Global health-topic 5

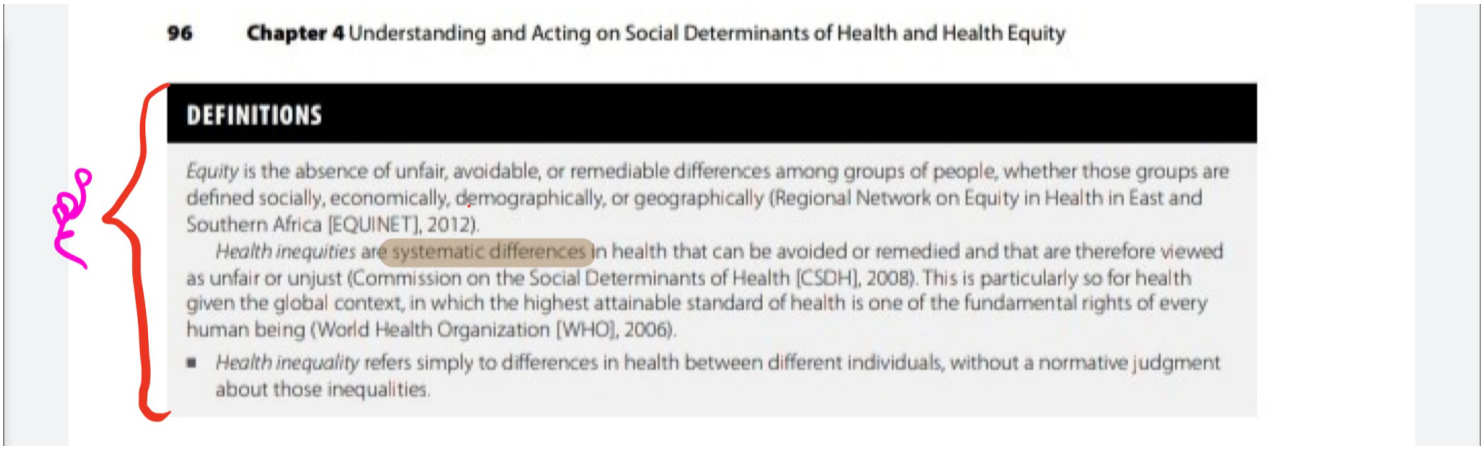
*health improves when action is taken on the underlying causes of ill health, and particularly those causes that lead to social differences in ill health.

*Such underlying social, economic, political, legal, and material factors that affect health are collectively called social determinants of health (SDH).
*Beyond biological processes in the human body and the disease-causing germs that are determinants of health, health outcomes have social origins.

*These (SDH) have a general impact on health outcomes.With the global understanding that everyone has the right to the highest attainable standard of health (United Nations, 1976), there is also increasing international attention on social differences in health that are avoidable and unfair (termed "health inequities")

*SDH associated with avoidable differences.

social determinants of health equity (SDHE):



96 **Chapter 4** Understanding and Acting on Social Determinants of Health and Health Equity

DEFINITIONS

Equity is the absence of unfair, avoidable, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically (Regional Network on Equity in Health in East and Southern Africa [EQUINET], 2012).

Health inequities are systematic differences in health that can be avoided or remedied and that are therefore viewed as unfair or unjust (Commission on the Social Determinants of Health [CSDH], 2008). This is particularly so for health given the global context, in which the highest attainable standard of health is one of the fundamental rights of every human being (World Health Organization [WHO], 2006).

- *Health inequality* refers simply to differences in health between different individuals, without a normative judgment about those inequalities.

Turrell et al. (1999) identified SDH at three discrete, yet closely interrelated stages or levels-namely, upstream, midstream. and downstream.

The upstream (or macro-level) factors include—> inter-national influences, government policies, and the fundamental social, physical, economic, and environmental determinants of health.

The midstream(or intermediate-level)factors include—> psychosocial factors, health-related behaviors, and the role of the healthcare system.

The downstream(or micro-level)—>factors include physiological and biological functioning.

This model (Turrell)has been used to identify interventions targeted at entry points in all three levels, either singly or in combination.

"rainbow" model of determinants. (The Dahlgren and Whitehead model)

*This model has at its core the individual biological determinants that are not considered to be SDH-age, sex, and constitutional-as characteristics affecting health that are largely fixed. From here, the framework adds layers of determinants that are socially determined from individual lifestyle factors.

