



CHAPTER 4

# Understanding and Acting on Social Determinants of Health and Health Equity

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## ► Introduction

A large and growing body of evidence shows that 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. “These underlying causes are complex, often reflecting systematic social, political, historical, economic and environmental factors that accumulate across people’s lifetimes and are transferred across generations” (Sadana et al., 2014, p. 8). 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, such as in the way people live and work and their economic and political systems, known as the social determinants of health. Identifying them enables us to understand and intervene to improve health, and has been a longstanding goal of public health measures. For example, such

interventions may include measures to counter the marketing of tobacco to reduce smoking, or creation of cycling paths and green spaces in urban areas to promote physical activity.

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”). Beyond the broad understanding of the social factors that cause disease, the persistent and sometimes growing differences in health within and between social groups and countries raises questions about how SDH are associated with avoidable differences in the opportunities for a healthy life as well as the differential benefits from interventions for improved health. When this analytic lens is applied, those factors may be termed the *social determinants of health equity* (SDHE). This chapter explores the understanding and application of SDH to improve health, and, as a matter of increasing importance globally, to improve 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.

In a chapter in an earlier edition of this text, Kelly and Doohan (2014) explored in some detail how the understanding of social variations in ill health and its prevention developed over time. They described the causal pathways from SDH to individual disease outcomes and population-level patterns of disease.

This chapter does not seek to repeat their well-presented explanations of the causal pathways from SDH to health outcomes. Rather, it focuses on the *application* of the concepts, with examples from a range of countries globally, particularly from low- and middle-income countries (LMICs), especially those in east and southern Africa. The conceptual frameworks, discussed later, show how SDH can be organized into different and deepening levels, each of which incorporates different elements. We do not aim to discuss all the diverse SDH in this chapter, but instead present more detail on some of these elements, given their role in improving health and health equity.

Thus, this chapter describes published work on the following topics:

- The development of conceptual frameworks for understanding SDH and SDHE, including how these frameworks relate to frameworks for human rights and gender equality
- Intersectoral action for health (IAH) and health in all policies (HiAP) as approaches used to apply the conceptual understanding of different types and levels of SDH, from immediate material determinants to deeper socioeconomic and policy determinants, to improve health and health equity
- The implications of an SDH perspective for health systems and services, understanding the health system itself as a social determinant of health and health equity
- The roles of and interventions to address social exclusion, social agency, and power as cross-cutting SDH, affecting other sociopolitical, socioeconomic, and material determinants

- The increasingly global dimensions of SDH in a globalizing world, their role in national-level SDH, and the different levels of responses to them
- How to evaluate action on SDH aimed at improving health and health equity

## ► Conceptual Frameworks for Understanding Social Determinants of Health and Health Equity

Analysis of the relationship between disease and the social and material environment dates back to ancient medico-philosophical systems. With advancing understanding of the causes of ill health and their origin in human activity, it has become clearer that socially determined health risks can be prevented, including as a matter of social justice (Kelly & Doohan, 2014). In recent decades, as public health has shifted its focus from individual risk–health relationships to more complex, multifactorial causal networks, a range of increasingly comprehensive conceptual frameworks have emerged, drawing on evidence to support analysis of the SDH and their role in health equity. This section explores how these conceptual frameworks have developed, with increasing attention over time to the relationship between SDH and health equity.

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 international 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. Some social factors, such as

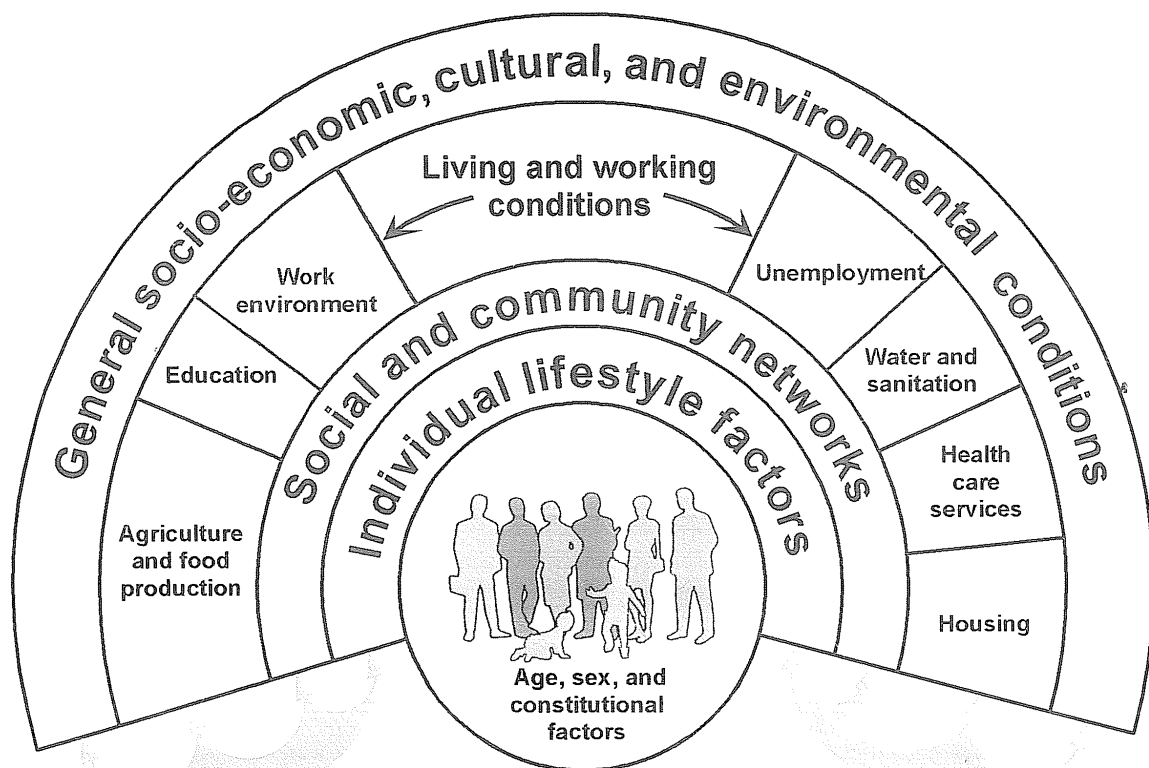
culture, beliefs, values, and norms, are seen to influence decision making, actions, and behavior at both upstream and midstream levels. The downstream (or micro-level) factors include physiological and biological functioning. This model has been used to identify interventions targeted at entry points in all three levels, either singly or in combination. While acting upstream (such as with tax policies) may have wider population effects, demonstrating its influence is often more complex.

Dahlgren and Whitehead (2007) developed a similarly multilayered and widely used “rainbow” model of determinants, shown in **FIGURE 4-1**. 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; farther upstream are those factors and services that impact on health at the population level and that are theoretically modifiable by policy. This model shows not only the different levels, but also the preponderance of factors that may be considered as SDH. These factors may be

health promoting (e.g., provision of adequate housing) or protective, by eliminating risk of disease (e.g., pollution control). In this model, healthcare services coexist with other determinants to impact on health. Dahlgren and Whitehead (2007) propose that a comprehensive health strategy should address and link the different levels of downstream and upstream determinants of health shown in Figure 4-1.

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. For example, poor working conditions may account for a higher share of the *difference* in the burden of disease between affluent and low-income groups than in the *overall* burden of disease. Thus, they argue that 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. For example, urban

## The Main Determinants of Health



**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/10665/107751/1/EB9384.pdf> (accessed 22 June 2017).

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, unless specific measures are in place to protect their tenure or well-being.

The *social gradient* in health describes the pattern that is formed by comparing health outcome measures with some measure of social position, such as occupation, education, or income (Kelly & Doohan, 2014). A population-level public health intervention that affects the whole population in the same way may shift the gradient upward by the same amount for all, without affecting the relative differences between the different social groups.

If the goal of a policy or an 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 steep (Kelly & Doohan, 2014). 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 may, indeed, worsen inequalities in outcomes. For example, as health technologies are introduced or health screening scales up, uptake may initially be more rapid in wealthier households, which widens (rather than narrows) the social gradient, unless specific measures are implemented to promote uptake in poorer groups (**EXHIBIT 4-1**). A more detailed discussion of absolute and relative measures of social status and their relationship to absolute and relative measures of health outcomes can be found in the chapter by Kelly and Doohan (2014).

#### **EXHIBIT 4-1** Closing the Equity Gap: A Case Study of the Health Gradient

This example illustrates the way the health gradient does, and does not, respond to new public health interventions and the “stubborn” influence of SDH. In the state of Ceará, in a poor area of northeastern Brazil, the 1980 infant mortality rate was greater than 100 infant deaths per 1,000 live births and malnutrition was common. Based on the findings of a 1986 statewide survey of child health and nutrition, new health policies were implemented, including growth monitoring, oral rehydration, breastfeeding promotion, immunization, and vitamin A supplementation—interventions collectively known as GOBI (growth monitoring, oral rehydration, breastfeeding, and immunization). As lack of access to health services was a major problem, community health workers and traditional birth attendants were widely introduced and responsibility for health services was decentralized to rural municipalities, where health indicators were poorest. A social mobilization campaign for child health used media and small radio stations to broadcast educational messages. This work was supported by four consecutive state governors, all of whom gave high priority to improving child health, and the outcomes were reviewed through surveys in 1990 and 1994.

The surveys showed improved population coverage of the four GOBI interventions by 1994. The use of oral rehydration increased to more than 50% in children with diarrhea; nearly all children had a growth chart, and half had been weighed within the previous three months; immunization coverage rose above 90%; and the median breastfeeding duration increased from 4.0 months to 6.9 months. These improvements were noted in all income groups. The prevalence of low-weight-for-age and low-height-for-age children in the population younger than age 5 fell from 13% to 9% and from 27% to 18%, respectively, while diarrheal disease incidence in the previous two weeks was nearly halved.

While the child health interventions were applied to all families, including the poorest, the social differentials in disease and infant mortality rate between rich and poor remained largely unchanged between 1987 and 1994. In that period, family income inequalities persisted and remained largely unchanged. Diarrheal disease incidence remained approximately 60% higher among poor children, income inequalities remained largely unchanged, and the inequity ratio between rich and poor persisted.

One explanation for these findings given by the authors of the Ceará study was that wealthy families had made greater and earlier use of both public-sector and private-sector services to protect their children's health. They noted that even when public health programs are targeted at the poorest households, it is difficult to close the inequity ratio group if the richer households have not yet themselves achieved high levels of coverage with the specific services. The conclusions suggested that, even when public health programs are targeted at the poorest members of a society, the wealthiest are likely to continue to benefit from the introduction of new health technologies, and that further investments are needed to make existing and new interventions more widely accessible to the poorest populations so as to change the health gradient and close the inequity gap (Bonnefoy et al., 2007; Victora et al., 2000, cited in Kelly & Doohan, 2014).

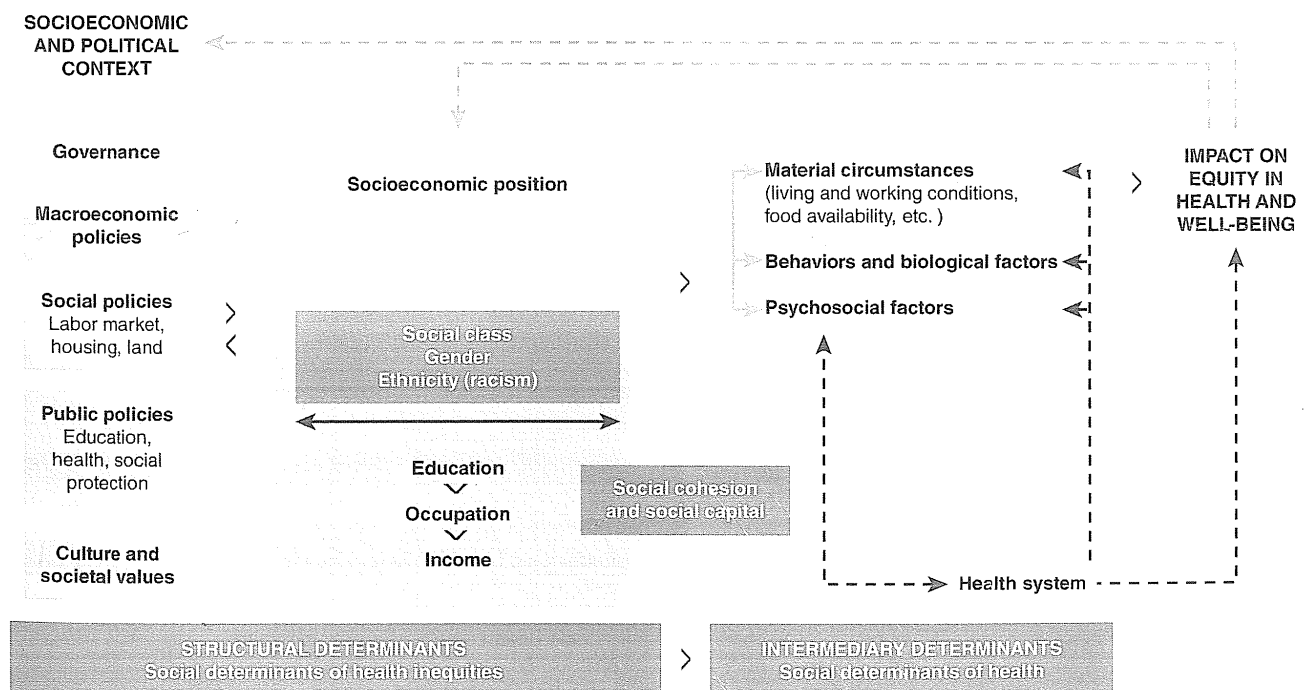
Dahlgren and Whitehead (2007) note that understanding how SDH are linked to improving health equity calls for investigation of what is causing the social gradients in exposure to different health hazards and in access to health-promoting or health-protective factors, such as those described in Exhibit 4-1. Analysis of these SDH associated with distributional outcomes is used to identify the approaches and additional resources that may be needed to address social gradients in health, such as through “leveling-up” strategies. Once these SDH that have positive or negative influence on social gradients are identified, specific strategies can be designed to integrate them within health policies and programs. Dahlgren and Whitehead argue further that policies and programs that influence health should be assessed for their distributional impacts across different socioeconomic groups.

