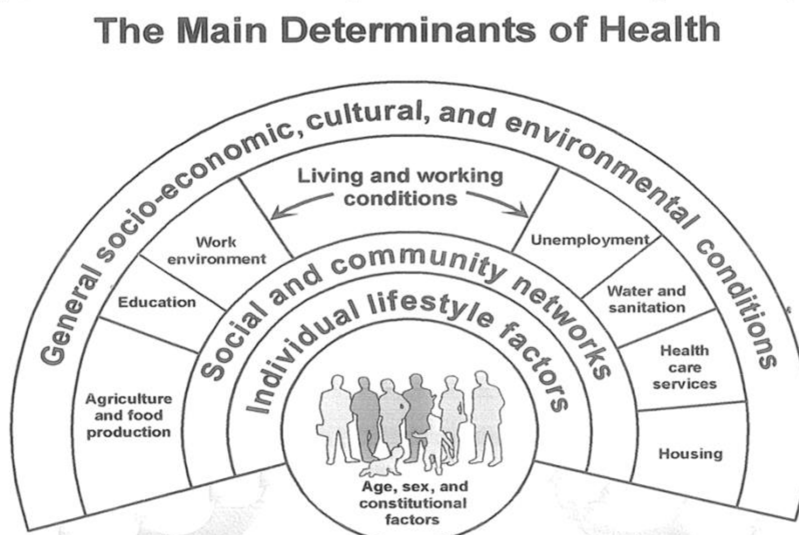

FIGURE 4-1 The "rainbow" model of determinants of health, including social determinants of health.

Reproduced from Dahlgren G., Whitehead M. (2007). Levelling up (part 2): A discussion paper on European strategies for tackling social inequities in health. Copenhagen, Denmark: WHO Regional Office for Europe. http://apps.who.int/iris/bitstream/10665/107791/1/E89384.pdf (accessed 22 June 2017).

This model divides SDH into two subgroups:

1. Health promoting factors: e.g., effective (adequate) housing.

2. Health protective factors: e.g., pollution control measures.

BUT we have problems (Limitations of these models):

1. These models do not show how these different social determinants of health are related to health equity outcomes.

- **For example, in rainbow model, we have that individual in the middle that we want to achieve health equity for him, so shall we make intervention at the level of community and social network or in the Macro-level or shall we focus on the individual himself and lifestyle issues he faces, actually we can't answer that question by these models. (Limitations of these models as frameworks).**

2. Another problem in these models is that their relative contribution. (or the relative impact) on the outcomes is also unknown.

- **For example, people with cardiovascular activity need to improve their physical activity and housing, now working on improving their life styles (by improving the surrounding environment, housing, streets, parks, etc) this may seem extremely perfect for these patients, but the problem is that we may face other unexpected issues, taxes will go up for example, living in these improved places may cost the patients much more money, so the net outcome didn't achieve the health equity at the end.**

SO:

▶ **For achieving equity we need to make sure that our interventions won't cause other problems (the idea is that we want an intervention that when applied ,people who are less advantaged would pick the benefits of this intervention faster than the others).**

An example on that from the book :

▶ **is that health technology (e-health) is being applied by some countries to make the access to health care systems easier.**

The problem was that already wealthy people were able to use this technology because they already have the resources for such a technology, on the other hand people who are really in need for such a service don't have the acquired resources nor the enough knowledge to use such a technology, so instead of improving the conditions this service has worsened them (the gap increased between the two groups of people, so we had a failure because we didn't improve health equity).

✔ **To sum up:**

▶ **We have conceptual frameworks that clarify the SDH, such as the rainbow model, these models help me to understand the layers and factors that affect health and illness, BUT they don't help where to intervene, how to intervene, what are the relative contributions of my interventions on the overall health equity.**

▶ **The third framework we have, is CSDH (commission on SDH), just know that this is a model was introduced by WHO to clarify the connections between various types of social determinants of health and their relation to health equity.**

▶ **We need to know that these approaches (models) are not mutually exclusive, rather they are better to be used as complementary to each other. Also don't forget that the overall goal of our interventions is to improve health equity.**

GENDER, EQUALITY AND HUMAN RIGHTS AND THEIR RELATION TO SDH:

▶There is no doubt that SDH differs between males and females, these economic, legal, political and social factors related to men are not as same as these related to women (in developed or developing countries as well), now the questions is are these differences related to sex or to gender? And to answer that questions we need to know the difference between these two concepts:

Sex: biological differences between females and males. (e.g., genitalia and genetic differences).

Gender: refers to the socially constructed rules, rights responsibilities and limitations for women and men.

▶So, for example, if want to apply an intervention that states that people should go out for walking for an hour daily, is this intervention applicable to both women and men? If your answer is no, then you are talking about gender differences (social rules).

Focus on the concept of gender equality and gender equity, by now we know the difference between equity and equality, but gender equality is about giving equal conditions and **opportunities** for both genders, on the other hand when we talk about equity we talk about **fairness** (and that what we really want).