*This model shows not only the different levels, but also the preponderance(الغلبة)of factors that may be considered as SDH.

These factors may be:
1.health promoting (e.g., provision of adequate housing)
2.protéctive, by eliminating risk of disease (c.g., pollution control)

*The Dahlgren and Whitehead model suggests the determinants that may be included in the definition of what is socially determined and the relationship between these different levels of SDH on health outcomes. Nevertheless, it does not show how these different SDH relate to health equity outcomes.

The authors do, however, argue that the determinants of Inequities in health may be different from the determinants of health

*actions on SDH may **not** automatically address equity. and that specific attention needs to be paid to the distributional impact of those actions for them to achieve this goal.

Example:developments to improve the quality of housing and green spaces are actions on SDH that may improve health, but may also raise housing costs and push local residents into more marginal urban zones, forcing them out from areas where they have been long-time residents. This trend will affect the distribution of health benefits,

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* intervention is to improve health equity, the rate of improvement should be faster for those groups whose starting point is worse initially, making the health gradient less sleep. If the gradient simply shifts upward at the same rate for all groups, such that all groups improve at the same rate in their absolute outcomes, then the relative differences between the groups remain unchanged and in that sense, health inequity has not changed. Population health interventions that are applied universally to address specific SDH without taking social differentials into account indeed, worsen inequalities in outcomes.

* Dahlgren and Whitehead argue further that policies and programs that influence health should be assessed for their distributional different socioeconomic groups impacts across different.

WHO's Commission on Social Determinants of Health (CSDH).
This framework makes an explicit connection to health equity by seeking to profile how SDH relate to and address unfair, avoidable, or remediable differences in health among population groups. You can see it in page5 in the highlighted book

*The CSDH framework repeats many elements of the earlier frameworks for SDH, but applies an equity lens.

*In all of these models, applying an equity lens to SDH to identify and address these social determinants of health equity calls for robust evidence on the distribution of health and its determinants, and for monitoring and evaluation systems that contribute such evidence to policy decision making. Evidence on SDH often extends beyond familiar health indicators, and assessing changes in health gradients and across social,features, areas, and time can be complex.

Relationships Between SDH, Gender, Equality, and Human Rights

*The conceptual frameworks highlighted earlier indicate that SDH intersect with the distinct but linked concepts of gender and human rights, particularly when applying an equity lens. While sex is a biological determinant, gender refers to the socially constructed roles, rights, responsibilities, and limitations assigned to women and men, boys and girls -which often privilege male power or characteristics.
*These spect of gender are socially constructed and amenable to change.

*Gender norms, roles. and relations can affect (health) risk and vulnerability, health -seeking behavior,and health outcomes for men and women of different ages and social groups.

*Gender norms and relations are a persistent basis of the social hierarchies and stratification mentioned earlier, intersecting with social class ethnicity, education, occupation, and income; influencing socioeconomic position and the distribution of other SDH.

*health for all," the "all" are not the same. Gender-related differences that lead to inequities in health arise from the different health needs and challenges that men and women face across their life course and the ways in which they intersect with other SDH. Gender-related differences exist in a range of SDH. including living and environmental conditions, employment and income opportunities, and control over decisions about and uptake of health services.

*Many of these differentials derive from women's status in society, and their control over a range of areas affecting health, including over their own bodies, their reproductive health, and their working conditions and income. Women are at greater risk of physical violence and sexual abuse and face deficits in protection in law or its enforcement.

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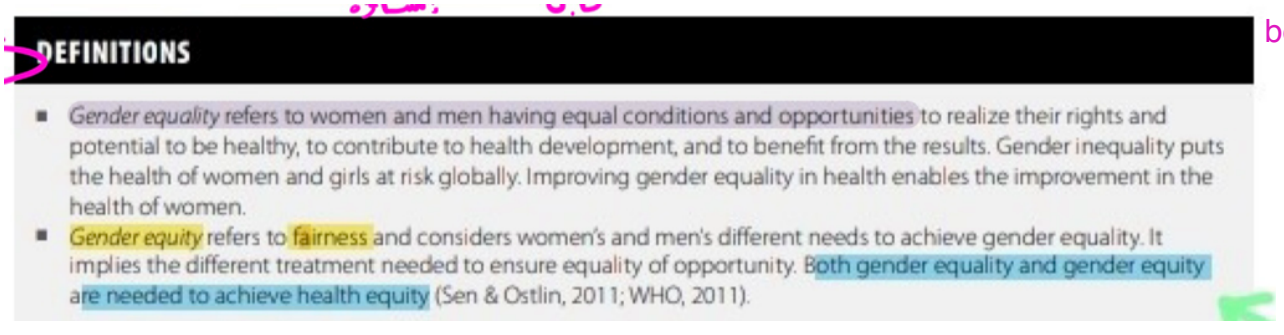