The SDH that have a distributional impact may arise within any of the bands of SDH in the rainbow model shown in Figure 4-1. For example, social position is an important determinant of inequities in health, as are social networks and health behaviors. Groups that are socially and economically better off typically have more power and opportunities to live a healthy life than groups that are less privileged (Australian Institute of Health and Welfare [AIHW], 2012). Legal and institutional arrangements, political and market forces can consolidate these inequalities. The relationships are not purely negative. In contrast, and as exemplified

in Exhibit 4-8, shown later, education may be a positive factor in closing inequalities, as it can enhance the power and opportunity of less privileged groups to avoid unhealthy living and working conditions. The freedom and power that people have to influence their own life and society, including through greater political and economic democracy and through control of commercial markets (such as marketing of alcohol), is also a positive factor in tackling social inequities in health (EQUINET, 2012; EQUINET SC, 2007).

Given the increasing concern voiced regarding remediable inequalities in health, Solar and Irwin (2010) elaborated the conceptual framework that was used by the WHO’s Commission on Social Determinants of Health (CSDH). This framework, shown in **FIGURE 4-2**, 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, as an appeal to ethical norms and a matter of social justice.

The CSDH framework repeats many elements of the earlier frameworks for SDH, but applies an equity lens. It locates SDH within a hierarchy of structural and intermediary determinants that gives specific focus to the political, social, and economic contexts and institutions and the cultural and societal values (all SDH) that *generate, configure, and maintain social hierarchies and that stratify people* by income, education, occupation, gender, race/ethnicity, and other factors (also



**FIGURE 4-2** The Commission on Social Determinants of Health (CSDH) conceptual framework.

Reproduced from Solar, O. and Irwin, A. (2010). *A conceptual framework for action on the social determinants of health. Social Determinants of Health. WHO Discussion Paper 2 (Policy and Practice)*, Geneva, Switzerland: WHO. [http://www.who.int/sdhconference/resources/ConceptualFrameworkforActiononSDH\\_eng.pdf](http://www.who.int/sdhconference/resources/ConceptualFrameworkforActiononSDH_eng.pdf) (accessed 22 June 2017).

SDH). It includes the SDH—including state policies and programs—that *redistribute resources* and nurture relationships and systems that *close social differentials*. These structural determinants and the socioeconomic positions to which they lead, shown in the left-hand columns in Figure 4-2, thus have a central role as SDHE. They jointly shape intermediary SDH, such as material, behavioral, and psychosocial determinants. These factors largely act as SDH but may have a role in equity where they influence *differentials in exposure and vulnerability* to conditions that affect health or the social consequences of ill health, as discussed for the health system later in this chapter. The health outcomes of these conditions can themselves “feed back” on people’s social position, such as by compromising employment opportunities or reducing income.

While previous models have noted the role of the health system in dealing with social determinants of health, this framework positions the health system as one of the *intermediary determinants*. It recognizes that health systems both reflect existing patterns of

social inequality and provide a site from which to contest them (a topic discussed in more depth in a later section). The CSDH framework also recognizes the effect of globalization and global-level drivers on SDH at the national and local levels (also discussed later).

Policies and interventions that seek to improve equity may be targeted at SDH at both the structural and the intermediary levels: from the “micro” level of individual interactions (such as individual dietary practices), to the “meso” level of community conditions (such as neighborhood environments), to the broadest “macro” level of universal public policies (such as tax and investment policies), including in the global environment and in relation to the role and impact of private actors and corporations. Applying the framework entails assessing the distributional impact of actions and action across multiple areas of SDH. As shown in **FIGURE 4-3**, the CSDH framework identifies these distributional impacts at the level of impacts on social stratification, on differentials in exposure, on differentials in vulnerability to risks, and on the unequal consequences of illness.



**FIGURE 4-3** The CSDH framework for tackling inequalities in health.

Reproduced from Solar, O. and Irwin, A. (2010). *A conceptual framework for action on the social determinants of health*. *Social Determinants of Health*. WHO Discussion Paper 2 (Policy and Practice), Geneva, Switzerland: WHO. [http://www.who.int/sdnconference/resources/ConceptualframeworkforactiononSDH\\_eng.pdf](http://www.who.int/sdnconference/resources/ConceptualframeworkforactiononSDH_eng.pdf) (accessed 22 June 2017).

Across each of these dimensions, identifying and taking action on SDH to reduce health inequities may have the following benefits:

- Remedy health disadvantage among specific populations—as, for example, in SDH interventions for the Roma community, outlined in Exhibit 4-7
- Close health gaps between two groups, usually the worse-off and better-off groups, as intended in the work of community health workers in Guatemala to improve service uptake in poorer groups, described in Exhibit 4-7
- Address the social health gradient across the whole population—as, for example, is a policy intention of the various features of universal health systems described in later in this chapter

These approaches are not mutually exclusive, but rather may bring together action on different SDH at different levels. As discussed later in this chapter and in Exhibit 4-1, strategies that tackle one or more of these outcomes may be complementary, such as when additional measures for single mothers are embedded within general social protection schemes. Such action on SDH calls for input from multiple sectors, as explored later in this chapter.

Understanding the SDH that affect how different social groups access or experience universal interventions can point to specific additional measures that need to be integrated to close the gap or gradient. Such analysis, as a form of “equity proofing,” can, for example, be integrated in health impact assessments (HIA) to check for the likely equity implications and consequences—both intended and unanticipated—of a particular action, policy, or intervention, and to recommend proactive measures to improve health equity (Simpson, Mahoney, Harris, Aldrich, & Williams, 2005).

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.

Solar and Irwin (2010) observe that there is a dearth of evidence, including data on impacts, to support policy action on SDH and inequities in health. Cochrane reviews of studies of tobacco control, for example, rarely assess the impact of policies or programs in relation to socioeconomic dimensions (Oxman, Lavis, Lewin, & Fretham, 2009). As noted earlier, the interventions are often multifaceted, combining different levels of SDH and sectors, relative to the often narrower biomedical/clinical health interventions. The former are context dependent, are delivered within a constantly changing health and social policy environment, and involve diverse disciplines (Oxman et al., 2009). While there is growing recognition of and research on these SDHE, further development of methods that take the complexity of such interventions into account is still needed, and funding for this research is still limited relative to that allocated for the biomedical sciences (CSDH, 2008). The CSDH (2008, p. 186) has noted that “action on SDH is best served through developing a rich and diverse evidence base.” This chapter thus includes evidence from multiple disciplines and methodological traditions, ranging from analysis of repeated household surveys, to qualitative studies, policy analysis, studies of power relations, practice reviews, and system-level evaluations.

The conceptual frameworks discussed in this section also suggest that social processes and power differentials play an important role in the social hierarchies that stratify people and in acting on SDH that affect health equity, as exemplified in the case of indigenous people in **EXHIBIT 4-2**.

#### **EXHIBIT 4-2** Understanding Systematic Discrimination Against Indigenous People as an SDH

Indigenous people in Australia (as in other countries) are not merely “disadvantaged citizens.” The poverty and inequality in health that they experience reflect the association with systemic discrimination over centuries. Thus, addressing these issues is not simply a matter of provision of material or service inputs, but rather requires addressing ways to increase their control over their physical environment, their dignity, and their community self-esteem, and the matter of justice (Calma, 2007). Such systemic processes of discrimination and disempowerment cannot be simply understood as historical events reflected in poorer current health outcomes for indigenous people, but must be recognized as persistent in their social consequences and within current sociopolitical contexts, with continued negative impacts on health outcomes (Axelsson, Kukutai, & Kippen, 2016). The CSDH (2008) and the indigenous health research community have called for such effects of colonialism to be more explicitly incorporated into epidemiologic analysis and monitoring systems.

Health interventions and systems are thus not simply technical or biomedical in nature, but rather affect social power and status and reflect procedural justice, such as through decision-making processes that are transparent to, accessible to, and inclusive of the input of those affected by them. The next sections explore further how intervening on SDH to promote equity calls for institutions and processes that provide opportunities and spaces for disadvantaged and marginalized groups to engage in decisions that affect their health, that are responsive to need, and that recognize and deliver on health rights, as noted in the 2008 CSDH report: “Changing the social determinants of health and health equity is a long term agenda requiring sustained support and investment . . . recognizing that . . . at the centre of this action should be the empowerment of people, communities and countries that do not have their fair share” (p. 23).

Integrating concepts of power into the analysis of SDH and into the responses to the resulting inequities in health both clarifies and complicates frameworks. Solar and Irwin (2010, p. 21) argue that while power is “arguably the single most important organizing concept in social and political theory,” it is also contested and subject to diverse and often contradictory interpretations. It draws public health professionals into the sometimes less familiar terrains of social justice and rights-based approaches, of sociopolitical and systems theory, and of activism, discussed further in the chapter.

## 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 (WHO, 2011). These aspects of gender are socially constructed and amenable

to change, as an SDH that leads to *differentials in exposure and vulnerability* to conditions that affect health and thus health equity (Sen & Ostlin, 2011).

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, including through stereotypes, discrimination, and the gender-based division of labor (Sen & Ostlin, 2011; WHO, 2011). 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; and being influenced by the wider socioeconomic and political context, culture, and societal norms and values (Sen & Ostlin, 2011). The Definitions box summarizes the related concepts of *gender equality* and *gender equity*. Within universal policies such as “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 (WHO, 2011). Gendered norms, behaviors, and socially constructed roles intersect with other SDH to generate differential social and health outcomes.

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 (for example, see **EXHIBIT 4-3**). Women are at greater risk of physical violence and sexual abuse and face deficits in protection in law or its enforcement (Sen & Ostlin, 2011). In addition, female, lesbian, gay, bisexual, transgender, and intersex (LGBTI) people risk poorer health outcomes than males or people who are not LGBTI because of gender power relations (Sen & Ostlin, 2011).

### 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).



**EXHIBIT 4-3** Child Marriage and Its Gendered Health Effects

Child marriage is a union (official or not) of two persons, at least one of whom is younger than 18 years of age. It is driven by gendered values and beliefs about girls' roles and contributions, affects girls and boys differently, and is more prevalent among girls. In Niger, for example, 77% of women age 20 to 49 were married before age 18, compared to 5% of men in the same age group. Collecting data on such unions poses a challenge, because child marriages are often not registered. However, worldwide, more than 700 million women in 2014 were married before age 18, and about 250 million before age 15, with the highest rates found in South Asia and sub-Saharan Africa. There are educational, regional, urban-rural, and wealth differences in this practice: In Malawi, nearly two-thirds of women with no formal education were child brides compared to 5% of women with secondary or higher level schooling; in Amhara, northern Ethiopia, the rate of child marriage is 75%, compared to 26% in Addis Ababa; and girls in the poorest quintile are 2.5 times more likely to marry in childhood than those in the wealthiest quintile.

Girls who are married before age 18 experience greater negative impacts on physical and mental health and well-being than do boys in this situation, primarily due to complications from early pregnancy and childbearing, increased risk of and vulnerability to human immunodeficiency virus (HIV) and other sexually transmitted infections, and gender-based violence and discrimination. Complications during pregnancy and childbirth are the second leading cause of death for 15- to 19-year-old girls globally. Adolescent mothers are often socially isolated from family, friends, and other sources of support, such as health services; have limited opportunities for education and employment; and may be less empowered to break the cycle of poverty due to their lower levels of education. Early maternal age affects infant mortality and growth, compounding intergenerational inequality. Furthermore, unregistered child marriages may mean that the child's birth is also unregistered, potentially affecting the child's access to health, social, and educational services (UNICEF, 2014, 2016; WHO, 2014; WHO Regional Office for Europe [WHO Europe], 2016).

In terms of reducing health inequities,

[because] of the numbers of people involved and the magnitude of the problems, taking action to improve gender equity in health and to address women's rights to health is one of the most direct and potent ways to reduce health inequities and ensure effective use of health resources. Deepening and consistently implementing human rights instruments can be a powerful mechanism to motivate and mobilize governments, people and especially women themselves. (Sen & Ostlin, 2011, p. 74)

International human rights instruments provide a framework for universality and a legal obligation for states to ensure policies that support conditions and opportunities for health for all (Braveman & Gruskin, 2003). Human rights-based approaches thus raise the relevance of acting on SDH for improved health, so as to meet the 1948 Universal Declaration of Human Rights Article 25 provision: "Everyone has the right to a standard of living adequate for the health and well-being . . . including food, clothing, housing and medical care and necessary social services" (United Nations, 1948).

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" for all, as provided in Article 12 of the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR) (United Nations, 1976). The ICESCR General Comment 14, in addition to identifying universal access to specific SDH for the whole population, identifies the core state obligations in relation to health as ensuring *nondiscriminatory access* to health facilities, goods and services, *especially for marginalized groups* (United Nations, 2000). The right to health provides for claims by people as rights bearers to key SDH, including health care, and its achievement depends on the realization of these entitlements and freedoms (Gesellschaft für Internationale Zusammenarbeit [GIZ] & WHO, 2011a). While some rights violations, such as access to safe water, are measurable and have clear health consequences, there is some debate on what the right to "the highest attainable standard of health" means in practice. It has been argued that one dimension of this is closing avoidable inequalities in health within and across countries (EQUINET, 2012).

