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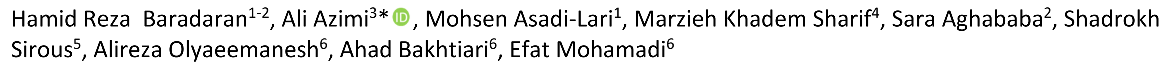
Social Determinants of Health in Iran: Policy Evolution, Intersectoral Governance, and Equity Monitoring



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Abstract

Background: The Social Determinants of Health (SDH) encompass the systemic conditions shaping daily life and health outcomes. In the Islamic Republic of Iran, health equity and SDH have been institutionalized as core components of sustainable national policy to address the "causes of the causes" behind health disparities. This study aims to evaluate the strategic evolution of Iran's health system, focusing on upstream SDH policies, intersectoral institutional frameworks, national research productivity, and the longitudinal development of monitoring mechanisms established to identify and mitigate inequities.

Methods: This is a policy review article with qualitative key-informant input, covering the initiation of SDH efforts through the end of 2023. The study analyzed 25 national upstream policies, the functionality of 32 effective intersectoral councils, and the outputs of 38 specialized SDH research centers. Primary data were gathered through 26 semi-structured interviews with key authorities conducted between 2020 and 2023 and verified through member checking.

Results: Since the 1980s, Iran has established significant infrastructure, primarily through the Primary Health Care (PHC) network. Key reforms include the Universal Health Insurance Act (1994) and the Comprehensive Welfare and Social Security System (2004). Governance is driven by the Supreme Council of Health and Food Safety. While research output is robust—exceeding 4,200 indexed articles—operational challenges persist, including a 39% out-of-pocket expenditure rate, overlapping council mandates, and the deteriorating impact of international sanctions on equitable access.

Conclusion: Iran possesses an advanced architecture for tracking 69 health equity indicators. However, reducing disparities requires moving beyond indicator collection to sustained political commitment, legally institutionalized intersectoral alignment, and translating data into targeted socioeconomic interventions.

Keywords: Social Determinants of Health, Health Equity, Intersectoral Collaboration, Primary Health Care, Iran, Public Policy

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Introduction

The World Health Organization (WHO) defines the Social Determinants of Health (SDH) as the conditions in which people are born, grow, work, live, and age, as well as the broader set of forces and systems that shape the conditions of daily life (1). These include economic policies and systems, development agendas, social norms, social policies, and political systems. At the Ottawa Conference in 1986, five action areas for health promotion were identified: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services (2). Since then, numerous global platforms have continued to emphasize the role of SDH. The Shanghai Conference in 2016 established critical priorities, emphasizing healthy cities, health literacy, good governance, and cross-sectoral actions as key drivers of the Sustainable

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↑*What is "already known" in this topic:*
Social Determinants of Health (SDH) are globally recognized as the "causes of the causes" behind health inequities. Iran has historically established a robust PHC network and implemented national policies, such as Universal Health Insurance, to address these disparities.

→*What this article adds:*
This article provides a longitudinal analysis of the evolution of Iran's SDH through the end of 2023. Furthermore, it identifies critical operational barriers, including overlapping council mandates, budget constraints, and the deteriorating impact of international sanctions.

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Development Goals (SDGs) (3, 4). These factors, often referred to as "the causes of the causes," are shaped by the distribution of money, power, and resources at global, national, and local levels (5). While the realization that social conditions affect health dates back to 19th-century pioneers such as Rudolf Virchow, the modern conceptualization of SDH is inextricably linked to Sir Michael Marmot. Marmot led the landmark Whitehall Studies, which first demonstrated a distinct "social gradient" in health, showing that mortality rates were higher among lower-grade civil servants compared to their higher-grade counterparts, even after controlling for traditional risk factors such as smoking (6). The formal initiation of SDH as a global health priority occurred in March 2005, when the WHO established the Commission on Social Determinants of Health (CSDH), chaired by Marmot (1). This commission was tasked with marshaling scientific evidence to promote health equity. Its final report, "*Closing the Gap in a Generation*," became the foundational text for the field, arguing that social injustice is a "*matter of life and death*"(1). The health domain's engagement has evolved through several key milestones:

-- The Rio Political Declaration (2011): Global leaders committed to addressing SDH to reduce health inequities.

-- Healthy People 2030 (7): In the United States, SDH became one of the five overarching goals for national health promotion (Healthy People 2030, n.d.).

-- Mandatory Reporting (2025–2026) (8): By 2026, health systems in several regions are transitioning from voluntary to mandatory SDH data collection and reporting to better integrate social needs into clinical care.

In 2025 and 2026, the field has expanded to address structural determinants, including climate change, digital transformation, and systemic discrimination (9). The recent global evidence emphasizes the intersectionality of these factors, noting that health inequities are widening globally due to income inequality, which has nearly doubled in some countries over the last two decades (9). Modern health strategies increasingly focus on "social prescribing" and on using AI to analyze standardized SDH data for personalized population health management (8).

Figure 1 illustrates the complex, multi-layered pathways through which social factors influence health equity and well-being. The model is divided into two primary categories of determinants: Structural and Intermediary (10).

1. Structural Determinants (SDH Inequities)

The framework's foundation is the Socioeconomic and Political Context, which includes governance, macroeconomic policies, social policies (labor market, housing), public policies (education, health), and prevailing cultural and societal values. These contextual factors shape the Socioeconomic Position of individuals (Figure 2), defined by Social Class, Gender, and Ethnicity (including the impact of racism), Education, Occupation, and Income. These structural mechanisms are the "causes of the causes"(6) as they generate social stratification and determine an individual's access to resources and opportunities.

2. Intermediary Determinants of SDH

The structural determinants operate through a set of intermediary factors that directly impact health outcomes. These include (11):

-- Material Circumstances: Living and working conditions, food availability, and the physical environment.

-- Behavior and Biological Factors: Individual lifestyle choices and genetic predispositions.

-- Psychosocial Factors: Stressors, relationships, and social support systems.

Social Cohesion and Social Capital act as a bridging element between socioeconomic position and these intermediary factors.

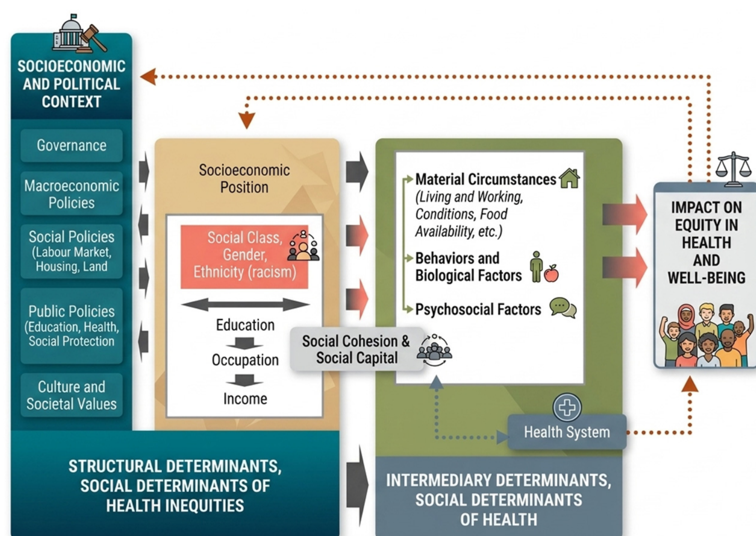

Figure 1. Conceptual framework of social determinants of health (adapted from: (10), regenerated using ChatGPT 5.3 to improve the quality. The authors reviewed and verified the content and remain fully responsible for the final figure).