DEFINITIONS

- *Gender equality* refers to women and men having equal conditions and opportunities to realize their rights and potential to be healthy, to contribute to health development, and to benefit from the results. Gender inequality puts the health of women and girls at risk globally. Improving gender equality in health enables the improvement in the health of women.
- *Gender equity* refers to fairness and considers women's and men's different needs to achieve gender equality. It implies the different treatment needed to ensure equality of opportunity. Both gender equality and gender equity are needed to achieve health equity (Sen & Ostlin, 2011; WHO, 2011).

*A human rights-based approach also draws attention to the SDH that affect health equity, to ensure the "right to the enjoyment of the highest attainable standard of health without distinction of race, religion,political belief, economic or social condition"

Addressing SD Through Intersectoral Action and Health in All Policies

*identified the need for both comprehensive health services and joint action with other sectors to tackle the SDH and root causes of poor health.

*joint action with other sectors.

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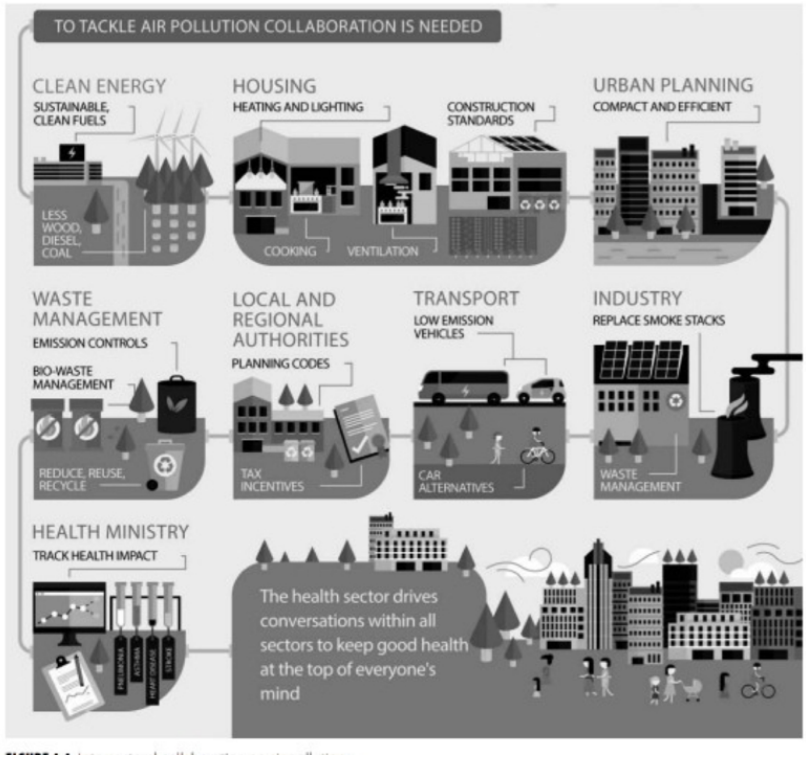

Implications for Health Systems and Services

Health Systems ffective health services are a determinant of population health, contributing to reducing mortality and increasing life expectancy, particularly through 1.preventive services and 2.health promotion.

*resource mobilization, financing, and service delivery, and involve a network of public and private organizations, institutions, and resources.

*Health systems not only provide individual and population-level services that position them as an intermediary SDH, but they can also influence the policies and coordinate with the actions of other sectors to address SDH.

*Health systems can promote health equity when they tackle the physical and social environments that affect differential exposure and vulnerability to ill health, including through intersectoral action, 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 translates into effective coverage and care, and whether health funding protects against impoverishment(إفقار) when people fall ill.

