IFMSA Policy Document
Health Equity and Social Determinants of Health

Proposed by Team of Officials
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Policy Statement

Introduction:

Social determinants of health are the economic, commercial, environmental and social conditions that influence health status. These health determinants describe the way people are born, grow up, live, work and age, and are integral to understanding the health disparities between regions, countries and communities. These factors are recognised as one of the major contributing factors to attain health equity through employment conditions, social exclusion, globalization or health systems' coverage, among others. While the concept of health equity promotes a fair opportunity to realize the health potential of a community, health disparities prevent this objective from being achieved and hinder the possibility of integrating health equity into the healthcare system in a cohesive way. This is why there is a need to act upon those determinants to achieve better health for all.

IFMSA position:

The IFMSA, as future healthcare professionals, calls for an effective and cohesive integration of health equity in the healthcare system by means of addressing the social determinants of health (SDH) in all aspects. We demand full participation from healthcare stakeholders to take interdisciplinary action in understanding the impact of the SDH and take inclusivity measures to ensure no one is left behind. IFMSA firmly believes that there can be no healthcare without tackling the SDH, and therefore immediate action is needed towards achieving social justice. Health equity must be placed at the centre of all decision-making processes within our health systems.

Call to Action:

IFMSA calls for:

Governments to:
- Integrate all types of health determinants into health policies, including the social, environmental, commercial and economic determinants, and their manifestation along the social gradient.
- Evaluate health determinants of communities to plan, implement, and monitor the distribution of health resources according to health needs.
- Commit to providing national healthcare facilities funding to develop and implement policies and plans to ensure that vulnerable groups are treated fairly.
- Ensure universal health access to minimize health inequities, and to provide affordable, timely, comprehensive, inclusive, and quality healthcare to all vulnerable groups.
- Adopt policies that place health at the centre of decision-making processes.
- Launch an intersectoral and an intercultural dialogue to define the neglected health determinants of the community and their most urgent health problems, with potential plans to solve them.

United Nations, World Health Organization and Non-Governmental Organizations (NGOs) to:

- Include health equity into all their policies and internal operating guidelines so they could lead by example.
- Engage the general population, particularly vulnerable groups, in decision-making processes, policies, and services that meet the health sector needs.
- Encourage countries to address gaps in healthcare faced by vulnerable populations, and monitor their progress using a clear set of indicators.
- Adopt an intersectoral approach in planning initiatives, including capacity building platforms, and create interdisciplinary interventions to achieve health for all.
- Encourage research and information dissemination on the importance of addressing health determinants in achieving equitable healthcare services.

Healthcare facilities and healthcare professionals to:
- Ensure multidisciplinarity is present in healthcare teams, from patient assessment to management plan and follow up.
- Implement workplace training on empathic, culturally sensitive, evidenced-based, and non-discriminatory treatment of vulnerable groups.
- Promote health literacy among the general population for informed clinical decision-making, better health outcomes, and widespread equitable access to healthcare for all.
- Commit to continuous professional development on health equity and improving health determinants.

Universities, education providers and academic/research institutions to:
- Integrate health equity and health determinants into the health-related curricula, with a focus on interdisciplinary healthcare delivery.
- Conduct systems-based research on the impacts of health determinants and the role of intersectoral collaboration and education in achieving health equity.
- Integrate updated evidence-based guidelines, intersectoral perspectives, and social accountability to create multidimensional solutions to health inequalities.

Private Sector to:
- Increase the partnership opportunities with the public sector in regard to financing value-oriented implementation plans within healthcare facilities.
- Prioritize health over revenue, understanding the co-dependency of the health and systems productivity and in alignment with health for all policy.
- Facilitate health initiatives in coordination with government efforts and align their strategic goals to ensure equitable resource allocation.
- Provide financial assistance to innovative youth-led initiatives to address health determinants and work towards health equity.

IFMSA National Member Organizations (NMOs) and medical students to:
- Empower students in healthcare to promote health equity and health determinants through capacity building and advocacy opportunities.
- Advocate for inclusion of SDH discussions in all policy making processes on both national and local levels, focusing on equitable access to healthcare.
- Enrol and report their activities under the relevant IFMSA program to promote sharing of best practice among NMOs and empower the stances of the federation as a global youth-led organization.
- Engage with different stakeholders' initiatives through a more interdisciplinary dialogue.
- Develop the skills and dedication to social accountability in order to give back and empower their communities.