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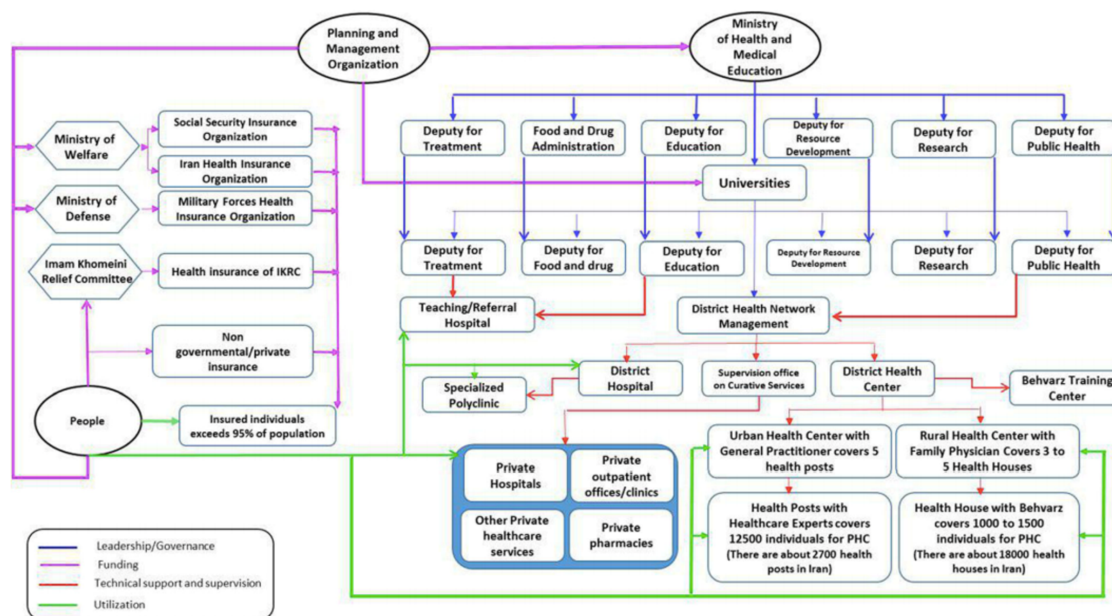

Figure 2. Structure and connection of different parts of the health system in Iran. Data from (14) with some adaptation.

3. The Role of the Health System and Impact

The Health System is positioned as an intermediary determinant, but it also plays a specialized role in mediating the differential consequences of illness and providing equitable access to care. The cumulative interaction of these determinants results in the final Impact on Equity in Health and Well-being. The model also indicates feedback loops (dotted arrows), suggesting that health outcomes can, in turn, influence an individual's socioeconomic position and the broader political context (12).

To better understand the structural pathways, the Commission on Social Determinants of Health (CSDH) introduced a comprehensive conceptual framework developed by Solar and Irwin in 2010 (13). This framework illustrates how a country's macroeconomic and structural policies dictate individual socioeconomic positions. These positions, in turn, shape material circumstances, biological factors, and psychosocial conditions, directly influencing health outcomes and either reinforcing or reducing systemic health inequities.

Methods

Study Design and Scope

This is a descriptive policy review with an embedded qualitative key-informant component. The study aimed to map the evolution of SDH in Iran from the early development of national health equity initiatives to the end of 2023. The review focused on four interrelated domains: national upstream policies relevant to SDH and health equity, intersectoral governance structures, the institutional development of SDH-related research capacity, and the national health equity monitoring framework. The study combined documentary review, institutional mapping, secondary data synthesis, and key informant interviews to reconstruct the historical and policy trajectory of SDH-related action in Iran.

Data sources and document review

The documentary component included national policy documents, legal and regulatory texts, institutional reports, administrative records, and published scientific evidence related to health equity and SDH in Iran. The review examined 25 upstream national policies and regulatory documents that were directly or indirectly related to SDH domains. Documents were included when they met at least one of the following criteria: they explicitly addressed health equity or SDH; they contained provisions related to one or more recognized SDH domains; they shaped intersectoral action relevant to population health; or they provided institutional, legal, or monitoring mechanisms for reducing health inequalities. Documents that were not relevant to health equity, SDH, or intersectoral health governance were excluded from the synthesis.

Institutional mapping

To assess the intersectoral governance structure for SDH, the study mapped 32 national councils and intersectoral authorities with mandates relevant to health equity, public policy, social welfare, environmental health, employment, education, urban planning, food security, insurance, taxation, traffic safety, and vulnerable populations. The councils were reviewed according to their formal mandate, policy domain, potential contribution to SDH, and relevance to Health in All Policies. The institutional mapping also included 38 SDH-related research centers recognized by the Ministry of Health and Medical Educa-

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tion (MoHME). Available information on their institutional role and research output was reviewed to describe the development of national SDH research capacity.

Data Collection and Scope

To obtain the most reliable data, we conducted a meticulous analysis of National upstream policies and regulatory frameworks, as applicable. Primary data were gathered through 26 semi-structured descriptive interviews conducted with key authorities and subject-matter informants who held leadership roles during the periods under study. These interviews took place between September 2020 and December 2023. This extended timeframe was necessitated by the logistical challenges and significant lead times required to secure access to high-level officials and historical informants. To ensure the highest level of rigor, all interviews were recorded and transcribed verbatim, and transcription accuracy was verified through member checking, in which interviewees reviewed and confirmed the transcripts shortly after the sessions. For sensitive or classified information, specific names and data points were omitted from the final manuscript when explicit consent for publication was not granted.

Qualitative key-informant interviews

To complement the documentary review and clarify historical and administrative details, 26 semi-structured interviews were conducted with key authorities, policymakers, senior managers, and subject-matter experts with direct experience in SDH-related policy development, intersectoral governance, health equity monitoring, or institutional implementation. Interviews were conducted between September 2020 and December 2023.

The interviews were used primarily to verify timelines, clarify institutional responsibilities, interpret policy implementation processes, and identify operational barriers not fully captured in published documents. The interview guide focused on the historical development of SDH activities, the role of the SDH Secretariat, the functions of intersectoral councils, the development of national health equity indicators, implementation challenges, and policy options to strengthen SDH governance.

Where consent was provided, interviews were recorded and transcribed. Interview notes and transcripts were reviewed by the research team and used to cross-check documentary evidence. When interviewees requested anonymity or when information was considered administratively sensitive, names, positions, and identifiable details were not reported.