Rights-based approaches in health imply not only intervention on intermediary SDH, but also processes that include participation, information sharing, and accountability in setting priorities, planning and design, and implementing and monitoring policies and programs that are set in more structural SDH. They imply that states and others charged with duties

The United Nations Human Rights-Based Approach (UNHRBA, 2003) to development has as its purpose to assist UN agencies in mainstreaming human rights into their activities and programs within their area of work with the expected outcome of realization of one or several human rights (e.g., the right to health). Human rights principles should guide programming in all sectors, and include capacity building of rights holders to make their claims and of duty bearers to meet their obligations (UNHRBA, 2003).

have the resources and capacities to meet their obligations; and that social groups—particularly vulnerable groups—have the information and capacity to claim their rights, with access to redress mechanisms such as human rights commissions, policy reviews, audits, and courts to pursue violations.

Nevertheless, the resource constraints facing states, particularly in low-income countries, also generally imply a principle of progressive realization of the right to health (and its determinants)—that is, to move as quickly and effectively as possible toward their achievement. ICESCR General Comment 14 refers to core obligations that require immediate action versus obligations that can be progressively realized, supported by measures to show constant progress (United Nations, 2000). States need to demonstrate that they are taking deliberate, concrete, and targeted steps towards realizing these health and SDH rights, to put all appropriate and available means in place for this progress, and to monitor and report on their implementation against agreed benchmarks (GIZ & WHO, 2011b).

There is an interaction between gender and human rights frameworks in addressing SDH. Human rights principles of equality, participation, and nondiscrimination applied in addressing SDH address gender inequalities and gender equality not only as an SDH, but also as a human right. Addressing gender inequalities is, further, essential to realizing human rights, including the right to health (WHO, 2011). Gender mainstreaming as a strategy thus applies a human rights-based approach, in analyzing the impact of gender norms, roles, and relations on rights to health, and in implementing measures to address rights violations and institutionalize gender equality, in a manner

that integrates the participation of affected women (WHO, 2011).

Hence, despite their differences in focus, SDH, gender equality, and human rights frameworks share some common features: All are explicitly guided by an ethical (normative) foundation that values and promotes procedural justice; all identify health outcomes as the result of wider social and material conditions (and seek to generate evidence and analysis on this relationship); and all recognize the role of social processes and power differentials in creating health inequities. Moreover, all three see the state and participation of affected populations as central in the response to health inequity and action on the SDH, through actions across numerous sectors, including the health sector.

## ► Addressing SDH Through Intersectoral Action and Health in All Policies

The diversity of SDH noted in the frameworks introduced earlier in this chapter implies that actions on SDH call on many sectors. The concept of *intersectoral action for health* was formally introduced at the 1978 International Conference on Primary Health Care (PHC) in Alma-Ata. The PHC approach explicitly identified the need for both comprehensive health services and joint action with other sectors to tackle the SDH and root causes of poor health (Public Health Agency of Canada [PHAC], 2007), with subsequent global processes further stressing the importance of dialogue and joint action with other sectors (CSDH, 2008)

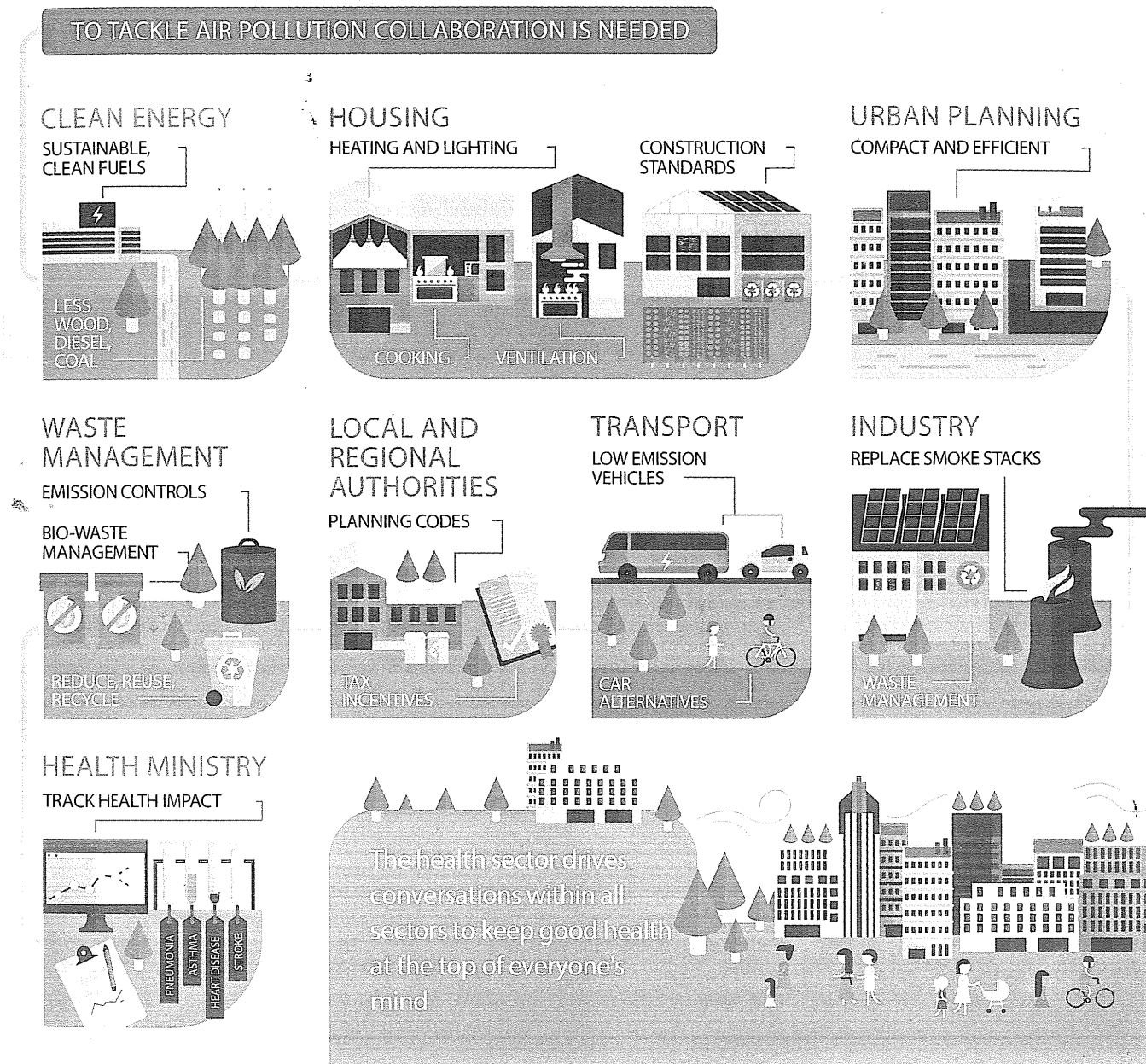
Many SDH lie outside the remit of the health sector (CSDH, 2008). For example, a global review of evidence on the determinants of diabetes identified that improving health outcomes for this condition involves the following measures: (1) limiting the availability of unhealthy food and environments; (2) tackling the obesogenic environment through improving urban infrastructure to promote physical activity; and (3) reducing exposure and addressing increased vulnerability among certain groups by improving

### DEFINITION

*Intersectoral action* refers to processes in which “the objectives, strategies, activities, and resources of each sector are considered in terms of their implications and impact on objectives, strategies, activities, and resources of other sectors.” It is advanced as a means for overcoming policy fragmentation; as a way to plan, implement, and monitor service delivery; and as a means to address “upstream” the determinants of health (Loewenson, 2013a, p. 8).

screening and access to and uptake of health care (Whiting, Unwin, & Roglic, 2010). The health sector thus needs to cooperate with other sectors to improve health outcomes, as demonstrated in **FIGURE 4-4** in regard to the actions needed to tackle the health burdens from exposure to air pollution.

Such intersectoral action to address SDH can be located as a shared goal across government, with “Health in All Policies” (HiAP) being one such approach. A HiAP approach is driven from within government as a whole, linking specific programs and measures to wider government policy agendas



**FIGURE 4-4** Intersectoral collaboration on air pollution.

Reproduced from WHO. (2015). *What is health in all policies?* Infographic on air pollution. [http://who.int/social\\_determinants/publications/health-policies-manual/HiAP\\_Infographic.pdf?ua=1](http://who.int/social_determinants/publications/health-policies-manual/HiAP_Infographic.pdf?ua=1) (accessed 19 May 2017).

**DEFINITION**

*Health in All Policies* is an approach to public policies across sectors that systematically takes into account the health and health systems implications of decisions, seeks synergies, and avoids harmful health impacts, with the goal of improving population health and health equity. A HiAP approach is founded on health-related rights and obligations.

(Shankardass, Solar, & O'Campo, 2012). While formally articulated as policy concepts from the 1970s, HiAP and intersectoral action for health have their roots in the early history of public health and "healthy public policy." HiAP builds on experiences of intersectoral action and health promotion, and has been given a greater international profile since 2000 (Friel, Harris, Simpson, Bhushan, & Baer, 2015; PHAC, 2007).

**EXHIBIT 4-4** provides an example of HiAP in South Australia, located within the overall state strategic plan. Applying HiAP calls for information systems and strategic review involving all relevant sectors to gather evidence and evaluate how joint actions are affecting the distribution of SDH as well as the social gaps and gradients in health, so as to adopt appropriate responses (Loewenson, 2013a; WHO, 2013a).

As noted in Exhibit 4-4, intersectoral action calls for measures to build collaboration and coordination across sectors, often departing from the administrative, budgetary, and functional siloes that exist within states. It involves whole-of-government approaches, which lever action across all levels and sectors of government, and whole-of-society approaches for public outreach, including through parliaments/legislatures, civil society, and the private sector (Delaney et al., 2016; WHO Europe, 2013). A review of experiences in more than 15 countries identified key measures for the successful implementation of intersectoral action, shown in **EXHIBIT 4-5** (PHAC, 2007; Rasanathan, 2011).

The HiAP approach and the implementation steps in Exhibit 4-5 can be applied to embed health equity as a goal across all relevant national policy, law, and

#### **EXHIBIT 4-4** The South Australian Approach to Health in All Policies

HiAP in the South Australian government, as adopted in 2008, was developed as a central process of government, rather than one run by and for the health sector. It was integrated in the implementation of the South Australian Strategic Plan, which aimed to improve prosperity and well-being, foster creativity, build communities, and sustainably expand opportunity. The approach sought to better utilize social, economic, and environmental levers to influence population health, and in turn to contribute to achievement of the overarching government vision for South Australia as articulated in the strategic plan. HiAP is thus deliberately and strategically positioned as a central process of government, rather than a process run by the health sector to achieve solely its objectives. A range of agencies use HiAP in partnership with South Australian Health as a mechanism for achieving their own goals, aligned to the objectives and related targets of the strategic plan. The implementation of HiAP is supported by central government, in partnership with the health sector.

The 2011 South Australian Public Health Act provides for the systematic integration of HiAP approaches in government functions and for mechanisms for embedding health considerations in government decision-making processes. The act mandates use of HiAP in public health planning by local municipalities and in health impact assessments and any other measures that they use, such as a health lens analysis. Health lens analysis builds on traditional methods for health impact assessment and incorporates additional methods used by other sectors, such as economic modeling. Such analyses have, for example, focused on water sustainability, regional migrant settlement, digital technology access and use, healthy weight, and active transport. A small HiAP unit was established within South Australian Health to facilitate health lens analysis and sustain the partnership with other government agencies in applying HiAP to their targets (Bucket, Williams, & Wildgoose, 2011; WHO, 2013a).

#### **EXHIBIT 4-5** Measures for Steps Necessary for Successful Implementation of Intersectoral Action for Health

1. Create a policy framework and an approach to health that are conducive to intersectoral action.
2. Emphasize shared values, interests, and objectives among all partners and potential partners.
3. Ensure political support, building on positive factors in the policy environment.
4. Engage key partners at the very beginning.
5. Ensure appropriate horizontal linking across sectors and vertical linking of levels within sectors.
6. Invest in the alliance-building process by working toward consensus at the planning stage.
7. Focus on concrete objectives and visible results.
8. Ensure that leadership, accountability, and rewards are shared among partners.
9. Build a stable team of people who work well together, with appropriate support systems.
10. Develop practical models, tools, and mechanisms to support implementation of intersectoral action.
11. Ensure public participation through education and awareness raising of SDH and intersectoral action.

programs, when specific focus is given to those SDH that have a role in closing the gap or gradient. For example, in 2007, a Norwegian parliament whole-of-government approach aimed to reduce social inequalities in health in 2007–2017 by “leveling up” across the social gradient. The strategy linked efforts to reduce social inequalities in health to government policy initiatives to improve employment, welfare, and inclusion, and to support early intervention for lifelong learning (Norwegian Ministry of Health and Care Services, 2007). Another example of such a “whole-of-government” approach in Mozambique is described later in Exhibit 4-12.

While there may be technical evidence or consensus on the relevance of specific SDH to health outcomes, not all countries have the high-level leadership support, policy space, or institutional systems to support such whole-of-government approaches to cooperation across sectors. Where this is the case, intersectoral action may be built by the health sector itself collaborating with one or more sectors to support the shared goals of both sectors. For example, education measures that support secondary school completion rates for girls, such as those described later in Exhibit 4-9, contribute both to improved education outcomes and to improved adolescent health, with longer-term health, socioeconomic, and well-being gains for girls—and their future children—extending into adulthood (Loewenson, 2013b).

These approaches help to build the confidence in, relationships for, and systems to support intersectoral action for health. Tackling health inequities, and particularly those that are affected by structural determinants, often demands the deeper and more sustained levels of collaboration through the whole-of-government approaches described earlier, as found in a review of experiences of 19 countries in Africa, Southeast Asia, and the Western Pacific (WHO, 2013a). In one such experience, described in **EXHIBIT 4-6**, Vietnam sought to improve road safety and to alleviate traffic congestion, both of which had the potential to have positive impacts on health and health equity.