Position Paper

Background information:

Determinants of health are the range of personal, social, economic, and environmental factors that can have an impact on health status. (1) They include policymaking, social factors, health services, individual behaviour, and biology and genetics. In other words, social determinants of health (SDH) are a subset of the health determinants and they comprise the circumstances in which people are born into, grow up, and develop as individuals. (2)

Many factors determine how SDH impact individuals across societies and countries, and this unfair distribution of social resources produces avoidable health inequalities. (3) These disparities place individuals in different "layers of influence" relating to various life factors such as "lifestyle, social and community networks, living and working conditions, and the general socioeconomic and cultural environment". As such, reducing health inequalities requires action at all levels, including tackling poverty, education, unemployment, among other factors. (4)

The Social Determinants of Health (SDH) are fundamental principles of the International Federation of Medical Students' Associations (IFMSA), representing our common understanding of the current global health situation and our vision for the future of global health. Beyond the social determinants of health, and within the era of Sustainable Development Goals (SDG), more determinants need to be thoroughly recognized and addressed in order to achieve health equity.

Discussion:

Definition of SDH

Social determinants of health are the economic, commercial, environmental and social conditions that influence health status. Gender, race, ethnicity, social support networks, education - all these factors (among others), either directly or indirectly determine our overall access to health care both in terms of accessibility and quality. (2) These social determinants are in turn moulded by public policies and ultimately by the political geographic ideologies. (5) While this is true for most of the social determinants of health, public policies alone cannot be held accountable for the existence of health inequities. Factors like gender roles and casteism take their origin from culturally entrenched traditions, rituals and stereotypes. (6) Taking all of these factors into consideration, mitigation of health inequities is not possible until greater political interventions are taken in recognizing the complex way in which history, culture, social factors, politics and policy collectively influence health. (7)

Moreover, another concept intrinsically related to health equity is the existence of a social gradient when talking about SDH. According to the Institute of Health Equity, social gradient describes "the phenomenon whereby people who are less advantaged in terms of socioeconomic position have worse health (and shorter lives) than those who are more advantaged". This trend has been authenticated by several scientific projects, such as the Whitehall study of British civil servants. (8)

The positive relationship between socioeconomic status and health is well established, and those who are in a more advantageous financial position tend to have better health and better health habits. (9) As economic determinants of health, income and capital are factors that are closely connected to access to health care. There is a social gradient in which a lower socioeconomic position is associated with worse health outcomes. This is especially evident in countries where wealth disparity is high. (10) Moreover, data from the Economic Co-operation and Development (OECD) show that unmet health care needs due to costs are more concentrated among people of lower income as they are less likely to seek medical attention compared to those in higher income group (e.g., lower-income individuals consistently have a lower utilization of preventive services such as breast cancer screening). (11) In

addition to income and wealth, economic opportunity, defined as the prospects for upward socioeconomic mobility, can be regarded as another economic determinant of health, as it is shown to be positively associated with self-reported overall, physical, and mental health. (12) Since economic factors are closely interlinked with health, making sure that economic policy is formed in a way that is conscious of its effect on health is going to be imperative for improving public health. (13)

Environmental determinants of health can be defined as external agents which can be connected to a change that influences health status, social and environmental determinants of health are closely linked together, as such determinants mediate environmental exposures such as water sanitation, hygiene and working conditions. (14) Environmental risk factors make up a significant fraction of the global burden of disease and 23% of global deaths. Moreover, environmental determinants are included in the Dahlgren-Whitehead model of social determinants of health. (15,16) Exposure to environmental risk factors is unequally distributed along the social gradient. Evidence shows that exposure is more prominent among the lower wealth quintiles, through factors such as an increased probability of living in damp housing, lack of sanitation coverage, higher noise exposure, and a closer distance to polluted or polluting sites. (15,17) In many European countries, children from less-affluent families are more likely to be exposed to second-hand smoke at home and are more likely to become smokers themselves as they age. Related to this, data shows that individuals in low- and medium-income countries (LMICs) were more likely to smoke if they receive little or no formal education. (18,19) Moreover, adverse childhood experiences, specifically emotional, physical, sexual abuse, battered mother, household substance use, parental separation or divorce, criminal household member and mental illness in the household, have a graded relationship with depressive disorders in adulthood. (20)