Data extraction and synthesis

Data were extracted into structured matrices covering policy title, year of approval, responsible institution, SDH domain, target population, implementation mechanism, monitoring relevance, and documented challenges. For intersectoral councils, the extraction focused on the council mandate, policy sector, potential influence on SDH domains, and relation to health equity. The national health equity monitoring framework was reconstructed by reviewing available documents and workshop records related to the development of 52 initial indicators and their subsequent expansion to 69 indicators across five domains: health outcomes, human and social development, economic determinants, physical environment, and governance. The final synthesis integrated documentary evidence, institutional mapping, secondary indicators, and key-informant input.

Validation and triangulation

Triangulation was conducted across three sources: official and institutional documents, published literature, and national/international datasets, and key-informant interviews. Historical dates, institutional changes, and quantitative figures were cross-checked whenever possible. When documentary evidence was incomplete or inconsistent, clarification was sought from relevant authorities or informants familiar with the respective policy process. The synthesis was finalized after repeated reviews by the authors to ensure consistency among the reported timelines, institutional descriptions, and policy interpretations.

Ethical Considerations

The study did not involve patients, clinical interventions, biological samples, or personal health information. The qualitative component consisted of key informant interviews with officials, managers, policymakers, and subject-matter experts in their professional capacity.

Before each interview, the purpose of the study was explained to the participants, and participation was voluntary. An explicit ethical commitment was made to protect the identity of all interviewees. Therefore, names, positions, institutional identifiers, and any information that could reveal the identity of the interviewed authorities or informants have not been reported. The same confidentiality commitment was applied to individuals who provided administrative documents, institutional records, or background information for verification purposes.

Because some interviews and documents contained sensitive administrative or policy-related information, the authors avoided reporting identifiable details unless the information was already publicly available or permission for disclosure had been granted. Interview recordings, notes, transcripts, and internal documents were stored securely and were accessible only to the research team. The findings are presented in an aggregated, descriptive form to preserve confidentiality while maintaining the accuracy of the historical and policy analyses.

Results

In this paper, we aim to briefly examine upstream documents and regulations on this subject, introduce influential associations, councils, and organizations, and provide a concise review of measures taken in Iran up to December 2023. Before these, we will present an introduction to the Iranian healthcare system and its most significant health indicators**.** A comprehensive overview of the hierarchical and functional architecture of the Islamic Republic of Iran's health system could be categorized into four primary domains of interaction.

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1. Leadership and Governance

The Ministry of Health and Medical Education (MoHME) serves as the central governing body. It exercises authority through several specialized departments, including:

- Deputies for Treatment, Public Health, Research, Education, and Resource Development, as well as the Food and Drug Administration.
- This governance extends to Medical Universities across the country, which replicate this internal structure to manage regional health services.
- The Planning and Management Organization provides high-level strategic oversight and coordinates with the MoHME and various ministries.

2. Funding and Financial Flow

Funding originates from the Planning and Management Organization and flows through several key channels to ensure coverage for over 95% of the population (15):

- Public Insurance: Managed through the Social Security Insurance Organization, Iran Health Insurance Organization, and the Military Forces Health Insurance Organization.
- Supportive Organizations: Entities like the Imam Khomeini Relief Committee (IKRC) provide specific health insurance for vulnerable populations.
- Private Sector: Non-governmental and private insurance organizations offer supplementary or independent coverage options.

3. Technical Support and Service Delivery

The system is organized into a tiered network that transitions from medical education to primary and tertiary care (15):

- Medical Universities supervise Teaching/Referral Hospitals and District Health Network Management.
- District Level: Management oversees District Hospitals, Specialized Polyclinics, and District Health Centers.
- Primary Health Care (PHC): This is the foundation of the system, split between urban and rural settings.
    -- Urban: Health Centers and Health Posts staffed by healthcare experts.
    -- Rural: Health Centers and Health Houses (staffed by Behvarz), which dedicated Behvarz Training Centers support.

4. Utilization by the People

The "People" (beneficiaries) interact with the system at various levels, primarily utilizing services provided by the Health Houses and Health Posts at the PHC level, as well as accessing the Private Sector (hospitals, clinics, and pharmacies) and specialized Teaching Hospitals.

Iran's SDH Structure

The Islamic Republic of Iran features a population exceeding 90 million, with 74% residing in urban settings (16, 17). Financing for the healthcare system relies on public revenues, out-of-pocket expenditures, basic insurance premiums, and general taxation (18). Over the past few decades, national health indices—such as infant mortality, under-five mortality, and vaccination coverage (DPT coverage stands at 99%)—have shown substantial overall improvements (19, 20). Despite these historical achievements, severe structural challenges persist. International sanctions have had a deteriorating impact on the Iranian economy, driving up inflation, restricting access to essential medicines and medical equipment, and ultimately increasing out-of-pocket health expenses (20, 21). While compulsory public schemes provide fundamental coverage, over 8.5% of citizens remained uninsured as of 2018 (20). Substantial disparities in mortality rates, life expectancy, and resource distribution are visible between urban centers and marginalized rural areas (17). Table 1 demonstrates selected national health equity metrics that emphasize the scope of these disparities.

Evolution of SDH Actions in Iran

With Iran's rapid development in the 1970s and 80s and the successful control of communicable diseases, which constituted the primary disease burden at the time, the MoHME shifted its focus. Aligning with international declarations such as Alma-Ata and the 1986 Ottawa Conference, policymakers began prioritizing non-communicable diseases and the SDH.

Led by the MoHME, a coalition of institutions and min-

Table 1. Selected health equity indicators in Iran. *Data from the World Health Organization's observatory (https://www.who.int/data/gho), excluding Fair Financing Contribution from the Global Health Expenditure Database (https://apps.who.int/nha/database/Select/Indicators/en), both sites, were accessed on 24 August 2024.

Aspect of health equity	Indicator	Estimate
Fair Financing Contribution	Current Health Expenditure (CHE) as % Gross Domestic Product (GDP)	7
	Domestic general government health expenditure (GGHE-D) as % Gross Domestic Product (GDP)	3
	Out-of-pocket (OOPS) as % of Current Health Expenditure (CHE)	39
	Population pushed below the $1.90 a day poverty line by household health expenditures (%)	0.13
	The population pushed below the $3.10 a day poverty line by household health expenditures (%)	0.72
Equity in access and utilization of healthcare	Hospital beds (per 10,000 population)	15.6
	Density of physicians x (per 1000 population)	1.5
	Density of nursing and midwifery personnel x (per 1000 population)	1.6
	Density of dentistry personnel x (per 1000 population)	0.44
	Density of pharmaceutical personnel x (per 1000 population)	0.2
Equity in health outcomes	Life expectancy at birth (years)	77.35
	Maternal mortality ratio (per 100,000 live births)	16
	Under-five mortality rate (per 1000 live births)	12.94
	Neonatal mortality rate (per 1000 live births)	8.26
	Estimated road traffic death rate (per 100,000 population)	21.47

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istries implemented a series of measures to manage the social and economic drivers of health, significantly impacting citizen well-being. These actions are summarized in the following timeline (Table 2).