Advancing intersectoral action calls for governance arrangements and systems to design and implement coherent multisectoral and cross-sectoral policies on SDH. This is often a challenge, particularly when health professionals are perceived to be overlooking other sectors’ goals and challenges and drawing resources *from* other sectors *to* a health sector agenda, rather than as efforts to mutually improve each sector’s policies (Rasanathan, 2011). The goals of other sectors should thus be used to orient analysis and explore areas of mutual interest across sectors. WHO’s SDH Sectoral Briefing Series (covering housing, education, transport, energy, and social protection) provides further information

#### **EXHIBIT 4-6** Multisectoral Collaboration Through the National Helmet Law in Viet Nam

The motorcycle is the primary mode of transportation in Viet Nam and contributes to more than half of all road traffic fatalities (Passmore, Tu, Luong, Chinh, & Nam, 2010). Passengers, particularly children, are vulnerable to injury due to widespread lack of helmet use. Despite helmet legislation since 1995, with amendments in 2000, 2001, and 2003, the National Traffic Safety Committee charged with implementation of this law faced challenges due to legislative loopholes. A 2007 law sought to close these loopholes by requiring all riders and passengers to wear helmets on all roads without exception and by increasing penalties tenfold. Although 50,000 helmets were distributed to low-income families nationwide, more loopholes were identified after introduction. For example, no reference was made to the correct use of helmet wearing, and the existing legislation meant neither children younger than 16 years of age nor adults carrying them could be fined. These legislative loopholes were subsequently addressed and attention given to barriers to effective helmet use, including improved availability and quality of helmets for the climate, raising public awareness, and changing beliefs about the impact of helmet use. Multisectoral collaboration was built across government agencies and with key nongovernmental organizations and the private sector. This resulted in three national mass-media campaigns and distribution of free helmets to school-age children sponsored by private companies. Monitoring showed helmet-wearing increased from less than 30% to more than 95%, with this change estimated to have saved more than 1,500 lives and prevented almost 2,500 serious injuries.

This example illustrates an approach to policy change backed by strong political support, integrating legislative, research, and media work and strategic alliances. There was cross-sectoral support because the actions were seen to yield benefits for a range of sectors, including road safety, alleviation of traffic congestion, improved health, and reduced costs to the state and families from serious injury and potential loss of income. Focusing distribution of helmets on low-income families aimed to support equity by facilitating compliance with the law among those who were least able to afford a helmet, but most reliant on motorcycle travel (Nguyen, Passmore, Cuong, & Nguyen, 2012; Passmore, Tu, Luong, Chinh, & Nam, 2010; Passmore, Nguyen, Nguyen, & Olivé, 2010; WHO, 2013a).

to support such collaboration with sectors outside health, such as in supporting transport authorities' banning of lead and sulfur in gasoline as not only a health-promoting measure, but also as a contributor to improved air quality and a sustainable environment (WHO, 2017a).

## ► Implications for Health Systems and Services

As further elaborated in *The Design of Health Systems* chapter, effective health services are a determinant of population health, contributing to reducing mortality and increasing life expectancy, particularly through preventive services and health promotion (Loewenson & Whitehead, 2012; WHO Regional Office for Europe [WHO Europe], 2011). They encompass various functions, including stewardship, resource mobilization, financing, and service delivery, and involve a network of public and private organizations, institutions, and resources (WHO Europe, 2011).

Health systems not only provide individual- and population-level services that position them as an intermediary SDH, but, as outlined earlier in this chapter and in Figure 1.1, they can also influence the policies and coordinate with the actions of other sectors to address SDH, thereby providing a site from which to contest social inequalities (Solar & Irwin, 2010; WHO Europe, 2011). Health services and institutions can address differences in exposure and vulnerability, take a leadership or facilitating role in intersectoral action, and mediate or mitigate the financial, social, and physical consequences of illness in people's lives.

This role of the health system in addressing both disease and its underlying SDH is consistent with the application of the PHC approach as an organizational strategy and an underlying philosophy. Within the healthcare system, PHC requires the provision of comprehensive, integrated, and appropriate health services, emphasizing prevention, promotion, and the role of primary care and the role of the health sector in intersectoral action for health (Gilson, Doherty, Loewenson, & Francis, 2008). While past experience of the application of PHC has produced mixed outcomes, evidence of its potential to improve health

equity—compiled, for example, by CSDH—has sustained and increased calls for its implementation (Gilson et al., 2008).

There are a range of ways that health systems can achieve positive outcomes and influence the distribution of health and well-being, summarized in **FIGURE 4-5** overleaf. In the figure, the solid arrows show drivers of health inequity, whereas the dotted arrows show how the health system can mitigate these effects or promote health equity. 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 when people fall ill (Gilson et al., 2011).

In a rights-based approach, health systems can provide space for people to exercise their rights, to have an informed say in decisions and actions on health, and to hold the system accountable for its performance. Health systems directly influence other SDH, such as local employment and economies, gender equality, and organizational policies, by their own behavior and organization, in the way they help patients to claim welfare benefits; provide rehabilitation to enable people to keep jobs; manage personnel; procure inputs locally; and champion or facilitate political support to introduce or sustain actions that address SDH and promote health equity (Loewenson & Whitehead, 2012).

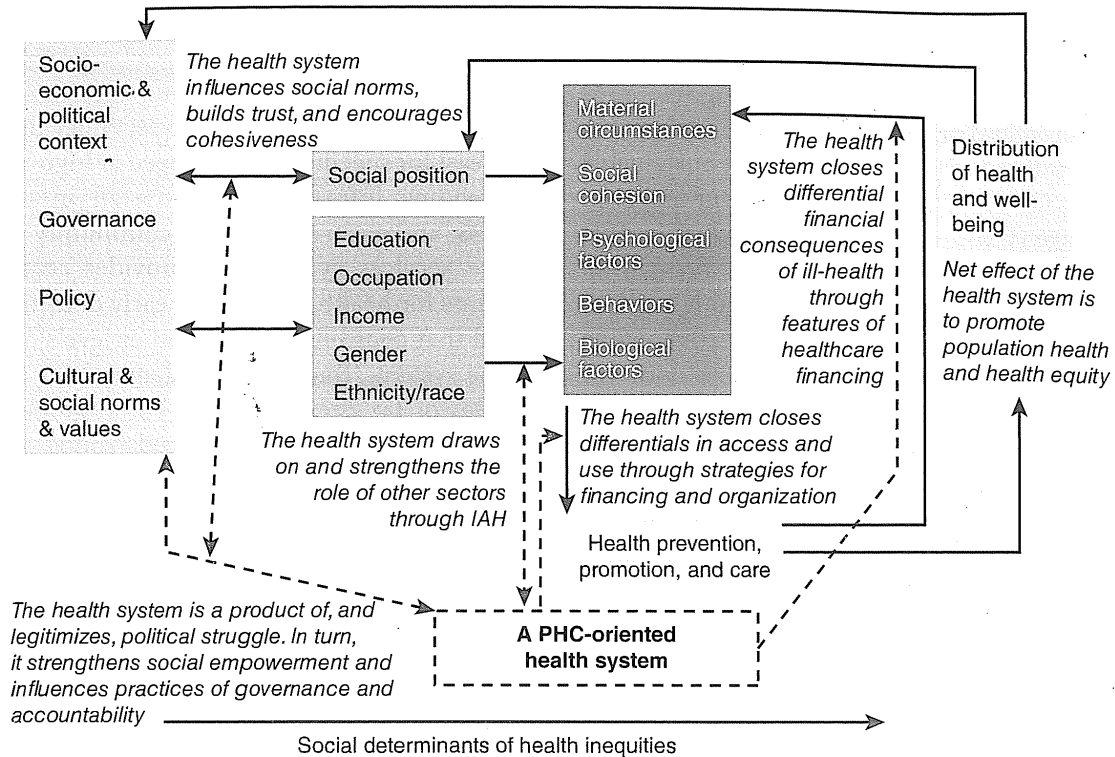
While the manner and extent to which these measures are implemented depends on the specific country and sociopolitical contexts, some principles and areas of learning apply more broadly in terms of how the health system implements its role in SDH and health equity.

## Investing in Primary Health Care-Oriented Services at the Local Level

Addressing health equity and SDH implies that health systems will pay attention to and direct resources toward health promotion and prevention of disease

### DEFINITION

*Health systems* encompass all the activities whose primary purpose is to promote, restore, or maintain health. They comprise the public and private organizations, institutions, and resources that aim to prevent disease, promote health, and provide health care, and they shape wider societal norms and values (Gilson, Doherty, & Loewenson, 2011).



**FIGURE 4-5** The health system as a social determinant of health.

Reproduced from Gilson, L., Doherty, J., and Loewenson, R. (2011). Challenging inequity through health systems, in J. H. Lee and R. Sadana (Eds.), *Improving equity in health by addressing social determinants*. Geneva, Switzerland: World Health Organization (WHO). [http://apps.who.int/iris/bitstream/10665/44793/1/9789241503037\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/44793/1/9789241503037_eng.pdf) (accessed 22 June 2017).

at both the individual and population levels, rather than focusing exclusively on individual curative or emergency care. Doing so requires investment in community- and primary care-level services and activities, to open up opportunities for engagement with civil society, communities, and other local services or interventions needed by marginalized groups (Gilson et al., 2008). It is at this level and in this kind of local interaction that many of the SDH and access barriers affecting service uptake can be most directly recognized and addressed, including cost, social, gender, and cultural and other barriers and discrimination; lack of information and knowledge; lack of voice or power; and unresponsive or poorly oriented service providers. This is especially the case if services are to reach and address the health needs of the most marginalized groups (Gilson et al., 2011).

As noted earlier, for health systems to address SDH successfully, they also need to provide public health leadership for and work with other sectors to address the wider social and economic determinants of health, so that people do not repeatedly need treatment after returning to the same conditions that made them ill. This is not simply a matter for those working in community health or health promotion. Rather, it is affected by the continuity and comprehensiveness of the healthcare system as a whole: how well it is able to

link preventive, treatment, and rehabilitation services; cover immediate- and longer-term mental, physical, and social health needs; and coordinate pathways from primary care to referral to secondary and specialist services around individuals and populations (Gilson et al., 2008, 2011; Loewenson & Whitehead, 2012; Training and Research Support Centre [TARSC], 2014). It calls for leadership, communication, and facilitation capacities; for the decision-making space and resources to make and manage links with the public and other sectors; and for the political and social awareness and support for health personnel when they act on public health needs (Gilson et al., 2008; Loewenson, 2016; WHO, 2008).

### Organizing Equitable and Universal Provision and Financing

In a universal system, everyone in a country should be able to access the same range of services on the basis of their need and pay for these services on the basis of their income. Universal health systems are generally publicly funded largely through general taxation or mandatory insurance 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 groups (Mackintosh, 2007). Universality is a key goal of the UN Sustainable Development Goals, expressed as achieving universal health coverage (UHC)—a system in which all people and communities can use the promotive, preventive, curative, rehabilitative, and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose them to financial hardship.

How countries achieve this goal varies across settings and may change over time. Many countries have funded health from general tax revenues or national mandatory insurance, in large pooled funds that allow for both cross-subsidies and the range of promotion, prevention, and care approaches necessary for addressing the social determinants of health equity. Currently, new prepayment approaches are being explored to secure adequate public funding, including for health promotion, taking into account not only how progressive they are, but also how they will impact on the goods, services, and behaviors that affect health. Such innovative financing sources include taxes on financial transfers, air travel, high-sugar products, tobacco, and alcohol, which may also be earmarked for specific purposes. In situations where formal and informal private payments for health services have risen, especially when arising as a result of inadequate or falling public funding, there are challenges for how to organize private payments into the forms of pooled prepayment that support universal systems and health equity and that invest in areas of public health that have less immediately perceived personal benefit (WHO, 2005). Organizing PHC-oriented, equitable, and universal health systems is not only a matter of how money is raised. It is also affected by whether resources and commodities are allocated according to need and invested in addressing social and service barriers to coverage, and whether there are mechanisms, such as health technology assessment, that bias public spending toward services with proven cost-benefit (Loewenson & Whitehead, 2012). Moreover, it depends on whether there is a motivated, competent health workforce deployed to areas of health need, trained and supported to implement actions on SDH and health equity.

### Addressing Barriers to Equity *Within* Universal Policies

As noted earlier, policies for universal coverage do not necessarily lead to equity of access or impact on the

SDH that affect uptake of care. Additional measures may be needed. Some measures for such “leveling up” have already been mentioned, such as ensuring that services are free at point of care, either universally, or at least for specific disadvantaged or high-need groups; providing infrastructure and staff in under-served areas; and ensuring a strong community and primary care services system that provides accessible entry points for health promotion, early detection, and care and that coordinates use of other levels of the health-care system. There may be demand for specific subsidies or tax exemptions for commodities consumed or used more by disadvantaged groups, such as basic foods. However, not all of the interventions are technical or on the supply side. Many address determinants that discourage uptake of services, such as by working with indigenous health systems and local civil society organizations (CSOs); providing joint entry points or working as multidisciplinary teams across health and other sectors, together with local political and community leaders and volunteers; creating entry points for health actions in settings (e.g., schools, workplaces, communities, marketplaces, areas) that people frequent; and sharing information and building a more participatory culture to involve community members in decisions and actions on their priority health needs (Gilson et al., 2011; Loewenson & Simpson, 2014). **EXHIBIT 4-7** provides some examples of programs that address the SDH affecting equity in health systems.