To achieve equity between the two genders, I should consider women and men different needs and give opportunities that are suitable for these different needs to let the two genders compete for this opportunity (If we don't do that, we may achieve equality, but not equity).

▶Now the above was about the relation between SDH and gender equality, now in regard to their relation to human rights, human rights state that every citizen has the right to have the highest attainable standard of health without distinction of race, religion, political belief, economic or social conditions.

Intersectoral action for health (addressing SDH through intersectoral action):

▶ This approach sakes for comprehensive health services in joined actions
with other sectors to tackle SDH and root causes of poor health.

▶ The book states an **example** on that: Diabetes problem, in order to apply
a successful intervention, we need the cooperation between different sectors. (Multi-sectoral, multi-factorial method).

▶ Another **example** is to tackle air pollution, also collaboration is needed (waste management, industry, transport and others).

Implications (importance) of health systems and services:

In the **Turrell** model, health systems were classified at **mid-stream level**.
Health systems: all organizations, institutions and resources that produce actions whose primary goal is to improve health (e.g., hospital, clinics and community centers).

▶ When these health systems work correctly (effectively), they can tackle the physical and social environments that affect differential exposure and vulnerability to ill health including intersectoral actions.

▶ They can reduce social gaps and gradients in health by influencing how health services perform, how different social groups experience the services
they receive, how widely their uptake or contact translate into effective coverage and care, and whether health funding protects against impoverishment when people fall ill (and thus, health systems can improve **health equity**).

▶So, for these health systems to work effectively, we should have some **universality**, which means that the approach of the health systems should have **standardization** and **equity** .

How to achieve this?

By having general taxation, mandatory insurance, free or very low-cost health care for people in need.
Also, we can achieve it through subsidization: in which rich people pay part of the costs for poor people.

▶On the other hand, don't forget that when we talk about universal approaches, we are challenged by achieving equity, because when we want to apply an intervention for all, this intervention won't reduce the problem (if unplanned correctly) because all people (rich and poor) can get access OR even it may worsen the problem (rich people can reach poor people cannot).
(Poor, disadvantage people are tending to be called the socially exclude)

Social exclusion, social agency and Power as SDH:

(These three (social exclusion, social agency and power are classified as SDH)).
▶In general, people attain different positions in social hierarchy, according
to their social classes, educational attainment, employment, income level, and sometimes it is because of gender only.

▶These positions can be derived from either resource-based measures (related to resources) or Prestige based measures (related to quality of

access)

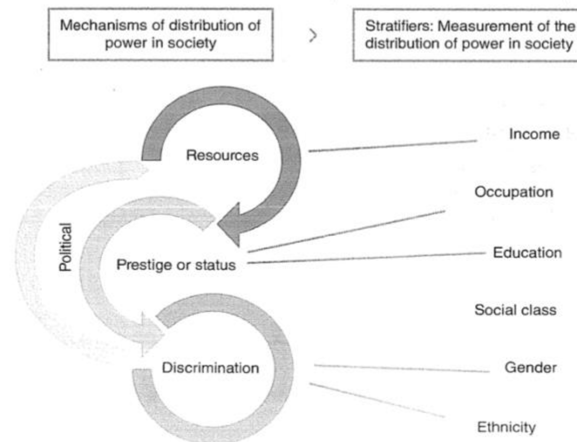

FIGURE 4-6 Mechanisms of distribution of power and their stratifiers.

Reproduced from WHO. (2016). *Innov 8: The Innov8 approach for reviewing national health programmes to leave no one behind*, Geneva, Switzerland: WHO http://apps.who.int/iris/bitstream/10665/250442/1/9789241511391-eng.pdf?ua=1 (accessed 22 June 2017).

▶ **Opposite to social exclusion is social cohesion: which refers to the mechanisms and perceptions that exist in a society regarding social integration across various differentials and for confronting discrimination.**

▶ **Social exclusion when happens has some features:**

Multidimensional, dynamic and relational.

Some don't like to use the concept of social exclusion, because it has a focus on social exclusion, which gives too much emphasis on the social inadequacies for specific groups of people rather than on the environment and the process that generate poverty and inequality.

In order to decrease social exclusion:

1. Universalist policies (for all citizens).

2. Release polices that target specific social groups.

3. Market approaches: seeks to use private or state subsidies to support choices in the consumption of services by poor.

Features of effective health systems:

Familiar to the community.

Integration in health planning.

Accessible information.

Socially appropriate.

▶**It is hard to judge on the success of any intervention if there is no evaluation program that implies how this intervention is applicable**

▶**Knowledge and evidence on the nature and extent of social determinants of health equity and to identify and implement policy or program actions to tackle them.**

▶**Evaluation of such interventions has been important to gather evidence and build learning from their implementation about options to address the social determinants of health inequities.**

V2+V3

▶In page 4 it isn't equality , It's equity

▶In page 7 it isn't rainbow model, it's Turrell model .