The goods that are marketed by companies become part of our environment and can thus have an impact on health (21,22). Commercial determinants of health have been defined as "strategies and approaches used by the private sector to promote products and choices that are detrimental to health". (21) The growing burden of non-communicable disease, especially in LMICs, can be attributed in part to the production and marketing of unhealthy goods, such as tobacco, sugar-sweetened beverages, alcohol, and foods high in fat, salt or sugar (HFSS) (21–23). Kickbusch *et al.* proposed that that companies employ various strategies to influence consumption, including political lobbying, sensationalized marketing to increase product desirability, social responsibility campaigns to deflect attention from company's malpractices (21). Corporate activity can also exert a more indirect influence on health outcomes through their "production process, environmental footprint, workplace conditions and remuneration practices, financial practices, and political behaviour". (23)

Apart from the economic, commercial, environmental and social conditions that influence health status, other health determinants also play a major role in an individual's health, such as employment, education level, health literacy, gender, housing, and food security. (24) Some determinants might play bigger roles than others but; in the end, they all either directly or indirectly affect population health.

Health Equity vs. Health Equality

The concept of equality is indispensable for the operationalization and measurement of health equity and is important for accountability under the human rights framework. Equality is defined as the allocation or distribution of an equal opportunity among everyone and can be assessed with respect to specific measurable outcomes. (25,26) Equity is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, geographically, or by other means of stratification. "Health equity" or "equity in health" implies that ideally everyone should have an opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential. (27) Consequently, health equity is closely related with the concept of social justice and the elimination of health disparities. The social determinants of health and health equity are deeply interlinked concepts, as they both confront pre-existing and emerging inequalities between individuals. Understanding the social determinants of health helps us tackle the root causes of health inequity.

Vulnerable groups:
Health inequity leads to unjust and avoidable differences in health outcomes among different groups of people and represents a barrier to achieving optimal and standardized health. (28) Different factors, such as ethnicity, gender, socioeconomic status, and immigration status contribute to differential health access. (28) Some of the most relevant vulnerable groups include:

- People living in poverty
- Minority groups
- LGBTQIA+ community
- Women
- Migrants
- Asylum seekers and refugees
- People living in zones affected by emergencies

LGBTQIA+ Community:
Discrimination represents a main barrier to health among the LGBTQIA+ community. In a 2009 survey conducted by Lambda Legal and its partner organizations, around 56% of LGB and 70% of transgender and gender-nonconforming participants reported experiences with discrimination in healthcare settings, such as being refused healthcare services, receiving blame for their health status, or healthcare professionals refusing to perform physical examinations, using derogatory language, or displaying abusive behaviour towards them. Moreover, almost half of LGB respondents and 90% of transgender respondents think that healthcare professionals aren't properly trained to care for LGBTQIA+ patients. (29) Research shows that LGBT patients are also at a higher risk of psychosocial comorbidities, such as suicide, substance misuse, eating disorder, as well as inadequate primary prevention, including breast and anal cancer screening. (30)

Women:
Gender inequalities and discrimination represent main obstacles to women receiving quality healthcare. Around 740 million women work in the informal sector, which means they do not receive governmental health protection. This puts women at a higher risk of impoverishment from catastrophic health spending due to lack of health coverage. Amongst women who receive regular income, gender norms can decrease the control women have on financial spending, limiting their access to health services. Many countries also fail to meet the standards set by the International Labour Organization (ILO) regarding maternity protection policies. Women working in the informal sector have to work late into pregnancy, increasing health risks to mother and child. In rural areas, where there is provision of fewer healthcare services, antenatal care and feminine hygiene products are often first to be neglected. Moreover, in societies with patriarchal roots, women in low-resource settings may be denied basic education and more susceptible to malnourishment due to provision of these opportunities to the male members of the household. (31) As a result, females experience greater morbidity despite a longer life expectancy. (32)

Violence against women is also a significant risk factor for unsafe sexual and reproductive practices (e.g., HIV, postpartum maternal death, illegal abortion) and poor mental health outcomes among women. Finally, while women make up 70% of the health workforce, they are consistently paid less than their male counterparts and hold fewer leadership roles. To successfully tackle gender inequality, it is crucial to increase female representation in executive decision-making and to ensure gender-responsive health systems and gender-inclusive health research are put into place (33,34).