Actions such as those described in Exhibit 4-7 can strengthen, or protect, equity-promoting features of health systems and are often connected with wider struggles for social justice and transformation (Rede Brasil de Direitos Humanos, n.d.). For example, wider struggles for democracy in southern Africa set the political basis for post-independence comprehensive PHC approaches (EQUINET SC, 2007), while struggles for participatory democracy in Brazil shaped the entitlements and governance arrangements established in the Brazilian universal health system (SUS) in 1998 (Cornwall & Shankland, 2008). A study of primary care in 31 European countries found that sustained social support for government’s responsibility for welfare provision was important to enable the longer-term reforms that strengthened the comprehensiveness and equity of primary care services (Kringos, Boerma, Zee, Van der Zee, & Groenewegen, 2013). In the United Kingdom, a redistributive publicly funded National Health Service has been sustained over more than 60 years by social and cross-party support (Pennington & Whitehead, 2014). In other countries, rights-based approaches have been used to clarify state duties and public entitlements and responsibilities (Loewenson & Simpson, 2014).



**EXHIBIT 4-7** Addressing the SDH That Affect Equity in Health Systems

In Spain, the *Health Promotion among Navarre Ethnic Minorities* program aims to reduce health inequities by improving the health of the Roma community in one area; the Roma are one of Europe's most disadvantaged social groups. Efforts are being made to design and implement prepayment schemes and to raise awareness with the Roma community about their health entitlements. Issues raised by the Roma community are integrated into training for health workers. The health information system carries out health equity surveillance, including for Roma populations, and the evidence is used to review and share practices across sectors and across countries. People from within the Roma community are trained as mediators and act as peer educators and as a liaison between the community and the central health, social, and education services. These mediators play a key role in documenting the health history of families in the area covered and drawing up a health plan in cooperation with the appropriate service providers. They highlight areas in which they need more information or education, as identified through the Roma associations—for example, on outbreaks of communicable diseases or issues related to lifestyle, life transitions, chronic diseases, and prevention. Staff from the relevant agencies meet once a year to incorporate additional items into the annual training program (Perez Jarauta, Goya Arive, & Merino Merino, 2010).

In England, *health champions*, local people trained by a U.K. nongovernmental organization, work with others in their communities to improve health. Health champions work with primary care personnel on health actions in the community; visit schools and community centers and bring local community members to health meetings; link local networks, knowledge, and experience with the practice knowledge and resources; use culturally relevant methods to gather local people to work with general practice staff; and explain to other patients how to make best use of the facilities and services provided. Health champions are reported to have improved input to local commissioning decisions, to have set up social and support groups for young mothers and for people with chronic conditions, to have improved individual and community literacy on prevention initiatives such as immunizations, and to have supported the use of appointment guides and other practice tools, especially for those persons for whom English is a second language. Their work is reported to have led to service and quality improvements (Pennington & Whitehead, 2014).

In rural Guatemala, *promotoras* (community health workers) have supported health service access and uptake. Low literacy rates, high rates of poverty, and gender inequalities impact on the uptake of child health services by indigenous Mayan women in the highlands of Guatemala. Indigenous leaders within the community—usually women who understand the local dialect and culture—have been trained as *promotoras*. The training is culturally adapted and recognizes local experience and environments. It includes space for the community to teach the teachers, such as on knowledge about the use of folk medicine to treat common ailments, while the *promotoras* are given information and skills to improve and manage basic health issues. An evaluation found these community health workers have had a positive impact on health and well-being, and the authors suggested that this experience may be relevant to meeting the health needs of immigrant populations in the United States.

Another paper describes how a needs assessment by the Organization for the Development of Indigenous Maya found diabetes to be a priority concern in indigenous communities. In 2012, the Organization for the Development of Indigenous Maya worked with community health workers trained as diabetes health promoters linked to primary care. Each worker had a caseload of 15–20 patients with whom they held a weekly diabetes club meeting, providing the attendees with information on self-management and group exercises. The community health workers also conducted weekly home visits and preconsults in the clinic to monitor each patient's progress and discuss specific challenges, create goals, and tailor exercise and nutrition plans. A significant decrease was found in mean blood glucose levels between baseline and follow-up in the people involved (Amerson, 2013; Micikas et al., 2015).

In recent decades, neoliberal globalization-related economic policies have dominated health system development in many countries. Given a more individualistic and consumerist society combined with conflicting political forces and values, these policies have challenged, fragmented, and weakened the universality and equity of health systems (Gilson et al., 2011; Mackintosh & Koivusalo, 2005). Thus, acting on SDH increasingly demands action to build public, professional, and political support, while also raising

the role of social agency and power as a social determinant of health equity, as discussed further in the next section.

## ► Social Exclusion, Social Agency, and Power as a SDH

As noted earlier in this chapter, people attain different positions in the social hierarchy, often characterized

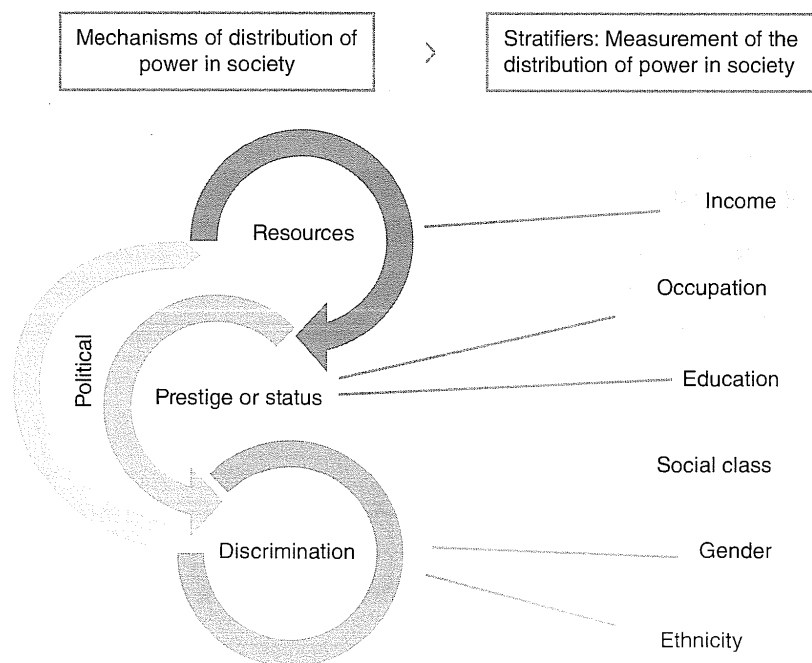
by their social class, educational achievement, occupational status, and income level, or based on gender. Socioeconomic position can derive from the following sources:

- Resource-based measures, referring to material and social resources and assets, including income, wealth, and educational credentials, as well as poverty and deprivation
- Prestige-based measures, including the level and quality of access to and consumption of goods, services, and knowledge; occupation; and education (WHO, 2016)

Beyond resources and prestige, stratification arises due to discrimination on social factors such as race, gender, color, sex, language, religion, political or other

opinion, national or social origin, or property (WHO, 2016). As social beings, humans need to feel valued and appreciated, and to derive meaning from and exercise a degree of control over their work and life conditions (AIHW, 2012). These drivers of social position are linked. Material deprivation generates social exclusion and stigma. Social power affects the ability people have to influence and make choices over health inputs and to use these inputs to improve their well-being (EQUINET SC, 2007). These factors and their role in stratification and power are summarized in **FIGURE 4-6**.

Social exclusion—and, conversely, social cohesion—has grown in profile as a conceptual lens through which to view problems of inequality, poverty, and disadvantage. Social exclusion has the following characteristics:



**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).

## 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).

- Multidimensional, encompassing social, political, cultural, and economic dimensions, operating at different social levels, and potentially reflecting violation of social rights to participation and inclusion
- Dynamic, impacting populations in different ways and to differing degrees at different social levels over time
- Relational, focusing on exclusion as the rupture of relationships between a group of people and the wider society (Popay et al., 2011)

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 (Popay et al., 2011).

The CSDH framework shown in Figure 4-1 positions social cohesion as an SDH that is structural, generating social differentials, and intermediary, as a condition. Popay et al. (2011) argue that applying an equity lens to the analysis of and response to SDH is more effective when social exclusion is understood in

terms of processes that embed unequal power relationships and produce social inequalities, rather than as a static “state” in which particular groups are labeled as “excluded.”

This perspective places inclusion and exclusion on a continuum that is a result of the distribution of social, economic, political, and cultural resources, capabilities, rights, and opportunities (Popay et al., 2011). This chapter points to various ways that such exclusionary processes manifest and affect health outcomes, such as in the transmission and response to the HIV epidemic in east and southern Africa (**EXHIBIT 4-8**), in slower and reduced access to services, in the impact of gender norms, or through precarious environments or displacement of people by large extractive industry projects.

Responding to processes and conditions that generate social exclusion is not a straightforward matter, and the responses are themselves affected by social determinants. In Colombia, for instance, people displaced by war were required to register with civil or military authorities as a means to access services, political rights, and social integration programs. Unfortunately, such registration also made people more visible, increasing their risk of discrimination and victimization and discouraging service uptake (Ojeda & Murad, 2005; Popay et al., 2011). Similar barriers to

#### **EXHIBIT 4-8** Social Determinants in the HIV Epidemic

The HIV and AIDS epidemic illustrates the complex relationship between exclusionary processes and health disadvantage. To start with, the epidemic has been most prevalent in countries (particularly in sub-Saharan Africa) that already experience social, economic, cultural, and political disadvantages. In the initial stages of the epidemic in east and southern Africa, HIV transmission was associated with more mobile, urban populations and adult HIV prevalence was higher in wealthier, more educated, and urban groups. The transmission reflected social differentials, however, such as in power and income between older men and younger women. As a reflection of the gender inequalities described earlier in this chapter, the HIV prevalence in young women age 15–24 years was more than twice that of their male counterparts in southern Africa in 2003. The changes in both HIV transmission and survival reflected common social differentials: The distribution of prevention and treatment interventions followed typical social differentials in the region, with lower coverage levels among rural, poorer people with lower education levels, raising their susceptibility and vulnerability. By comparison, urban, wealthier people lived longer lives with HIV—sustaining their prevalence rates—due to their better nutritional status and uptake of services and greater mobility.

A number of studies revealed the negative impact on these SDH on the epidemic, with households affected by AIDS facing higher levels of falling household assets, income, social security, food consumption, and increased social exclusion. The stigma and discrimination associated with HIV, combined with other exclusionary processes, exacerbated social, economic, political, and cultural inequalities, interfering with prevention, diagnosis, and treatment. The initial social characterization of HIV/AIDS as a moral issue exacerbated a culture of silence and denial by people living with HIV because of fear of rejection and isolation. Household survey data from four sub-Saharan African countries with different epidemic patterns (Ghana, Kenya, Swaziland, and Zambia) showed that AIDS increased the share of the population living in income poverty, with the strongest effects occurring in those just above the poverty line, placing demands on and further eroding the community-level safety nets and social support networks on which disadvantaged communities depend on (EQUINET, 2012; Rispel, Molomo, & Dumela, 2008; Salinas & Haacker, 2006; Southern African Development Community [SADC], 2003).

uptake have been found in programs that profile conditions that have been associated with social discrimination (e.g., HIV).

State-led responses to social exclusion are generally organized through a range of approaches. For example, *universalist policies*, reflecting values of social solidarity, extend rights to publicly funded services to all citizens, such as publicly funded national health services that are free at point of care. Universalist policies may address SDH and processes that drive social exclusion, as, for example, is intended in the health-promoting schools described in **EXHIBIT 4-9**. As noted earlier, they may need to be complemented by specific measures to address barriers to uptake or coverage in different social groups.

A second approach is through *policies targeting specific social groups*. These policies are specifically designed for disadvantaged groups, and intended to

remedy health disadvantages. In some cases, they take the form of *conditional targeted transfers*, involving some form of testing so as to target scarce services and health resources to those groups most in need, or to incentivize particular behaviors. They include social approaches, as exemplified in Exhibit 4-7. Targeted transfers include conditional transfers of cash or services, or a link between the two. As an incentive for service uptake in Brazil's Bolsa Familia, for example, recipients meeting the means test for a cash transfer must also ensure that their children attend health centers and school. Whether providing cash and/or services, these measures can bring resources to local services providers and promote economic inclusion. They are also documented to have limitations, however. For example, they are often insufficient to provide sustainable pathways out of low-income living, may impose bureaucratic barriers for some persons

#### **EXHIBIT 4-9** Universal Measures to Address Social Exclusion: The Healthy Schools Program in South Africa

In South Africa, schools have been a focus of community-based prevention of negative social factors—including social power imbalances, poverty, violence, and substance abuse—that place learners at risk, including for health problems such as HIV and AIDS. South Africa has the paradox of relatively poor health outcomes despite the country's relatively high aggregate gross domestic product and level of health expenditure. Inequalities in health stem from a history of racial and gender discrimination, a migrant labor system, and high levels of income inequality. The country has sought to address social, racial, and gender disparities and realize social rights through redistributive policies, largely in the social sector.

The percent of adults in South Africa without schooling fell dramatically from 18% in 2001 to 7% in 2010, although with continuing inequality in access to education by region and racial group. Western Cape province, for example, despite being the second richest province in South Africa, has high rates of poverty, economic inequality, unemployment, crime, commercial sex work in teens, and substance abuse, contributing to social exclusion and poor health outcomes. As one response to these conditions, education was seen by the community as a key asset supporting social inclusion and autonomy, promoting the sexual autonomy of girls, and reducing their risk of contracting HIV. Despite this, a large proportion of high school students drop out before completing secondary school and school-age pupils have been found to engage in cigarette smoking, drug and alcohol abuse, interpersonal violence, and unsafe road-related and sexual behavior.