Upstream Policies and National Plans

The baseline requirements for health and social welfare are rooted in the Constitution of the Islamic Republic of Iran. Articles 3, 15, 29, and 100 explicitly obligate the government to ensure equal access to healthcare, educa-

Table 2. Health Equity, Social Protection, and SDH Reforms in Iran (1994–2023)

Year(s)	Key Reforms and Milestones
1994	• Universal Health Insurance (UHI) Act approved by parliament
	• Government mandated to provide basic health insurance within 5 years
	• Supreme Council for Health Insurance (SCHI) mandated under the MoHME
	• Focus on uninsured rural and self-employed urban populations
1995	• Establishment of Medical Services Insurance Organization (MSIO)
	• Establishment of the Supreme Council for Health Insurance (SCHI)
2000–2022	School milk program implemented in underprivileged areas
2004	• Comprehensive Welfare and Social Security System (CWSSS) Act approved
	• Ministry of Welfare and Social Security (MoWSS) established
	• Centralization of welfare and social security functions
	• Social emergency hotline 123 launched
2005	• Family Physician (FP) program and rural health insurance launched
	• Coverage expanded to rural residents and cities with populations under 20,000
	• Iran nominated as a WHO partner for SDH strategic planning
	• Free treatment plan for accident victims launched
2006	• Secretariat of Social Determinants of Health established within the MoHME
	• Healthy City and Village project initiated
	• Inter-sectoral cooperation committee established
2007	• First Strategic Road Map on SDH developed
	• National think tank committee on health equity established
	• Multi-ministerial collaboration initiated on health inequities
2008	• Fourteen major social and economic determinants of health inequity were identified
	• National action plans for reducing health inequities prepared
	• Urban HEART rapid assessment initiated (2008–2009)
2010	• National action plans prepared for 14 SDH priority topics
	• System for monitoring and evaluating health equity established
	• SDH and health equity integrated with primary healthcare
	• National socioeconomic classification model designed
2011	• Pilot urban Family Physician program expanded to two cities
	• Local model for System of Monitoring Equity in Health (SMEH) proposed
	• SDH Monitoring System established
	• Cabinet approved 52 intersectoral health indicators (2011–2013)
2012	• Iranian Health Insurance Organization (IHIO) established
	• SCHI restructured
2013	• Joint provincial health governance guideline approved
	• Deputy for Social Affairs established within the MoHME
	• National Health Assembly (NHA) promoted public participation
	• Universities of Medical Sciences are mandated to establish social affairs, deputies
2014	• Health Transformation Plan (HTP) launched toward Universal Health Coverage by 2025
	• Subsidy reform and targeted health financing initiated
	• Mandatory health insurance coverage introduced with means testing
	• Health insurance extended to foreign residents and refugees
2016	• IHIO moved under the MoHME structure
	• Health equity indicators revised from 52 to 69 indicators
2017	• Fundamental Education Transformation Document implemented
	• Nine years of compulsory education emphasized
	• Rural and nomadic employment development programs expanded
	• Supportive housing construction for vulnerable populations (2017–2019)
	• Annual economic support for 2 million vulnerable households (2017–2020)
2019-2023	• Deputy for Social Affairs within MoHME abolished and responsibilities redistributed
	• Social and economic support for vulnerable groups during the COVID-19 pandemic (2019–2022)

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tion, and social services without discrimination. Furthermore, the national 20-year Vision explicitly prioritizes holistic health equity and development goals.

Based on the review conducted to identify and analyze documents and policies related to health equity and SDH, most formulated policies, directly or indirectly related to health equity, focused on creating access to health services and enhancing their utilization (22). It appears that this dimension of equity has been of greater importance to policymakers because service delivery and access are considered primary inputs of the health system and a prerequisite for health promotion. In other words, a necessary condition for improving equity in health outcomes is first improving equity in access to and utilization of health services. The high-level policies that are directly or indirectly related to health equity and the social determinants of health are summarized in Table 3.

Table 3. Higher-level policies that are directly or indirectly related to health equity and the social determinants of health

No.	Title of higher-level policy	Year of approval	Relevant SDH factors
1	Constitution of the Islamic Republic of Iran	1358	• Macro higher-level policies; social, economic, and cultural status • Unemployment, employment • Poverty and income inequality • Educational level • Geographic areas • Health system • Traffic accidents and crashes • Food security and malnutrition • Environment • Social capital/social health • Child development in the early years of life • Vulnerable groups • Lifestyle
2	Law on the Organization and Duties of the Ministry of Health, Treatment and Medical Education	1367	• Health system • Child development in the early years of life • Vulnerable groups
3	Law on Universal Medical Services Insurance of the Country	1373	• Poverty and income inequality • Health system • Vulnerable groups
4	Vision of the Islamic Republic of Iran on the Horizon of 1404	1382	• Macro higher-level policies; social, economic, and cultural status • Unemployment, employment • Poverty and income inequality • Educational level • Geographic areas • Health system • Traffic accidents and crashes • Food security and malnutrition • Environment • Social capital/social health • Child development in the early years of life • Vulnerable groups • Lifestyle
5	Law on the Structure of the Comprehensive Welfare and Social Security System	1383	• Macro higher-level policies; social, economic, and cultural status • Unemployment, employment • Poverty and income inequality • Geographic areas • Health system • Food security and malnutrition • Social capital/social health • Child development in the early years of life • Vulnerable groups
6	Law on Targeting Subsidies	1388	• Macro higher-level policies; social, economic, and cultural status • Unemployment, employment • Poverty and income inequality • Geographic areas • Health system • Traffic accidents and crashes • Food security and malnutrition • Environment • Vulnerable groups
7	General Policies for Reforming the Consumption Pattern	1389	• Macro higher-level policies; social, economic, and cultural status • Poverty and income inequality • Food security and malnutrition • Environment
8	Comprehensive Scientific Map of Health	1389	• Health system
9	Transformation Roadmap of the Health System of the Islamic Republic of Iran	1390	• Macro higher-level policies; social, economic, and cultural status • Unemployment, employment • Poverty and income inequality • Educational level • Geographic areas • Health system • Traffic accidents and crashes • Food security and malnutrition • Environment • Social capital/social health • Child development in the early years of life • Vulnerable groups • Lifestyle

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Table 3. Cont.