Migrants and refugees:
Migrants, including refugees, represent around 3.5% of the world's population, making migrant health a public health issue of high priority. (35) Many countries fail to provide migrants with accessible and affordable health care services. Due to poor labour conditions, migrant workers are also at a high risk of work-related injuries, diseases and even death. They also face a high number of factors that

increases their health risks such as: language and cultural barriers, social exclusion, discrimination, long work hours, sexual violence, and lack of social protection, among others. (36)

People living in poverty:
Due to lack of a safe shelter, clean water, and proper sanitation, people living in poverty face difficulties in maintaining personal health and accessing healthcare services when they are unwell. (37) The bureaucracy and complexity of health systems organization and functioning also present challenges to health resource navigation by impoverished communities, making changes in policy and practice crucial. (38)

Minority groups:
Racial and ethnic minority groups face many barriers to accessing healthcare services. This can be partially explained by the lack of familiarity with the health care system of the destination country, lack of health insurance, and/ or fear of discrimination by the demographic majority. Language and cultural barriers may also have a negative impact on the communication between patients and healthcare professionals. Patients may be unable to adequately explain their health concerns or may express differences in understandings of illnesses or symptoms. Limited health literacy among minority patients can deter use of health care services and present challenges to compliance with medical management, further worsening health outcomes. (39)

The 2014 National Healthcare Quality and Disparities Report demonstrates that African and Latino Americans were less likely than Caucasian individuals to receive treatment for depression and substance use disorder. These existing disparities in quality of care and access to care lead to higher morbidity and disease burden among minority groups. (40)

People living in areas affected by emergencies:
In zones affected by emergencies, health systems and infrastructures are compromised, worsening health outcomes. People are at risk of direct casualty and indirect illness secondary to the destruction and lack of many public health resources. (41) Disasters and conflict also jeopardize water systems, food security, housing, and healthcare facilities. As a result, populations living in such conditions are at higher risk of emotional and physical trauma and disability, as well as chronic and infectious diseases. (42)

Health in All Policies

By highlighting the importance of the determinants of health in explaining health inequity, the 2008 final report by the Commission on the Social Determinants of Health recommended that the health promotion research agenda should be broadened to include health analysis into government policies and processes, in addition to societal and cultural values. This has led to the inclusion of the Health in All Policies (HiAP) approach in decision-making processes. (43)

HiAP is an approach that aims to put all the health impacts into consideration that may arise as consequences of any health-related and non-related decisions. It is an overarching principle that is pertinent to the decision-making process of public policies in all sectors, with the main goal of identifying and avoiding negative impacts on health to facilitate improvement of the health of the population, while striving towards health equity for all. (44) In alignment with the Declaration of Alma Ata, the Ottawa Charter, the Final Report of the Commission on the Social Determinants of Health, and the Rio Political Declaration on the Social Determinants of Health, HiAPs is a collaborative approach towards improving overall health by incorporating health considerations into decision-making and policy development across all sectors and industries. (45) Consequently, HiAP is a vital paradigm shift because the impact of many determinants of health, including social, environmental and economic determinants, which are responsible for the population's health, extend beyond the health sector, to all public sectors. (44)

HiAP is an approach on health-related rights and obligations. It improves accountability of policymakers for health impacts at all levels of policymaking and reaffirms the commitment to and prioritization of health. HiAP includes an emphasis on the consequences of public policies on health systems, determinants of health, and well-being. It also contributes to sustainable development. HiAP requires public health practitioners to collaborate with other sectors to define and achieve mutually beneficial goals by integrating health considerations into policy making and programming. To elevate the health of all communities, emphasis on social responsibility is needed in all decision-making processes.

HiAP in the era of the Sustainable Development Goals:
In September 2015, the General Assembly of the United Nations adopted the 2030 Agenda for Sustainable Development. The 17 Sustainable Development Goals (SDGs) are a transformative agenda that commits to leaving no one behind. Health is present in all of the SDGs. The interdependent nature of the SDGs highlights the importance of interdisciplinary collaboration with other sectors in addressing the determinants of health to promote productive and healthy lives for all. HiAP provides a useful strategy and tool for progressing the Sustainable Development Goals. Receptive governance, strong partnerships, and shared leadership are at the centre of HiAP practice. These elements of HiAP, among others, can be translated to different contexts to help guide action in achieving the SDGs and ultimately a healthy and sustainable future. (46)