Education policy in the country has sought to strengthen universal access to education, and to support schools as sites for reaching adolescents and helping them acquire health-promoting skills and orientation. Based on the national health-promoting schools policy and approach, a program was initiated in Western Cape in 1995 in which program leaders worked with community leaders, school staff members, school health nurses, parents, and the community to make schools a healthy and health-promoting environment for young people. The program integrates broad health promotion and education services, and promotes individual and social well-being for those at school and their families and community. It tackles content issues affecting social determinants, such as road safety, personal hygiene, substance abuse, HIV, and nutrition, and develops and supports alternative youth (and youth-led) activities such as teenage clubs, cultural activities, and camps. It incorporates local social and cultural resources, integrating local and indigenous knowledge, mentoring, and storytelling.

McNab (2013) found that this type of work depends more on a change in mindset rather than on the provision of major new resources, and on making a link between the "top down" influence of public policy and the "grass roots" approach of constructive community engagement. The social dimensions of the Western Cape program were seen to be a central element of its success: At a 2006 national conference, many presenters and participants highlighted the need to listen to and strengthen all voices in the program, and particularly the marginalized voices of local communities and indigenous wisdom, and of the learners themselves (Loewenson, 2013b; University of Western Cape, 2006).

with high health needs, and, as individual-based strategies, may have limited impact on promoting socio-political rights or building more inclusive political cultures (Lauthier, 2005).

A third strategy, *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. For example, disadvantaged groups may obtain subsidies in insurance schemes to support their access to services or subsidies to address health determinants such as housing. This kind of market support is argued to face similar barriers as those detailed in relation to targeted transfers, and may potentially lead to poorer-quality services for subsidized groups and neglect deeper determinants of such disadvantage (Popay et al., 2011).

Whatever the overall approach, as the example in Exhibit 4-9 suggests, involvement of the people who are the intended beneficiaries of policies and actions that aim to reverse exclusionary processes is essential, as both as a resource and as a right. This implies building a deeper understanding of social power and agency as both determinants and key dimensions of successful policy and action. It suggests that actions that seek to tackle exclusionary processes should strengthen the power and capacity of those affected to engage in meaningful participation, while addressing resistance from professional workers who see it as a challenge to their technical power.

The demand for social participation, power, and agency in health has grown with increased social literacy and with democratic pressures for people's values and preferences to be incorporated into public decision making. The CSDH (2008) identified participatory approaches as a critical feature of health system action or intersectoral action for health to tackle SDH. Social participation has been integrated as a demand-side "intervention" to address barriers to access and acceptability of services and as a means to involve people as active participants in their own health care (Mittler, Martsof, Telenko, & Scanlon, 2013). As a pragmatic measure, participation is seen to contribute to a range of areas necessary for the effective functioning of health systems:

- Community health literacy, public information, and the use of community knowledge on health
- Assessment, identification, and prioritization of health needs
- Health planning and decision making on spending priorities, resources, and budgets
- Policy deliberation and formulating strategic policy direction

- Co-design, coordination, and coproduction/implementation of health actions
- Oversight, monitoring, evaluation, review, and improvement of services, actions, and quality, including measures of social outcomes (Cornwall, 2008; Gilson et al., 2008; Loewenson & Gilson, 2012; Loewenson et al., 2014)

In a pragmatic and sometimes depoliticized approach, people as consumers or as volunteers may have minimal control over policies affecting structural determinants, but assume responsibility for implementation of compensatory actions. There may be limited change in current norms, processes, and mechanisms. While people may exercise oversight by monitoring, reviewing, and holding services accountable for their performance, they may not have the power to make the decisions that shape these services and may as volunteers take on unpaid burdens of care (Loewenson, 2016).

Participation has also been a product of political drivers, including through the actions of popular movements that have generated demand and sometimes conflict around health and around codetermination and accountability (Amar Amar & Echeverria Molina, 2008). As noted earlier, participation is viewed as the right to guide the duty bearers (states) in their implementation of other human rights. Citizens, including those engaging as health activists or in social movements, have pursued these rights through collective demands for change in areas of power, discrimination, beliefs, policies, and practices that are perceived as inequitable or as limiting their well-being, whether in relation to access to services or the SDH that affect the health of different social groups, or as a claim for shared decision making and oversight (Cornwall & Leach, 2010; Loewenson, 2016). The power, voice, and agency of affected groups can be found in invited spaces—created by external actors and in which people are invited to participate—or in *claimed/organic spaces*—created by people themselves, often as collective and popular self-organizing spaces around a common cause (Cornwall & Leach, 2010).

There are thus different conceptualizations of participation, taking different forms that express the different power relations that exist and the control that people have over events and resources. For example, a group may exert power "over" another group (such as when men control women's use of reproductive health services), may claim the power to be part of processes (such as when people living with HIV participate in price setting for treatment), may exert a shared power "with" each other (such as when communities organize as a group to engage service providers on delivery), or

may build a shared consciousness of themselves and their conditions in the form of a power “within” (such as when youth identify and call for changes in the way mental health services are organized to reflect their needs). In participatory processes where communities express their own collective voice and agency to an increasing degree, they build shared power as well as a consciousness and confidence to act. In contrast to fears that this paradigm diminishes the power of technical actors, it can be shown to create complementary

forms of power that enable positive change, especially for community-level and frontline services, as exemplified in the case of Zambia described in **EXHIBIT 4-10**.

A growing number of studies using experimental or quasi-experimental designs in LMICs have demonstrated the potential of participatory interventions to generate health and health equity gains (Pronyk et al., 2006; Wallerstein, 2006). It is not easy, however, to be prescriptive about the specific mechanisms and measures to achieve these changes, as they are context

#### **EXHIBIT 4-10** Social Participation and Power in Improving SDH in Lusaka, Zambia

Zambia is a lower-middle-income country; Lusaka is its capital city and home to 1.7 million people. The Lusaka District Health Office (LDHO) is the local health authority within Zambia’s Ministry of Health. For more than a decade, LDHO has used participatory reflection and action (PRA) approaches to strengthen health services delivery at the primary care level and the role of neighborhood health committees (NHCs) as a more formal, sustained space for participatory interactions. As a matter of policy, NHCs involving elected community members are expected to identify and voice community health needs and to support information exchange between health services and communities.

In 2005, however, planning and budgeting for PHC was not participatory, and these committees were often poorly organized or not effective in their role. Growing public health problems in Lusaka motivated community members, health workers, and LDHO to address these shortcomings. Various participatory tools were used to identify needs, system barriers, and areas for change, and to build a shared identification of problems and actions to remedy them across health workers and community members. Information sharing between health workers and community members increased, community members became more confident in approaching health workers for information, and health workers provided the needed information to them for planning and resource allocation purposes. A range of actions were taken, including a cholera prevention strategy that led to significantly fewer cholera cases and deaths than in previous years, despite the heavy rains. By the end of this first phase of work, the community members had developed greater confidence and enthusiasm in seeing the process move forward. Likewise, health workers noted the benefits of improved communication with the community, though some feared losing power.

In 2008–2009, the same PRA approaches were used to scale up the health system by establishing new health centers in the city, while consolidating and building capacities to institute the approaches in existing ones, and building partnerships with a range of other sectors in areas such as clean-up campaigns, solid waste management, healthy food production, and services performance and uptake. These efforts were complemented by a range of approaches to organize and use community evidence. Photovoice (community photography), for example, presented evidence on community concerns with blocked sewers, health facility corruption, poor water supplies, and solid waste management during clinic and district health meetings held to trigger actions to resolve these problems. A wider community-level health literacy process with Lusaka residents drew evidence from their lived experience, facilitating community-level diagnosis, providing relevant health information, and stimulating action and engagement with health systems, in partnership with service providers, civic leaders, and the local authority. These approaches positioned the communities as change agents. Every three months, those working on the action plans met to review their work, reflect on their experience, and evaluate their progress.

Pre- and post-intervention surveys and reports from health workers and communities about the initial 2006–2008 PRA work found improved interactions between health workers and community members and partnerships with other actors, and increased confidence of community members in providing inputs to planning processes in support of action on health. There is also some evidence of positive health outcomes associated with this work. For example, the clinic catchment areas where these activities took place had no cases of cholera in 2012–2015, at a time when other areas still reported cases. While it is not possible to solely attribute the positive outcomes to the PRA program, the removal of waste sites that were once a site of disease and the measures to increase community health literacy and action were perceived to have made an important contribution. The health literacy work and the engagement with neighborhood health committees is now being expanded beyond Lusaka in a national scale-up in light of the positive outcomes from the work done in Lusaka District (LDHO & TARSC, 2016; Lusaka District Health Management Team & TARSC, 2015; Mbwili-Muleya, Lungu, Kabuba, Zulu Lishandu, & Loewenson, 2008; Ministry of Health Zambia, LDHMT, & TARSC, 2012).

dependent. Many of the approaches are triggered by or involve action outside the health system, in other sectors and organizations, and within the community itself. Various features of health systems have, however, been found to support the spaces and shifts in social power that enable effective participation. These approaches include the following:

- Setting health interventions in sites that are familiar to communities, such as markets or schools
- Integrating community mapping, monitoring, and preferences in health planning
- Producing accessible information (such as through newsletters, meetings, and social media) that shares local experience and responds to perceived needs
- Using socially appropriate and participatory methodologies that build on and validate local experience and knowledge
- Involving and supporting community-elected and -located community health workers to strengthen communication and linkages between health systems and communities
- Providing opportunities for dialogue on community perceptions of services, through community audits, health watches, community councils, participatory research, and legal action
- Devolving meaningful budgets to lower levels of the health system to facilitate and support social roles
- 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
- Investing time and resources in, and providing management support for, health worker competencies and incentives for participatory processes (Benequista, Gaventa, & Barrett, 2010; Cornwall & Leach, 2010; Gilson, 2007; Loewenson, 2016; Loewenson et al., 2014; Mbwili Muleya et al., 2008).

Implementing such measures depends on wider contexts, including the political freedom, spaces, and capacities that groups have to voice their views and to exercise influence; the constitutional, legal, and policy frameworks, social organizations, and systems that enable participation and support an active and democratic culture; the sociocultural conditions and relations within communities and families; and a comprehensive understanding of health and well-being that integrates and is accessible to society (Arenas-Monreal, Piña-Pozas, &

Gómez-Dantés, 2015; Loewenson, 2016). These factors are not just shaped at local and national levels. That is, the local SDH and the social, institutional, and technical processes that affect them are increasingly influenced by global processes, and by decisions made by global and international actors. This topic is discussed in more depth in the next section.

## ► Global SDH, Local Impact: Experiences of Extractive Industries in East and Southern Africa

As noted earlier, globalization is transforming many of the social conditions that have the greatest impact on health, while also affecting the public policies and programs that target these determinants. Many of the elements identified within the socioeconomic and political context in Figure 4-2 are now influenced by global policies, institutions, and processes.

A review of international evidence on globalization and SDH identified that while globalization has both positive and negative impacts on health, its benefits are unevenly distributed (Labonte & Shrecker, 2008). In this review, the benefits were reported to have been primarily obtained by countries and communities that already had financial, land, physical, institutional, and human capital assets. While globalization has certainly brought opportunities, such as the flow of information and new global funding to address health issues, the rules of current forms of globalization were found to favor already rich countries and people, which have greater resources and power to influence their design (Labonte & Shrecker, 2008; World Commission on the Social Dimensions of Globalisation 2004). In sub-Saharan Africa, globalization policies were associated with debt crises, capital flight, and structural adjustment programs that were reported to have contributed in part to increased inequality in health and reduced gains in life expectancy (Labonte & Shrecker, 2008). Examples of the mix of positive and negative outcomes are shown in **EXHIBIT 4-11**.

With the growing impact of global determinants on health, an analysis of globalization and SDH merits deeper attention than a subsection of a chapter. The distribution of positive and negative impacts of global determinants of health is further discussed in the *International Trade and Health*, and *Global Health Governance and Diplomacy* chapters in this text, and

**EXHIBIT 4-11 Globalization, Women's Occupational Roles, and Nutrition in Sub-Saharan Africa**

A 2010 review of 62 peer-reviewed publications on pathways between globalization, women's occupational roles, and nutrition found a mix of positive and negative outcomes, although with greater documentation of negative outcomes for women's health and nutrition.

At the global and national level, 5 papers reported largely positive outcomes for SDH, with globalization-related innovations in technology and information, global normative commitments, and improved incomes, markets, and opportunities for improved diets from investments where women are involved in export-oriented farm production. However, 24 papers reported largely negative outcomes, with trade liberalization, terms of trade, market access, and value-added food chains largely benefiting existing wealth and foreign corporations; gender inequity in access to investment, technology, and extension services due to "gender-neutral" trade policies; shifts to imported foods and processed foods displacing local food crops with livelihood losses for women; and diminishing healthcare resources raising the costs of care.

At the community and household levels, 7 papers noted largely positive impacts in terms of improved returns from new technologies in crop yields, increased nonfarm employment, and information flows that challenged gender-related discrimination improving women's conditions, with positive returns for household nutrition. Here, too, however, the larger number of papers (34) pointed to negative impacts at the community and household levels from determinants related to global trade, arising due to weak consideration of existing gender inequities in access to and control over production inputs in policy and program design; insecurity of and poor wages in new forms of employment; decreased time for household needs and neglect by women of their own well-being to meet time and resource demands; and decreased availability of local foods and increased consumption of higher-cost and poorer-quality imported and processed foods (Loewenson, Bambas Nolen, & Wamala, 2010).

so is not covered in detail here. This section explores global drivers of local SDH and the responses to them through the example of the extraction of mineral resources from Africa, largely through global corporations and interacting with global capital markets. It also highlights how global and regional norms can be positively applied to address negative health outcomes.