No.	Title of higher-level policy	Year of approval	Relevant SDH factors
10	Policy Document for Promoting Community Mental Health	1390	• Health system • Social capital/social health • Vulnerable groups • Lifestyle
11	National Document on Nutrition and Food Security	1391	• Health system • Food security and malnutrition • Vulnerable groups • Child development in the early years of life • Lifestyle
12	General Policies of the Resistance Economy	1392	• Macro higher-level policies; social, economic, and cultural status • Unemployment, employment • Poverty and income inequality • Food security and malnutrition • Vulnerable groups
13	General Health Policies	1393	• Macro higher-level policies; social, economic, and cultural status • Health system • Food security and malnutrition • Environment • Vulnerable groups • Lifestyle
14	Treatment Transformation Program	1393	• Poverty and income inequality • Geographic areas • Health system • Food security and malnutrition • Vulnerable groups
15	General Population Policies	1393	• Macro higher-level policies; social, economic, and cultural status • Social capital/social health • Child development in the early years of life • Lifestyle
16	Youth Health Document	1394	• Health system • Traffic accidents and crashes • Food security and malnutrition • Social capital/social health • Vulnerable groups • Lifestyle
17	Non-Communicable Diseases Document	1394	• Geographic areas • Health system • Traffic accidents and crashes • Food security and malnutrition • Environment • Child development in the early years of life • Vulnerable groups • Lifestyle
18	Health Transformation Program	1394	• Poverty and income inequality • Geographic areas • Health system • Food security and malnutrition • Child development in the early years of life • Vulnerable groups • Lifestyle
19	Higher Education Program in the Health Sector	1394	• Health system
20	General Environmental Policies	1394	• Environment
21	General Family Policies	1395	• Macro higher-level policies; social, economic, and cultural status • Unemployment, employment • Social capital/social health • Child development in the early years of life
22	Regulation on Non-Governmental Organizations	1395	• Social capital/social health
23	Executive Guideline for Evaluating the Performance of Food and Beverage Supervision Management	1396	• Food security and malnutrition • Health system
24	Development Plans (Sixth, Fifth, and Fourth)	1396 1389 1383	• Macro higher-level policies; social, economic, and cultural status • Unemployment, employment • Poverty and income inequality • Educational level • Geographic areas • Health system • Traffic accidents and crashes • Food security and malnutrition • Environment • Social capital/social health • Child development in the early years of life • Vulnerable groups • Lifestyle
25	Second Step of the Revolution Statement	1397	• Macro higher-level policies; social, economic, and cultural status • Unemployment, employment • Poverty and income inequality • Geographic areas • Environment • Social capital/social health • Vulnerable groups • Lifestyle

Access and Primary Healthcare (PHC): Policies related to enhancing access primarily address the Family Physician program, referral systems, level-based care (stratification), and the health network (23). Official statistics and numerous studies demonstrate that establishing a tiered network of health services, particularly in primary healthcare, has had a profound impact on improving equity in access to and health outcomes, especially in rural

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areas (24). Regarding the Family Physician program, although it is a national law emphasized in multiple high-level documents—such as Article 8 of the 2014 General Health Policies and various articles in the 5th and 6th Development Plans—its full implementation across all urban areas remains incomplete. This lack of full execution is not solely dependent on the Ministry of Health's commitment; it is directly linked to the resources, authorities, and facilities granted by Parliament (25). Furthermore, conflicts of interest among stakeholders and efforts to maintain existing benefits can act as barriers to the full implementation of the scheme.

Fair Financial Contribution: At the time the policies were drafted, a significant number of individuals required support for health services. Simultaneously, individuals with higher incomes benefitted from government subsidies to the same extent as those with lower incomes, as financial capability (means testing) played no role in the distribution of government financial support (26). This remains a major challenge for the health system in achieving equity in financing. To align these policies with health equity, they should precisely define the method and extent of participation based on scientific foundations, explicitly linking an individual's contribution to their ability to pay rather than to their level of service utilization. Another issue is the existence of contradictions within a single policy—such as the conflict between Articles 13 and 14 of the Universal Insurance Law regarding premium payments for villagers—which leads to overlaps and inequities in practice.

Equity in Health Outcomes: An analysis of policy texts on equity in health outcomes shows that most focus on improving the quality-of-service delivery. Macro-level policies rarely targeted health outcome equity directly; instead, they addressed the need for access or general reductions in mortality (27). Policies specifically aimed at fair health outcomes are often found in executive guidelines rather than macro-level documents. As previously noted, the focus remains on inputs, with the assumption that infrastructure and access are the most significant factors influencing equity in health outcomes.

Thus, while numerous comprehensive policies have been formulated to address all dimensions of health equity and SDH, greater attention must be paid to laying the groundwork for implementation. One of the most vital requirements is establishing a common language among macro-level policymakers and decision-makers to enhance intersectoral collaboration (28). This common language can be fostered through increased awareness and skill-building via education and experience, leading to a more holistic and multilateral approach to the policymaking process.

Cross-Sectoral Councils & Institutional Framework

Since many determinants of health fall outside the health sector's direct jurisdiction, the Iranian government has established more than 250 ministerial-level bodies for collective decision-making. These entities allow cross-sectoral negotiation on social, economic, and environmental conditions that shape public well-being. Table 4 lists 32 distinct national councils with the most significant mandates for health equity and SDH.

SDH Secretariat in the Ministry of Health

Recognizing SDH as a global movement since the 1980s, the Ministry of Health and Medical Education (MoHME) established the SDH Secretariat in 2006. Originally under the Health Deputy, it was moved in 2010 to function directly under the Policymaking Council. The Secretariat promotes a "health-in-all-policies" approach by fostering intersectoral collaboration to reduce health inequities. Key functions include gathering evidence of inequities, detecting community needs, and mobilizing extra-sectoral support to align current national policies with health equity goals.

The secretariat's impact is analyzed in two periods: pre-

Table 4. Specialized councils and intersectoral authorities driving the Social Determinants of Health in Iran.

No.	Council / Authority	No.	Council / Authority
1	Supreme Council of Health & Food Safety	17	Supreme Council of Youth
2	Supreme Council of Environmental Protection	18	Supreme Council of Judicial Development
3	Supreme Council of Medical Science Poles	19	Supreme Council of Welfare & Social Security
4	Supreme Council of Sports	20	Supreme Council of Statistics
5	Supreme Council of Administration	21	Supreme Council of Labor
6	Supreme Council of Standards	22	Supreme Council of Taxation
7	Supreme Council of Provinces	23	Supreme Council of Information Technology
8	Supreme Council of Employment	24	Supreme Council of Urban Planning & Architecture
9	Supreme Council of Cultural Revolution	25	Supreme Council of Crisis Management
10	Supreme Council of Water	26	Supreme Council of Land Management
11	Supreme Council of Education	27	National Council of the Elderly
12	Supreme Council of Management & Economic Planning	28	Social Council of the Country
13	Supreme Council of Insurance	29	Road Safety Commission
14	Supreme Council of Health Insurance	30	Anti-Narcotics Headquarters
15	Supreme Council of Scientific Research	31	Toxic Substances Control Committee
16	Supreme Council of Traffic Accidents	32	Zoonoses Disease Coordination Council

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2006 (uncoordinated efforts) and post-2006 (systematic interventions). Historically, Iran's Human Development Index (HDI) rose significantly between 1960 and 1995, transitioning the country to "medium human development". Post-revolution strategies focused on Primary Healthcare (PHC) and rural infrastructure, though urban-rural disparities remain a challenge. In 2006, Tehran's hosting of the WHO Commission on SDH meeting further formalized these activities.