*In a rights-based approach, health systems can provide space for people to exercise their rights, to have informed say in decisions and actions on health.

Organizing Equitable and Universal Provision and Financing

*Universal health systems are generally publicly funded largely through general taxation(الضرائب العامة)or mandatory insurance(التأمين الإلزامي)and provide care for free or at very low cost at the point of delivery. To support equity wealthier (and relatively healthy) people cross-subsidize the use of health care by poorer people, who are also more likely to be ill.

*This transfer of resources from wealthier to poorer groups in redistributive health systems can also assist to close gaps in income and living standards between poorer and wealthier group.

Social Exclusion, Social Agency, and Power as a SDH

people attain different positions in the social hierarchy, often characterized by their social class, educational achievement, occupational status, and income level, or based on gender. Socioeconomic position can derive from the following sources:
1.Resource-based measures. 2.Prestige-based measures.

Social exclusion-conversely, social cohesion-as a conceptual lens.

Social exclusion has the following characteristics:
1.Multidimensional.
2.Dynamic.
3.Relational.

*On the one hand, "exclusion' may be seen as a less stigmatizing label than "poor," and to make clearer links to concepts of social rights and justice. On the other hand, a focus on social exclusion can place too much emphasis on the social inadequacies of specific groups of people, rather than on the environments and processes that generate poverty and inequality.

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State-led responses to social exclusion are genrally organized through a range of approaches:
1.**universalist policies,** reflecting values of social solidarity, extend rights to publicly funded services to all citizens.

2.**policies targeting specific social groups**. These policies are specifically designed for disadvantaged groups.

3.**market approaches**, seeks to use private or state subsidies to support choices in the consumption of services by poor people to address economic or social barriers to such choices for the most marginalized households.