In 2009, Africa's oil, gas, and minerals exports were worth roughly five times the value of international aid to the continent (\$246 billion versus \$49 billion), with African oil and mineral resources sought after by high- and middle-income countries, including the emergent economies of China, Brazil, and India (Loewenson, Hinricher, & Papamichail, 2016). A surge in demand led to exploration and development of many new mining sites and new agreements exchanging investment in infrastructure for mining rights to oil, coal, and various strategic minerals (Besada & Martin, 2013; Shelton & Kabemba, 2012). As a consequence of this activity, African countries are increasingly engaging in global markets. At the same time, the rewards from these ventures are reported to be skewed toward those countries and individuals who have existing economic power (Birdsall, 2005). African countries that are rich in these mineral resources have experienced high levels of inequality and poverty—often referred to as “the resource curse” (Global Witness, 2012). A literature review of the health and SDH related to extractive industries in east and southern Africa found that

they are significant economic actors in the region, but with limited forward or backward linkages into the national economy and limited job creation outside the sector, unless specifically stimulated (Loewenson et al., 2016).

This finding draws attention to how extractive industry (EI) activities, as a determinant of health, meet their responsibilities to protect against harm to health and make fiscal contributions to health care for the populations who work in or are affected by them. Corporations have duties to assess the potential risks of their activities to workers and surrounding communities, and to prevent and manage these risks. In recent years, more attention has been given to environmental risks associated with EIs, to EI company's duties to populations displaced by their activities, and to the duties that they have to inform and enable co-determination and participation of those affected in making the decisions that affect their health (International Labour Organisation, 2014; Murombo, 2013).

The health benefits of EIs have largely come from employment, income, and some service provision, generally for those persons who are directly employed by the mining companies and their families, and from EI fiscal contributions to public services. Nevertheless, tax exemptions often reduce their contributions to social funding. EIs also bring risks to health: They have been found to lead to accidents, hazardous



working conditions, environmental hazards, degradation of ecosystems, poor environmental health infrastructure, and displacement of local people—all of which increase the risk of disease. The literature reports the spread of communicable diseases (such as tuberculosis) and cholera epidemics from poor environmental health infrastructure, sexually transmitted diseases, and HIV in communities surrounding the mines (Aaboe & Kring, 2013; Catholic Relief Services [CRS], 2011; Loewenson et al., 2016).

Poor communities living around the mines are reported to be particularly vulnerable to pollutants, given their poor living conditions, with less recognition or monitoring of their risks. They are also least able to obtain reliable information on these risks, or to register their concerns with decision makers (CRS, 2011; von der Goltz & Barnwal, 2014). Mining is associated with (sometimes forced) displacement of communities, with reports indicating several thousand families having been resettled to facilitate mining in some countries (Global Environment Facility [GEF], Open Society Initiative for Southern Africa [OSISA], & United Nations Development Programme [UNDP], 2013; Human Rights Watch [HRW], 2013). As a health determinant, poor planning of such displacement is reported to have led to loss of livelihoods; loss of access to water, flora, arable land, and pastures for livestock for these communities; and substandard living conditions. Affected communities were poorly consulted on plans discussed with government, making it difficult for them to hold companies accountable when they did not deliver on commitments, and generating social frustration (HRW, 2013). For those living near mines or displaced by mining, exclusion from decision making on measures to address the health and social impacts, noted in many reports, is reported to have led these groups to “bear a disproportionate share of the costs of mineral development without adequate compensation, and to receive an inappropriately small share of the economic and social benefits” (International Institute for Environment and Development, 2002, p. 208).

As a key structural determinant, the policies and actions of the state play a vital role in protecting the health of populations caught in the midst of these global processes. For the health sector, this calls in part for public health leadership to leverage cross-sectoral health-promoting actions to manage health risks. **EXHIBIT 4-12** overleaf tells the story of one such response—that is, the experience of Tete in Mozambique. Other examples exist of state action in the east and southern Africa region, including using environment and health impact assessments to assess

health risks, implementing audits to review the performance of EIs as in Zambia, and setting contract/lease renegotiations or renewals to review, require, or impose new obligations in Democratic Republic of the Congo, Zimbabwe, South Africa, and Mozambique (De Backer, 2012; GEF et al., 2013; Kabemba, 2014). While EI contributions for health and social welfare are generally identified as areas of voluntary corporate social responsibility (CSR), Democratic Republic of the Congo introduced a micro-levy on EIs in September 2014 to fight chronic malnutrition; in the same year, Zimbabwe lifted the exemption on the sector that had allowed EIs to avoid contributing to the AIDS Levy Fund (Loewenson et al., 2016).

As multinational EIs are themselves global actors, managing health in conjunction with EIs also calls for global governance arrangements to recognize and integrate social obligations for addressing SDH. At the global level, there are now numerous international standards, codes, or guidance documents related to the practices of EIs and multinational enterprises. These exist at the UN multilateral level, from Organisation for Economic Co-operation and Development (OECD) countries, at the African Union level, from financial institutions, and in CSR standards developed by international business and by civil society. Some regions, such as the Economic Community of West African States (ECOWAS) in West Africa, have moved toward a “strength in numbers” approach, with efforts to harmonize laws relating to EIs, including laws targeting health and social protection at the subregional level (Loewenson et al., 2016). The inclusion of these global norms as legal provisions in east and southern Africa and their strengthened implementation and oversight with accountability at the global, regional, and national levels, including in the source countries of EIs, have been identified in the literature as important measures to address the local health impacts of such global-level determinants (Loewenson et al., 2016).

The focus on EIs in this section presents one example of global-level SDH. Many others could be cited, including in the various dimensions of trade and health and climate change discussed in other chapters in this text. The experience in Tete described in Exhibit 4-12 and that of other countries in east and southern Africa in managing these challenging contexts suggests that while local communities and services may be organizing cross-sectoral responses to such global drivers, more attention is needed to determine how best to ensure that global standards are enforced, including by transnational, private actors.

**EXHIBIT 4-12** Managing SDH in the Context of a Growing Extractive Sector: Tete, Mozambique

Tete province's geographical positioning, significant natural assets, and influx of investment, people, and capacities offer opportunities for addressing health needs in this region. Investments in hydroelectric power and coal mining have dominated recent investments in Tete, such that the province had the second highest provincial GDP growth in Mozambique between 2002 and 2008, largely driven by extractive industries. While these investments have brought economic benefit, they have also placed demands on infrastructure and services, led to displacement of people, and increased risks of injury, ill health, and social risks from displacement, harmful alcohol use, and road traffic accidents. Within the context of the communicable, reproductive, and other health burdens in the province, there is evidence of high social deficits in the very districts that host these large projects. The population in Cahora Bassa, a district with significant new power projects, has poorer health status outcomes than the populations in districts with less investment; Moatize, where the mines are concentrated, has fewer health service resources and poorer coverage outcomes; likewise, Tete City, a richer area and the focus of economic activity, also has poor health status outcomes. Tete City, Cahora Bassa, and Moatize had calorie-adjusted poverty rates in 2007 that were higher than those in most other districts in the province, including districts that were worse off than these three districts in 1997.

These findings raise the question of how such economic investment can be better linked to improved population well-being. One route for managing these SDH is through upstream entry points, linking EI activities to value-added local production, including in small and household enterprises, and providing links to their markets and infrastructures. Further upstream entry points include improved corporate fiscal and other resource contributions for public spending on education, health, and other social services, and the integration of health and social impacts in environmental impact assessments prior to granting a mining license.

Within this context, an assessment of the SDH, opportunities, and deficits carried out in 2014–2015

with the Tete provincial department of health (DPS Tete) identified key areas of action for the five-year provincial health strategy, including the following:

1. Closing the gap in improved household living conditions implemented through an intersectoral mechanism; ensuring all schools and health centers are connected to the power network; promoting small enterprise production of clean technologies for household cooking and energy; earmarking budgets and levies from local businesses for rapid improvements in rapidly growing settlements, such as Tete City and Moatize; and monitoring risks, interventions, and health impacts.
2. Promoting and protecting worker and community health in production activities, with measures outlined to promote occupational and community health and protect against production-related risks, including through environment, social, and health impact assessments; involving health personnel in oversight of corporate duties related to resettlement; and integrating company roles and resources in health services and activities in their districts.
3. Coordinated multisectoral strategies to improve food security and nutrition.
4. Expanding and improving equity in access to PHC, and positioning the health sector as a key redistributive sector in inclusive development, including through entry points in schools and workplaces, through private-sector contributions to healthcare services, and by enhancing community health literacy.

The province is now building support within other sectors for wider cross-sectoral implementation of these actions under the leadership of the governor of the province and with representatives of sectors at the national, provincial, and district levels (Loewenson & Simpson, 2015; Ministério da Planificação e Desenvolvimento, 2013; Ministério de Saúde, Mozambique, 2014; Republic of Mozambique et al., 2016; Salvucci, 2014).

## ► Evaluating Action on the Social Determinants of Health and Health Equity

This chapter has presented evidence on the diversity of SDH and on the analysis and actions being applied to tackle them, including measures to address health equity. WHO's CSDH was a culmination of longstanding efforts by policy makers, state officials, academics, practitioners, and civil society to improve

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 (Simpson, Kelly, & Morgan, 2013). 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; one such evaluation is described in **EXHIBIT 4-13**.

One of the recommendations of the CSDH to “close the gap in a generation” was to “measure the

**EXHIBIT 4-13** Evaluating Interventions to Reduce Health Inequities

A six-year program was implemented in the Netherlands in the late 1990s to systematize learning from policies and interventions to reduce health inequities. Twelve studies were commissioned to evaluate a range of interventions to tackle SDH known to contribute to health inequities *and* to reduce exposure of lower-socioeconomic groups to these factors (e.g., poorer working conditions). Methods used ranged from observational to quasi-experimental to experimental studies. Evaluation of seven interventions gave positive results, with the researchers finding an improvement in at least one health outcome and/or an intermediate outcome. For example, a rotation of tasks among dustmen (i.e., garbage collectors) reduced physical workload and sickness absenteeism. Overall, the program sought to contribute to an evidence-informed approach for developing a national response to health inequities. It recommended that evaluation studies using a variety of approaches be embedded in all future interventions on health inequities (Stronks & Mackenbach, 2005; Simpson et al., 2013).

**DEFINITION**

A *realistic evaluation* approach combines assessment of design, process, and outcome and attempts to provide answers not only about which interventions work to address SDH, but also how they work and in which context(s) (Kelly et al., 2007).

problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health” (CSDH, 2008, p. 20). This includes ensuring routine local, national, and international monitoring of SDH and health equity; investing in and building capacities to generate and share new evidence on the relationship between SDH and population health and health equity, and on the effectiveness of interventions to tackle these SDH; and raising public awareness on the findings (CSDH, 2008).

To date, a significant body of evidence has been developed on the “problem,” on the link between specific SDH and health outcomes (particularly for intermediary SDH), and on the associations between SDH and health equity. By comparison, progress has been slower in evaluating the effectiveness and equity impact of interventions, and in generating attributions of impact to health or health equity and structural SDH. In part, this is due to the complexity of the methods used and the evidence needed to assess the commonly multicausal and context-dependent nature of the interventions for the “problem.” While there is increasing recognition of the value of implementation and health systems research using new methodological approaches, there has been a continued predominance of a biomedical paradigm in health research and the use of traditional evidence-grading systems to value evidence. This has led to intervention studies on SDH, and the qualitative methods used to understand contexts for and impacts of complex interventions on SDH, often being classified as “unscientific” and “value-laden,” despite their reliance on accepted

social science methods (Baum, 2010; Bonnefoy et al., 2011). That this situation is changing is evidenced, for example, by the growing efforts to measure action on SDH among and within countries, by the documentation of country-level action on SDH, and by the Cochrane Equity Methods Group guidance on explicitly addressing equity in systematic reviews (Campbell & Cochrane Equity Methods Group, 2017; O’Neill, Tabish, Welch, Petticrew, Pottie, Clarke et al., 2014).

The CSDH Measurement and Evidence Knowledge Network emphasizes that no single approach to the generation of evidence should be favored over others and that evidence should not be appraised on the basis of adherence to a single evidence hierarchy or method (Kelly, Morgan, Bonnefoy, Butt, & Bergman, 2007). Health impact and equity impact tools, such as those outlined earlier, and more comprehensive approaches such as “realistic evaluation,” support evidence on SDH and health equity because they move beyond simply estimating the likely effect of policy, to constructing logic models that show the implementation chain from policy to implementation in practice (Kelly et al., 2007). A range of methods and evidence enable practitioners to understand the complexity of mechanisms and the multifactorial nature of determinants that apply in practice and can make explicit the theories upon which programs are based. Realistic evaluation, for example, helps to capture the linkages between the context (the necessary conditions for an intervention to trigger mechanisms), the mechanisms (the aspects of a particular intervention that lead to a particular outcome in a given context), and the outcomes (the practical effects produced by causal mechanisms being triggered in a given context) (Kelly et al., 2007).