Supreme Council of Health and Food Security

To improve health indices, the Supreme Council of Health and Food Security was established during the Fourth Development Plan. At the provincial level, specialized workgroups assess local health status and coordinate efforts on AIDS prevention and food security. The Council evolved through several iterations:

- 1981: Supreme Council of Hygiene.
- 2002: Supreme Council of Health (focused on intersectoral coordination).
- Current Structure: Chaired by the President, the Council emerged from merging the Council of Food and Nutrition with the Supreme Council of Health to ensure high-level administrative authority.

Despite issuing 102 directives over a decade, only about 50% have been fully implemented due to budget constraints and limited law enforcement (27). Achieving a "leap" in health statuses, especially for the underprivileged, requires stricter, impartial supervision of these intersectoral activities.

Supreme Standards Council

The Supreme Standards Council is the official sovereign authority responsible for policymaking, oversight, and guidance of the national standards system. It ensures the quality of goods and services produced domestically, imported, or exported. The organization's activities focus on four core pillars:

1. Standardization
2. Metrology (Measurement Science)
3. Accreditation (Certification of Competence)
4. Conformity Assessment

Table 5 shows how this council affects the social determinants of health. To ground policy decisions in empirical data, the Ministry of Health and Medical Education approved the establishment of specialized SDH Research Centers. As of January 2024, there were 38 active research centers across 31 universities of medical sciences. Between 2015 and 2018, these centers published a cumulative total of 4,229 indexed scientific articles in international databases.

Supreme Sports Council

Developing public sports and institutionalizing a culture of sports among all members of society are among the Ministry of Sports and Youth's strategic policies and programs.

To achieve this, the National Public Sports Council and

Table 5. Health determinants affected by the Supreme Council of Standards

Health Determinants	Type of Multisectoral Council's Impact
Law and Legislation	Defining standards, identifying competent persons for compliance, reviewing compliance with laws, and policymaking regarding penalties for non-compliance.
Administrative Offices and Processes	Defining various standards for the administrative processes of institutions and organizations to achieve the standard certification mark.
Trade	Determining standards for goods or services, or banning the trade of certain goods/services.
Type of Settlements	Determining construction standards for settlements and the consumer goods used within them.
Transportation	Determining the standards applied in transportation systems.
Culture, Advertising, and Media	Promoting the culture of using standardized products.
Retailers	Determining standards.
Production, Distribution, and Consumption of Tobacco	Determining standards.
Food Production and Distribution	Determining standards.
Import and Export	Determining standards for imported and exported goods.
Industry (Construction, Automotive, etc.)	Determining standards across a vast range of industries.
Pollution (Water, Air, Industrial)	Determining standards for pollutants.
Agriculture	Determining standards for agricultural-related pollutants, including pesticides.
Environment	Determining relevant environmental standards.
Lifestyle (Nutrition, Physical Activity, etc.)	Determining standards that influence individual lifestyles.

Table 6. Health determinants affected by the Supreme Sports Council

Health Determinants	Type of Multisectoral Council's Impact
Law and Legislation	Development of laws related to public sports, urban planning standards, development of public sports spaces, etc.
Education and Schools	Development of public sports in schools and its requirements and standards
Transportation	Development of sports-based transportation, such as cycling
Culture, Advertising, and Media	Creation and development of cultural and advertising policies for public sports in mass media
Universities and their Distribution	Development of public sports in universities
Tobacco Production, Distribution, and Consumption	Bans on the sale and consumption of tobacco in public sports venues
Industry (Construction, Automotive)	Determining standards for creating public sports spaces in building complexes and urban planning standards
Lifestyle (Nutrition, Physical Activity, etc.)	Expanding a healthy lifestyle and physical activity

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Provincial Councils are formed to foster synergy and to utilize the capacities and capabilities of executive bodies, public institutions, and governmental/non-governmental organizations under the following conditions.

The National Public Sports Council is responsible for policymaking, planning, and supervision to expand the prevalence of public sports across all agencies, governmental and non-governmental institutions, and the private sector. The goals and duties of this Council include (29):

- Developing and generalizing public sports by providing suitable grounds to increase motivation and interest among various strata of society.
- Developing social health and vitality and encouraging various strata to maintain health through public sports.
- Developing and promoting public sports in rural areas with an emphasis on indigenous, traditional, and local sports.
- Increasing public awareness of the effects and benefits of sports through the national media.

The following table shows how this council affects the social determinants of health (Table 6).

Supreme Labor Council

The Labor Law of the Islamic Republic of Iran assigns various responsibilities to the Supreme Labor Council. To examine labor market supply and demand, create a balance between them, and establish coordination among agencies whose decisions affect the labor market, employment, and unemployment, and to monitor the fulfillment of quantitative and qualitative employment goals, the 'Supreme Labor Council is chaired by the President. Its goals and duties include (29):

- Regulating retirement, disability, and survivors' pensions.
- Regulations for minimum wage.
- Regulations for minimum wage across regions and industries.
- Regulations for labor organizations.

The following table shows how this council affects the social determinants of health (Table 7).

Supreme Water Council

The Supreme Water Council was established to coordinate and formulate policy for the supply, distribution, and consumption of water in the country. The following table

Table 7. Health determinants affected by the Supreme Labor Council

Health Determinants	Type of Multisectoral Council's Impact
Law and Legislation	Defining laws between workers, employers, and the government
Income	Determining minimum income
Industry (Construction, Automotive, etc.)	Job classification for wage determination
Welfare and Social/Health Insurance	Determining worker welfare policies
Macroeconomic Policies	Modernization of economic enterprises
Lifestyle (Nutrition, Physical Activity, etc.)	Determining the minimum non-material rights of workers and their work-life style

Table 8. Health determinants affected by the Supreme Water Council

Health Determinants	Type of Multisectoral Council's Impact
Law and Legislation	Legislation in water, sewage, agriculture, and water-intensive industries
Trade	Restriction or promotion of planting agricultural products
Settlement Dispersion	Restricting expansion in dry areas, preventing the depopulation of certain regions
Land Use	Permission or prohibition of agriculture, water extraction, and drainage control
Violence	Justification of water resource shortages for residents of drought-stricken areas
Health Services and Centers	Controlling the safety and health of drinking and sanitary water
Food Production and Distribution	Impact on agricultural production
Industry (Construction, Automotive, etc.)	Controlling construction in waterless areas, monitoring industrial water consumption, and controlling the dam industry policy
Security	Security issues in the water sector
Population Distribution and Type	Determining population capacity based on water resources
Pollution (Water, Air, Industrial)	Determining policies to combat water pollution through sewage, industry, and agriculture
Agriculture	A main determinant for the type and method of farming and water-polluting pesticides
Environment	Policymaking in the field of the aquatic environment

Table 9. Health determinants affected by the Supreme Council of Insurance

Health Determinants	Type of Multisectoral Council's Impact
Social Class	Supporting the weak social classes
Migration Status	Policymaking on social insurance policies for migrants
Law and Legislation	Legislation in the field of insurance and premiums
Transportation	Policymaking in accident insurance
Income	Policymaking regarding minimum individual income
Employment	Policymaking in the field of employee insurance
Occupational Hazards	Policymaking in the field of employee insurance
Health Services and Centers	Defining health insurance premiums and services, and professional liability insurance for medical staff
Import and Export	Defining insurance premiums related to goods
Accidents	Defining insurance premiums and covered items in accidents
Industry (Construction, Automotive, etc.)	Defining insurance for industrial workers and professional liability for employers
Security and Crises	Policymaking regarding natural and human-made disaster insurance
Welfare and Social/Health Insurance	Policymaking in employee insurance (focus on non-medical)

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shows how this council affects the social determinants of health (Table 8).