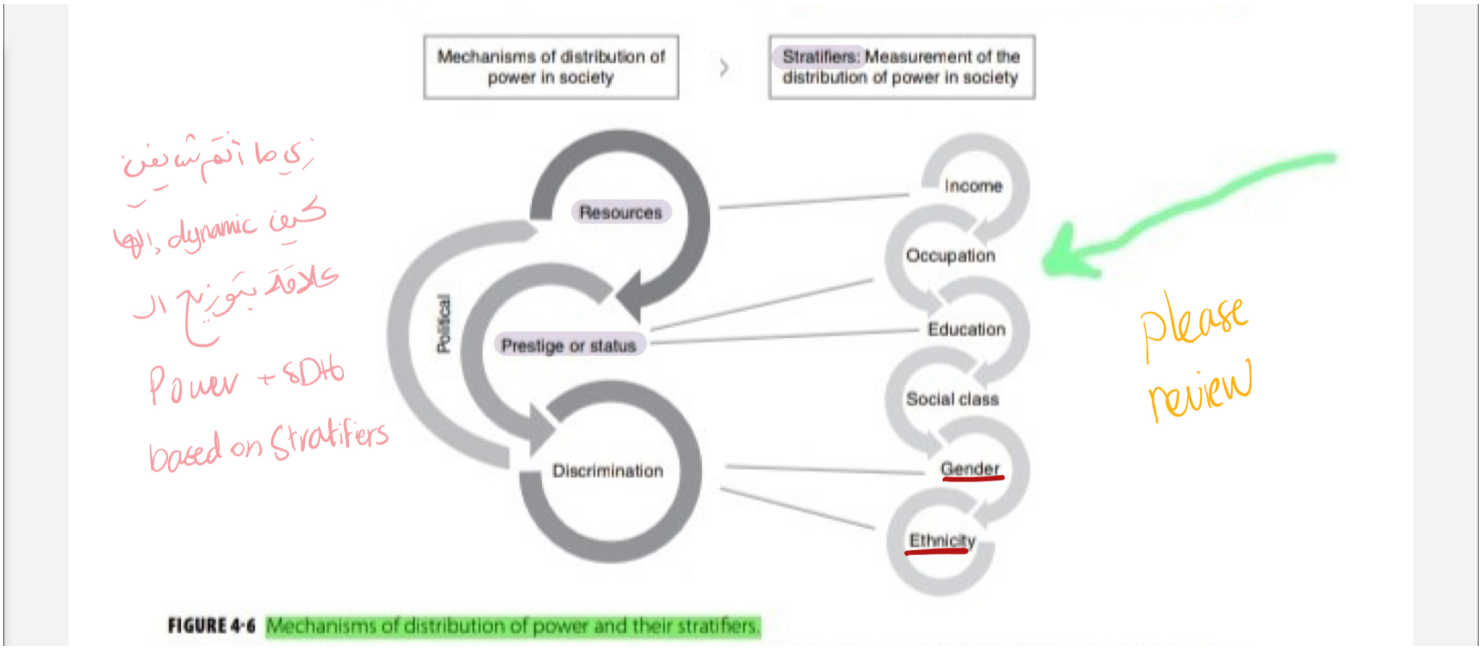

FIGURE 4-6 Mechanisms of distribution of power and their stratifiers.

Reproduced from WHO. (2016). *Annex B: The Second 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).

DEFINITION

Social cohesion refers to the mechanisms and perceptions that exist in a society regarding social integration across various differentials and for confronting discrimination. It affects the sense of belonging within society, together with features of trust, participation, and reciprocity (WHO, 2016). This concept is applied differently in different regions, contexts, and communities. The European Commission's (2016) concept of "active inclusion" means that every citizen, including the most disadvantaged, fully participates in society. It means having adequate opportunity for work, support for income and employment, and access to quality services that enable active participation in society, including through investment in individuals' capacities and opportunities for participation. In contrast, in post-independence South Africa, social cohesion has been identified with nation, peace-building, and diversity in a democratic dispensation, as a response to past racism and inequality (Palmary, 2015).

Social exclusion = Poor = disadvantaged

features of health systems, that enable effective participation.

1.**health interventions** in sites that are familiar to communities, such as markets or schools.

2.**Integrating community mapping**, monitoring and preferences in health planning.

3.**Producing accessible information** (such as through newsletters, meetings, and social media) that shares local experience and responds to perceived needs.

4.**Using socially appropriate and participatory methodologies** that build on and validate local experience and knowledge.

5.**Involving and supporting** communiy-clected and -located community health workers to strengthen communication and linkages between health systems and communities.

6.**Providing opportunities** for dialogue on community perceptions of services, through community audits, health watches, community councils, participatory research, and legal action.

7.**Devolving meaningful budgets** to lower levels of the health system to facilitate and support social roles.

8.**Enabling communities** to shape the "rules of the conversation" by giving them the ability, resources, and opportunity to define the terms and processes in which they participate and the issues they want to address, and to have input into national laws and policies.

9.**Investing time and resources in**, and providing management support for, health worker compeencies and incentives for participatory processes.

Evaluating Action on the Social Determinants of Health and Health Equity

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.

حكينا إنه أي تدخل على micro or intermediate or macro level فصعب اني احكم على نجاحه وصعب اتبناه اذا ما كان معاه evaluation
intervention بحيث يُدَّعِم لي مدى إمكانية استخدام هذا البرنامج
وهاي ال evalua actions مهمة جدًا، وللأسف مابنشوفها بشكل كبير عنا، لما تطلع المشكلة عنا بنشتغل بطريقة reactive (يعني مش proactive) بتتشكل لجنة وبحكولك يلا نعمل تدخل كذا (واذا اذا خلص هذا التدخل، فنادرًا ما بتابعو effectiveness لهذا العمل ونادرًا ما نسمع انه في برامج evaluation قائم حتى يعطيني report عن مدى نجاح هذا التدخل على المدى القريب والبعيد.

Without realistic evaluation for our interventions it will be really difficult to capture the links between the context, the mechanisms, then the outcomes.
وأنا فقط بال evaluation بقدر احدد،، في اشي اسمه mediation & moderation analysis لو بدي استخدمها بطريقة احصائية بقدر يجاوبني بالضبط على السؤال،
وهاي التدخلات بتشتغل على الناس بطريقة مختلفة، مثلًا ليه هاي التدخلات نافعة مع فلان وفلان ومش نافعة مع فلان وفلان آخرين؟ الجواب بشكل عام انه في SDH بتختلف من شخص لاخر ولكن هذا نظريًا (زي ماحكينا بال F.W) لذلك على أرض الواقع لازم أقيم التأثير الفعلي لهاي التدخلات.

Done by:Rama Harb.

Good luck🫶

٧٤ : الكلمات يلي عليها خطوط كانوا مكتوبين غلط 🙂