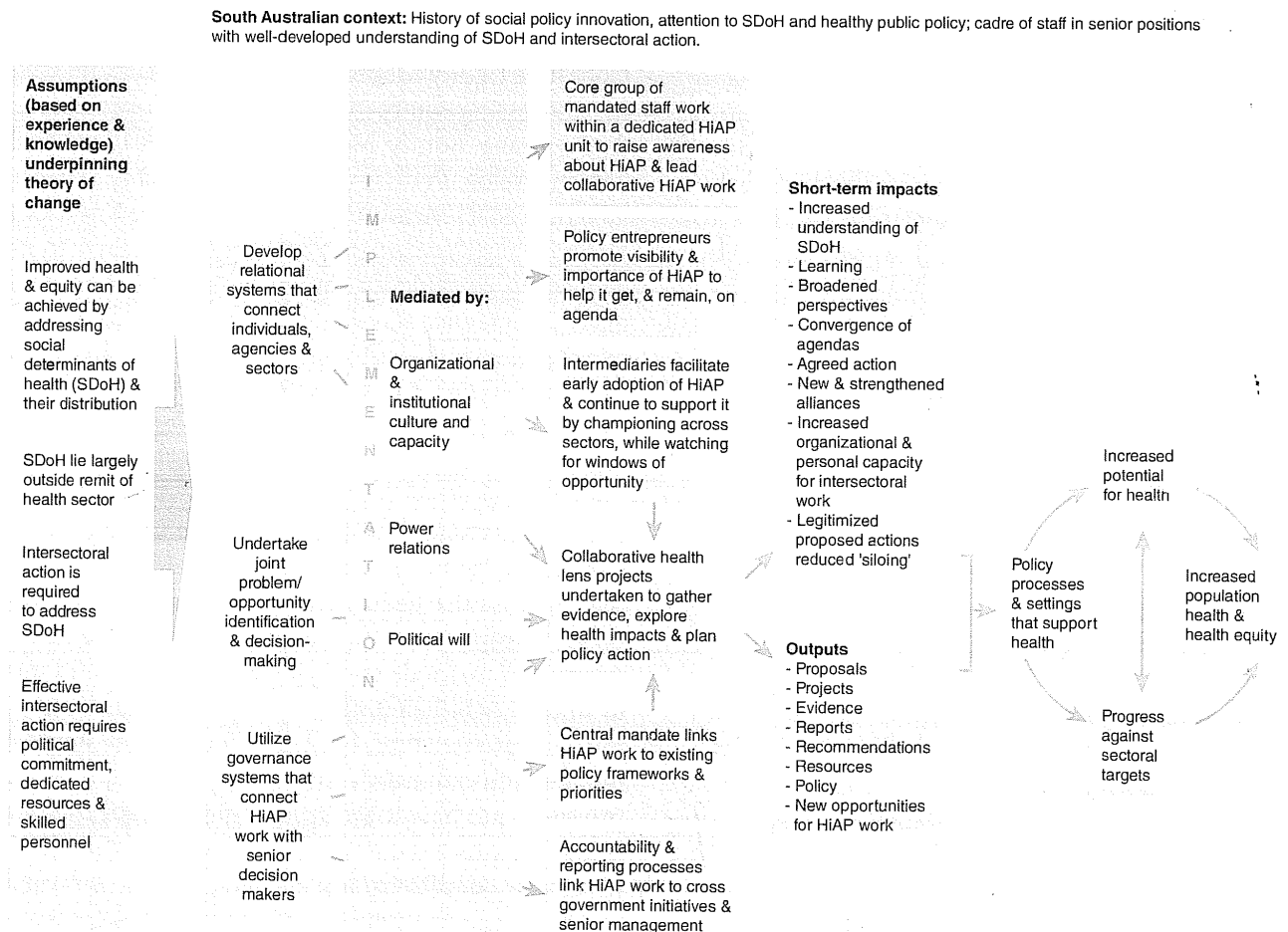
As argued earlier in this chapter, evidence and analysis contribute to the building of the relationships and complexity of interventions often needed to address SDH, including for intersectoral action and HiAP. Having an explicit and shared conceptual framework and theory of change at the outset helps to clarify the pathways for change, to identify shared outcome measures for assessing performance and impact, to prioritize action, and to test the thinking, thereby informing subsequent IAH work (Loewenson, 2013a). Analytic frameworks that explicitly include the assessment of equity in the design, implementation, and assessment of outcomes, while important, are not always present in evaluations of intersectoral action on SDH (Shankardass, Solar, Murphy, Greaves, & O'Campo, 2012).

The South Australian program on HiAP described in Exhibit 4-2 has, for example, taken a two-phase approach to evaluating its work: The first is an evaluation of perceptions of, interests in, and processes for HiAP implemented through interviews with senior South Australian public servants from the beginning of the

initiative and continued in tandem with the health lens analysis. The second is a more comprehensive approach implemented in three overlapping stages over a five-year period (2012–2016) and using mixed methods, including test of a logic model of and theories of change for the work, shown in **FIGURE 4-7** (Baum et al., 2014).

Semi-structured interviews were implemented with key political figures, officials, and other actors who have knowledge of the HiAP process to generate knowledge to support its development and implementation. In the second stage of the evaluation, the theories developed in the first stage were tested, and the program logic and practice of implementation of the HiAP examined in eight health lens analysis projects, with detailed analyses in two of these health lens analyses and online surveys of policy actors administered regularly over the five-year period. A final stage synthesized the evidence to produce transferable knowledge and disseminate findings in annual research forums for peer review and discussion (Baum et al., 2014).

The features of the South Australia evaluation, which included multiple methods, stages, and areas of



**FIGURE 4-7** A preliminary program logic approach for evaluating HiAP in South Australia.

Reproduced from Baum, F., Lawless, A., et al., 'Evaluation of Health in All Policies: concept, theory and application', *Health Promotion International*, 2014, 29 (suppl 1): i130–i142, by permission of Oxford University Press.

focus in the evaluation and multiple forms of evidence generated to support strategic reflection, are reflected in other processes for evaluating SDH. WHO has developed Innov8, an eight-step analytic process to be undertaken by a multidisciplinary review team to identify improvements in program performance and actions on SDH, health equity, and gender equality, as well as progressive realization of universal health coverage and the right to health. Innov8 applies realistic evaluations and integrates areas of human rights, health systems strengthening, and gender into its assessments. It builds a theory of change into the review analysis, including how and why interventions and activities are expected to produce results in these areas (WHO, 2016). A series of Innov8 publications and resources, including country case studies, are available that demonstrate application of this approach in areas such as adolescent sexual and reproductive health, maternal and child health, and cervical cancer screening (WHO, 2016).

Routine collection, review, and reporting of data on SDH are as important as specific evaluations for effecting changes in and ensuring accountability of policy commitments made. Further, while increasingly sophisticated methods are available for measuring and analyzing social gradients in health and the impact of interventions, actually *using* such information in policy and stakeholder forums is critical to realize improvements in SDH and health equity. WHO (2013b) provides a resource for ministries of health to support the monitoring of social determinants of health equity, through a series of eight online presentations and a link to the Health Equity Assessment Toolkit (HEAT; a software application that facilitates assessment within and across countries using available data).

Equity Watch reports provide a further example of use of evaluations—in this case, analyzing routine, household, and available community data on SDH and health equity in Africa (EXHIBIT 4-14). Almost all ESA countries have made policy commitments to promote equity in health. In 2007, the Regional Network on Equity in Health in East and Southern Africa (EQUINET)—a network of professionals, civil society, state, parliament, and academic actors promoting health equity—analyzed and reported on health equity in the region, building a cooperation with the east, central, and southern Africa (ECSA) health community to gather and report on evidence on health equity (Rasanathan, 2011). In 2012, an “Equity Watch framework” of 25 priority indicators of health equity was used to organize evidence from 16 countries in east and southern Africa, complemented by Equity Watch work in countries (EQUINET, 2012). National teams in six countries in the region involving state and nonstate actors and working with EQUINET

#### EXHIBIT 4-14 The Equity Watch in East and Southern Africa

An Equity Watch is a means of monitoring progress on health equity by gathering, organizing, analyzing, reporting, and reviewing evidence identified from policy commitments made and from research evidence deemed relevant for improving equity in health. In addition to areas of importance for specific countries, 25 progress markers are included in all Equity Watch reports:

- Five markers of advancing equity in health
- Seven markers of access to national resources and SDH
- Eight markers of resourcing redistributive health systems
- Five markers of a more just return from a global economy

Information and country and regional equity watch reports are available at [www.equinet africa.org](http://www.equinet africa.org) (EQUINET, 2012).

organized, analyzed, and presented quantitative and qualitative evidence to assess progress in addressing health inequities, to evaluate social determinants and health care, and to inform social dialogue on proposals for strengthening health equity. The national reports have been used to monitor implementation of equity in the implementation of the national health strategic plans (in Zambia and Zimbabwe) and to inform policy dialogue (in Kenya and Zimbabwe) and research (in Mozambique and Zimbabwe) (EQUINET, 2012; Rasanathan, 2011). The Equity Watch process is an evidence-driven approach to strengthening rights to participation and accountability on equity in relation to SDH and universal health systems.

A range of indicators are used in such processes for relative and absolute measures of health inequities (e.g., rate ratios and rate differences across two groups) and to gain insight into the patterns of health inequities in populations, such as through the Gini coefficient or the concentration index (Kelly & Doo-han, 2014). The indicators used may be related to the following issues:

- Political and legal factors, such as the presence of constitutional rights to health or, conversely, the presence of constitutional or legislative barriers to health, such as early marriage
- Economic factors, such as the gross domestic product, level of tax revenues, and household poverty or wealth, often expressed in quintiles of the population

**EXHIBIT 4-15** The EU's SOPHIE Project

The EU's "Evaluating the Impact of Structural Policies on Health Inequalities and their Social Determinants, and Fostering Change" (SOPHIE) project sought to generate new evidence on the impact of structural policies (macro-economy, welfare state, employment relations, unemployment, built environment, and housing policies) on health inequalities, and to develop innovative methodologies for the evaluation of these policies in Europe. The Gender group of SOPHIE developed guidance for assessing how gender intersects with other social, cultural, and economic determinants, and evidence on how gender-oriented and immigration-related policies affect health inequalities. This work enables strengthened and more comprehensive evaluations of the health equity impact of policy and interventions. The main findings of the SOPHIE project include the following: (1) Evaluating structural policies is a new methodological challenge; (2) mixed methods are essential to the evaluation of structural policies; and (3) realistic approaches help to address new and vital questions, while noting the need for a clear and efficient working protocol to be developed. Further information is available on the SOPHIE project at [www.sophie-project.eu/project.htm](http://www.sophie-project.eu/project.htm) (Palència, Malmusi, & Borrell, 2014).

- Services and entitlements, such as education completion, health service coverage, or social protection
- Living standards and material conditions, such as access to clean water, air pollution, traffic density, housing, and sanitation
- Social features, such as culture, residence, class, occupation, ethnic groups, age, gender, disability, and religion (Kelly & Doohan, 2014; Solar & Irwin, 2010)

Some key factors, such as power relations, social control/autonomy, and social support are less easily measured and often less effectively included in assessments. Factors such as gender may be intertwined with power relations and other SDH in generating health inequities. As noted at the beginning of this chapter, sociopolitical processes are themselves structural determinants that can persistently impact on health outcomes, such as the processes of colonization that negatively impact indigenous peoples' health (Axelsson et al., 2016). For this reason, research and evaluation of policies affecting determinants of health equity need to take all these dimensions and their intersections into consideration, as in the European Union's SOPHIE project (described in **EXHIBIT 4-15**).

It is important that the processes for evaluation, monitoring, and analysis strengthen the social power of those affected by these SDH, and do not alienate them. In part, this means explicitly including SDH prioritized by these groups, including those determinants that are difficult to measure, and directly involving affected communities as researchers and agents of change in analysis and learning from action, such as in participatory action research and participatory evaluation processes (Loewenson et al., 2014; SHaPeS Thematic Working Group of Health Systems Global et al., 2016).

## ► Conclusion

This chapter has explored a range of country experiences and published reviews and papers to develop a conceptual understanding of the different levels and types of SDH; their relationship to health equity, human rights, and gender equality; and their implications for health systems and for intersectoral and whole-of-government actions directed toward health and health-in-all-policies systems. While clearly a "work in progress," the growing body of evidence on all levels of SDH and their association with health outcomes is opening a deeper understanding of the "causes of the causes" in health outcomes. It is also building knowledge on how SDH at a structural level generate social stratification and social differentials in a range of intermediary SDH with an impact on health. Where these social differences in health are avoidable and remediable, they call for action on the SDH underlying them as a matter of social justice and human rights. The SDH perspective draws attention to measures to frame, understand, and integrate into interventions factors such as social exclusion, social agency, and power.

Through these approaches, those working in health-related fields can promote health and well-being and address differences in exposure and vulnerability. They can take a leadership or facilitating role in intersectoral action, and mediate or mitigate the financial, social, and physical consequences of illness. This is not just a matter for local and national levels to address. As this chapter has pointed out, globalization is influencing structural and intermediary SDH at the national and local levels, driving the need for normative and other actions on such SDH from the local level to the global level, to ensure fair benefits and prevent harms.

This chapter concluded with observations on how the positive or negative impact of these actions may be monitored and evaluated, including in terms of their distributional impacts. Evidence on and analysis of the relationship between SDH and health (equity) outcomes, while raising measurement and method challenges, is important to inform action, and to support evaluation of interventions and processes that seek to “close the gap.”

At the same time, these policies and actions need to be understood in terms of how they affect the social power and status of those communities affected by them, and how they impact procedural justice. Participatory processes, wherein communities document and express their collective experience, voice, and agency, can build forms of shared power and social support that enable and sustain action on SDH, and are a social asset and a right in processes that build knowledge and action on SDH. Addressing unfair, avoidable, or remediable differences in SDH and improving health equity outcomes among population groups is not simply a technical issue: It is an ethical issue, a matter of social justice, and an outcome of social power and action.

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## Discussion Questions

1. What is the difference between health inequality and health inequity?
2. What are the key features and dimensions of conceptual frameworks that explore the relationship between social determinants of health and health equity?
3. What are the different ways that action on SDH can reduce health inequities? Provide an example of each.
4. What role does gender play in health equity? How does a human rights approach affect the way this issue is addressed? Provide examples to demonstrate your response to both questions.
5. What can health systems do to support the measures for successful implementation of intersectoral action for health? Which features of health systems have been found to facilitate these roles? Provide examples to demonstrate your response to both questions.
6. “Social power affects the ability people have to influence and make choices over health inputs and to use these inputs to improve their well-being.” Explain, with concrete examples, the pathways through which social power may positively or negatively affect health equity.
7. What are the key features of approaches used to monitor and evaluate interventions on the social determinants of health equity?

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