Supreme Insurance Council

This council, as one of the pillars of Central Insurance, aims to strengthen expert and decision-making arms, inform the council of stakeholder opinions, increase the participation of the Insurers' Syndicate, and systemize decision-making processes (30). The following table shows how this council affects the social determinants of health (Table 9).

Supreme Youth Council

The Supreme Youth Council serves as the highest authority for decision-making and policymaking in youth affairs. From its inception in 1992 (1371 SH) until 1998 (1377 SH), the Council's Secretariat was housed within the Presidential Administration, headed by the Presidential Advisor on Youth Affairs, who also served as the Secretary of the Supreme Youth Council. In 1999 (1378 SH), per the decision and approval of the then-President and pursuant to the directive of the Administrative and Employment Affairs Organization (Directive of the Administrative and Employment Affairs Organization, dated March 13, 1999 (1377/12/22 SH).) The National Youth Center was established and assumed the Council's Secretariat role.

Following the formation of the National Youth Organization in 2000 (1379 SH), and in accordance with Article 157 of the Third Five-Year Economic, Social, and Cultural Development Plan, the Secretariat of the Supreme Council for Youth was integrated into the National Youth Organization's organizational structure. Its goals and duties include:

1. Balanced and comprehensive development of youth personality based on Islamic principles and ideals.
2. Meeting intellectual, social, physical, and spiritual needs and guiding the emotions of youth.
3. Providing grounds for youth participation in social, cultural, political, economic, and managerial fields.
4. Maintaining and strengthening youth vitality for the greatness of Islamic Iran.

Table 10. Health determinants affected by the Supreme Council of Youth

Health Determinants	Type of Multisectoral Council's Impact
Law and Legislation	Policymaking in cultural, sports, marriage, and youth employment affairs
Non-Profit Organizations	Guiding non-profit organizations active in the youth field
Culture, Advertising, and Media	Cultural and advertising policymaking in youth affairs
Employment	Supporting youth employment
Health Services and Centers	Creating pre-marital counseling centers
Individual Behaviors (Alcohol, Tobacco, Sexual)	Policymaking and culture-building in the youth field
Lifestyle (Nutrition, Physical Activity, etc.)	Policymaking to reform the youth lifestyle

Table 11. Health determinants affected by the Supreme Taxation Council

Health Determinants	Type of Multisectoral Council's Impact
Law and Legislation	Legislation and amendment of related tax laws
Trade	Legislation and amendment of related tax laws
Transportation	Tax laws related to transportation
Income	Legislation and amendment of related tax laws
Employment	Legislation on occupational taxes
Retailers	Legislation and amendment of related tax laws
Universities	Taxation related to universities and faculty members
Health Services and Centers	Legislation and amendment of related tax laws
Tobacco Production, Distribution, and Consumption	Legislation and amendment of related tax laws
Food Production and Distribution	Legislation and amendment of related tax laws
Import and Export	Legislation and amendment of related tax laws
Individual Behaviors (Alcohol, Tobacco, Sexual)	Taxation on tobacco products
Industry (Construction, Automotive, etc.)	Legislation and amendment of related tax laws
Welfare and Social/Health Insurance	Legislation and amendment of related tax laws
Pollution (Water, Air, Industrial)	Legislation and amendments to laws on taxes for polluting industries
Macroeconomic Policies	Policymaking in the field of taxation

Table 12. Health determinants affected by the Supreme Council of Urban Planning

Health Determinants	Type of Multisectoral Council's Impact
Migration Status	Policymaking on settlement locations for internal and external migrants
Law and Legislation	Policymaking on master and detailed plans for cities and villages
Settlement Dispersion	Main policymaker for the creation, expansion, or restriction of settlements
Type of Settlements	Main policymaker on how settlements are constructed
Land Use	The main policymaker in determining land use for construction
Transportation	Expanding the use of public transport systems in city design
Culture, Advertising, and Media	Cultural and social annexes in city design and development
Universities	Policymaker in the design and expansion of university campuses
Industry (Construction, Automotive, etc.)	Main policymaker in the construction industry
Pollution (Water, Air, Industrial)	Siting of industrial zones considering their risks for society
Environment	Determining urban development policies to preserve the environment

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Table 13. Health determinants affected by the Supreme Council of Land Management

Health Determinants	Type of Multisectoral Council's Impact
Migration Status	Policymaking for internal/external migration and settlement or reduction policies
Law and Legislation	Policymaking for macro development of urban/rural, agricultural, and industrial areas
Administrative Offices and Processes	Determining geographical limits for office activity development
Settlement Dispersion	Macro policymaker for the distribution and expansion scale of cities and villages
Land Use	The main policymaker in determining land use regulations
Employment	Determining employment policies considering the maximum population for each region
Security and Crisis	Main policymaker in national security related to land division and population dispersion
Population Distribution and Type	Main policymaker in areas related to land division and population dispersion
Welfare and Social/Health Insurance	Macro policymaking related to resources and population dispersion for maximum welfare
Agriculture	Main policymaker regarding areas prone to agriculture
Environment	Main policymaker for environmental protection

Table 14. Health determinants affected by the National Council of the Elderly

Health Determinants	Type of Multisectoral Council's Impact
Law and Legislation	Policymaking on welfare affairs for the elderly
Administrative Offices and Processes	Determining policies related to the retirement of office and organization employees
Non-Profit Organizations	Guiding non-profit organizations to work in the elderly field
Culture, Advertising, and Media	Improving the lifestyle of the elderly
Health Services and Centers	Policymaking in defining health services provided to the elderly
Industry (Construction, Automotive, etc.)	Policymaking in urban planning for the elderly movement
Welfare and Social/Health Insurance	Policymaking regarding the welfare of the elderly in society
Lifestyle (Nutrition, Physical Activity, etc.)	Improving the lifestyle of the elderly

The following table shows how this council affects the social determinants of health (Table 10).