Global and national implementation:
The focus on HiAP is becoming increasingly relevant. The 2030 Sustainable Development Agenda pushes us towards whole-of-government and whole-of-society approaches that leave no one behind and HiAP is the key to achieving this ideal. There are currently five key global WHO action frameworks that advocate for action across various health determinants, and they also reflect the collective responsibility required for sustainable development. All the frameworks draw from several cross-cutting implementation characteristics of HiAP, namely responsive governance; robust partnerships; dedicated capacity and resources (for intersectoral work); evidence and evaluation (across determinants). (47)

This framework provides nations with a practical and coherent means of executing HiAP. Some countries have already adopted a HiAP approach, whereas in other countries, the concept is new and has yet to be operationalized. This framework can also be adapted for international, national, and local level decision-making; the latter being particularly applicable in countries with a decentralization of government functions and empowered local governance. (48)

Interdisciplinarity as a key element

When talking about global health and health equity, multidisciplinarity is a concept that should be taken into consideration. Multidisciplinarity is defined as drawing on the knowledge, perspectives, and skills of different disciplines and sectors to tackle systemic problems. (49) Healthcare professionals are considered the key actors when addressing social determinants due their passion for fostering health equity, skills in advocacy in health and social policy, an understanding of SDH, and possessing the experience in clinical medicine to propose meaningful change in public health. However, they lack the non-medical expertise, time, resources, and oversight to resolve multidimensional problems independently. Some of these needed capacities to foster health equity are the cultivation of advocacy on health and social policy, a good understanding of what SDH are and their impact or an integrative view of clinical medicine together with public health. Furthermore, more resources will be requested to fulfil their work to attain health equity such as incentives and or mechanisms of reimbursement. Besides this, healthcare providers also face burnout and the burden of administrative work. (50) Ensuring health equity by means of integrating the SDH requires collaboration from strategic partners, stakeholders from social and health systems, institutions, decision-making bodies, and consulting experts for progress evaluation and monitoring, among others. (51)

According to the WHO Commission on the Social Determinants of Health (CSDH), actions towards improving SDH are most fruitful when implemented at the level of primary health care (PHC). (52)

Primary health settings and health systems are responsible for delivering general healthcare services across multiple domains of health and with an emphasis on primary prevention and anticipatory guidance. They are also in charge of promoting health and tackling the social, economic and environmental determinants that people are affected by. (53) The broad training of primary health providers enables them to address both the patients' medical and social needs. Therefore, their insight and multidisciplinary network is an optimal starting point for the proper integration of health equity and preventing the mistake on neglecting the impact of SDH on peoples' life.

Notwithstanding the evidence, SDH are not common elements taken into account at the point of care. Their recognition can lead to improved health outcomes and reduced costs for the public health system. It is estimated that only 10-20% of the modifiable contributors to health illness are covered by medical care. This means that 80-90% of these contributors can be accounted for by unaddressed social determinants of health. Healthcare professionals cannot afford to neglect SDH and health equity. However, there are both opportunities and challenges to overcome for a total inclusion of these concepts into medical practice. Universal access to care, affordable and personalized medicine, measurement of racial/ethnic disparities, and diversity within the workforce are some of the obstacles that the healthcare system would need to overcome. Nevertheless, many favourable circumstances would arise from this endeavour, such as the opportunity of gathering reliable and comprehensive data on the value of SDH and the means to implementation of effective interventions (i.e. innovation, technical package, performance management, partnerships with organizations, improved communication and political commitment). (54)

Different perspectives can be taken when addressing SDH in the medical facilities (hospitals, PHC clinics, etc.), depending on the level action taken. At the patient level, the first steps would be to ask about the social challenges that patients face with sensitivity and authenticity. Secondly, the healthcare provider could assist the patient in navigating social support services. At the practice level, the improvement of the care involves outreach to remote populations and the integration of more comprehensive services into the foundational primary healthcare that is typically offered. (55)

The overall idea highlighted by experts is that the whole system would need to shift from a more volume-based model to a value-oriented one. Henceforth, a culture based on the added value of health equity would reaffirm the impact of a patient's community on health and aims to improve health through a team-oriented approach for addressing SDH. (56)

Social accountability (SA):
Medical educators increasingly recognize that medical school graduates should not only be competent physicians, they should also be equipped to meet the challenges of providing care to underserved populations through a motivation to work with underserved communities and in them. (57,58) Global issues related to Human Resources for Health, such as health workforce shortages, resource maldistribution, healthcare provider burnout, and presenteeism impede the strengthening of primary healthcare-focused health systems and consequent health outcomes improvement. (59) These issues are particularly acute for the low- and middle-income (LMICs) countries. Maltreated or overworked healthcare workers lead to delays in all countries reaching comprehensive health coverage. (60) In high-income environments, however, realistic aim at entry and graduation was seen to correspond with actual practice venues, both in early postgraduate years and in subsequent practice. (61) We acknowledge the positive relation between the financial burdens to healthcare education and delivery system, which could be a barrier to achieve the graduate's competencies to meet the needs of their communities. Therefore, Social Accountability (SA) is considered a key concept to redirect the students and graduates towards their communities and their health determinants.

In the 1995's definition, the World Health Organization described SA in medical schools as the mandate to orient medical education, research, and service activities to tackling the high priority health problems of the community, region, and/or nation that students are trained to serve. (62) The Global Strategy on Human Resources for Health: Workforce 2030 proposes recruitment policies in alignment with SA, such as enabling greater allocation of health staff where they are most needed and targeting underserved

and disadvantaged communities. (63) This is repeated by the High-Level Committee on Health and Economic Growth's recent report stressing that socially accountable education should be institutionalized, emphasizing the role of training institutions in developing curricula that address the needs of the population and its health system. (64) In addition, there is an increasing global consensus that recognizes the importance of holding health professional schools accountable to society for these goals. The 2010 Global Consensus on SA paper, which represents the agreement of 130 organizations and individuals from around the world interested in health care, professional supervision, and policy taking, invited schools to redirect their education, research, and delivered services towards high priority issues. (65)

There is evidence that community-based and socially responsible health workforce education produces a workforce ready to work in partnership with underserved regions. (66) An example of community-engaged health professionals' education is The Training for Health Equity Network (TheNET). TheNET deliver a socially accountable curricula that underlines primary health care principles and integrates basic and clinical sciences with population health and social sciences. Any onsite equipment operation and specific preparatory training must also be addressed prior to departure for area of service. (67) To uphold the importance of SA in medical education and standardize its application, multiple guidelines including the Canadian CanMeds Framework' and the American Association of Medical Colleges' (AAMC), affirm the necessity of medical schools to educate future health workers on SDH to produce graduates who are able to better serve their communities and eliminate inequalities. (68,69)

Intersectoral/interprofessional education
Collaboration between different healthcare professions is the best framework for healthcare providers to meet patient needs and mitigate public health inequalities. Underserved communities with high health needs and vulnerable populations is perhaps the most vital place to ensure interdisciplinary collaboration. There has been a movement towards greater interprofessional cooperation and coordination in the last decade. (70) Interprofessional collaboration can bring about the necessary cooperation, communication, and teamwork to provide comprehensive healthcare for all patients, irrespective of socioeconomic backgrounds. Furthermore, interprofessional cooperation will contribute to better public health understanding and more soundly address health determinants through a multidimensional approach to healthcare. (71) Interprofessional education is suggested as a bridge to extensive, quality care, requiring healthcare trainees to work in interdisciplinary teams that embody these values. (72) This educational approach creates healthcare practitioners who are more clinically competent and have the critical communication skills needed to work effectively within a healthcare team. (73)

The role of civil society

Since health has always impacted many sectors within society, the active implication of civil society comes naturally as it has played a critical role in shaping health agenda. If we go back to the Alma Ata Declaration, it states that equity should be emphasized to address disparities at different levels. Therefore, civil society should be meaningfully involved in the preparation, implementation, surveillance, and evaluation of all best health practices with vast implications, particularly practices pertinent to improving public health outcomes. The articulation of medical needs, the assignment of health leadership roles, and the development of predictive health models are practical examples of how society informs health operations. Furthermore, the organizations and movements of civil society are also linked with economic and political realities which impact health determinants. (74)

Civil society efforts are essential to improve health in every way. Citizens have the capacity to represent themselves in voicing their adversities and advocating for the social changes that they seek. Through the freedom of assembly and organized movement, they have the ability to encourage other organizations to act in solidarity, thus building a stronger network of unified voices to legitimize their demands for change. (75)

Abbreviations

SDH: Social Determinants of Health
SA: Social Accountability
OECD: Economic Co-operation and Development
HiAP: Health in All Policies
CSDH: Commission on the Social Determinants of Health PHC: Primary Health Care
WHO: World Health Organization
ILO: International Labour Organization
SDGs: Sustainable Development Goals
TheNET: The Training for Health Equity Network
AAMC: American Association of Medical Colleges'

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