Supreme Taxation Council

The Supreme Taxation Council is the body for reviewing complaints against the rulings of Tax Dispute Resolution Boards. The following table shows how this council

Table 15. Key upstream national policies in Iran related to the Social Determinants of Health. Adapted from (32)

No.	Upstream Policy Title	Date	Relation to SDH Factors	No.	Upstream Policy Title	Date	Relation to SDH Factors
1	Constitution of the Islamic Republic of Iran	1358 (1979)	Macro policies; Socio-economic-cultural status; Unemployment; Poverty; Education; Geography; Health system; Traffic accidents; Food security; Environment; Social capital; Early childhood development; Vulnerable groups; Lifestyle	14	Treatment Transformation Plan	1393 (2014)	Poverty/Income inequality; Geography; Health system; Food security; Vulnerable groups
2	Law of Duties of the Ministry of Health & Medical Education	1367 (1988)	Health system; Early childhood development; Vulnerable groups	15	General Population Policies	1393 (2014)	Macro policies; Social capital; Early childhood development; Lifestyle
3	Universal Health Insurance Act	1373 (1994)	Poverty/Income inequality; Health system; Vulnerable groups	16	Youth Health Document	1394 (2015)	Health system; Traffic accidents; Food security; Social capital; Vulnerable groups; Lifestyle
4	20-Year Vision (Horizon 1404)	1382 (2003)	Macro policies; Unemployment; Poverty; Education; Geography; Health system; Traffic accidents; Food security; Environment; Social capital; Early childhood development; Vulnerable groups; Lifestyle	17	Non-Communicable Diseases Document	1394 (2015)	Geography; Health system; Traffic accidents; Food security; Environment; Early childhood development; Vulnerable groups; Lifestyle
5	Comprehensive Welfare & Social Security Act	1383 (2004)	Macro policies; Unemployment; Poverty; Geography; Health system; Food security; Social capital; Early childhood development; Vulnerable groups	18	Health Transformation Plan	1394 (2015)	Poverty/Income inequality; Geography; Health system; Food security; Early childhood development; Vulnerable groups; Lifestyle
6	Targeted Subsidy Act	1388 (2009)	Macro policies; Unemployment; Poverty; Geography; Health system; Traffic accidents; Food security; Environment; Vulnerable groups	19	Higher Education Program in Health	1394 (2015)	Health system
7	General Policies for Consumption Pattern Reform	1389 (2010)	Macro policies; Poverty/Income inequality; Food security; Environment	20	General Environmental Policies	1394 (2015)	Environment

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Table 15. Ctnd

No.	Upstream Policy Title	Date	Relation to SDH Factors	No.	Upstream Policy Title	Date	Relation to SDH Factors
8	Comprehensive Health Science Roadmap	1389 (2010)	Health system	21	General Family Policies	1395 (2016)	Macro policies; Unemployment; Social capital; Early childhood development
9	Health System Transformation Roadmap	1390 (2011)	Macro policies; Unemployment; Poverty; Education; Geography; Health system; Traffic accidents; Food security; Environment; Social capital; Early childhood development; Vulnerable groups; Lifestyle	22	Non-Governmental Organizations Regulations	1395 (2016)	Social capital/Social health
10	Mental Health Promotion Policy Document	1390 (2011)	Health system; Social capital; Vulnerable groups; Lifestyle	23	Executive Guideline for Food & Beverage Supervision	1396 (2017)	Food security; Health system
11	National Food & Nutrition Security Document	1391 (2012)	Health system; Food security; Vulnerable groups; Early childhood development; Lifestyle	24	Development Plans (4th, 5th, 6th)	1383-1396	Macro policies; Unemployment; Poverty; Education; Geography; Health system; Traffic accidents; Food security; Environment; Social capital; Early childhood development; Vulnerable groups; Lifestyle
12	General Policies of Resistance Economy	1392 (2013)	Macro policies; Unemployment; Poverty; Food security; Vulnerable groups	25	Statement of the Second Step of the Revolution	1397 (2018)	Macro policies; Unemployment; Poverty; Geography; Environment; Social capital; Vulnerable groups; Lifestyle
13	General Health Policies	1393 (2014)	Macro policies; Health system; Food security; Environment; Vulnerable groups; Lifestyle	—	—	—	—

affects the social determinants of health (Table 11).

Supreme Council of Urban Planning and Architecture of Iran

Established to coordinate urban planning for a better environment, elevate Iranian architecture, and provide principles for construction across various climatic conditions. The following table shows how this council affects the social determinants of health (Table 12).

Supreme Land Management Council

The Supreme Land Management Council determines strategies for spatial distribution of population and activity. The following table shows how this council affects the social determinants of health (Table 13).

National Council of the Elderly

Formed to enable the continued presence of the elderly in society, preserve their position in the family, and meet basic needs. Duties involve various ministries for housing assistance, food security, sports facilities, and cultural programs. The following table shows how this council affects the social determinants of health (Table 14).

Health Equity Monitoring and the 69 National Health Equity Indicators

One of the most important goals of the health system in the Islamic Republic of Iran is health equity, which remains a top priority for the government in aligning policies with a justice-based approach. Health equity monitoring is conducted to identify health disparities based on socio-economic variables at national, provincial, and district levels, with the goal of reducing inequalities (31). To maintain accountability, the SDH Secretariat designed a nationwide monitoring system. Through 20 collaborative intersectoral working sessions utilizing structured brainstorming, an initial set of 52 metrics was approved in 2011, which was subsequently revised and expanded to 69 distinct indicators in 2016 (Appendix 1). The development process of the national health monitoring framework was systematically reconstructed from policy guidelines and workshop records (Table 15).

To institutionalize this monitoring system, the Secretariat for Social Determinants of Health (SDH) developed a package of health equity indicators. This was achieved through 20 specialized sessions, including 1 introductory session, 15 core and sub-working group sessions involving brainstorming sessions with senior managers and experts, and 4 concluding sessions for final review and documentation. During these brainstorming sessions, participants conducted deep-diving discussions on data collection mechanisms, variable validity and reliability, IT requirements, data processing, and legal/financial requirements. Decisions were finalized through voting after a thorough technical review.

As a result of this intensive three-month collaborative effort involving both internal and external health sector experts, 52 indicators across 5 domains were identified and subsequently approved by the Cabinet. These were later expanded to 69 indicators. A comprehensive instruc-

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tional manual and data collection flowcharts were compiled into a book to be implemented across all administrative levels, down to the district level. The 69 indicators are categorized under 5 domains, including:

Domain 1: Health outcomes (Life expectancy, infant/maternal mortality, HIV/TB rates) by equity components (location, gender, education).

Domain 2: Human and social development (Literacy, food security, social support for women-headed households).

Domain 3: Economic determinants (Employment, income, unemployment rate).

Domain 4: Physical environment (Water/air quality, pesticide residues, healthy air days).

Domain 5: Governance (Participation in decision-making, NGO active members, donation-based health budget).

SDH Challenges in Iran

The goal of health equity is to eliminate injustice in socioeconomic, physical, and legal distributions. Below are the challenges identified (Table 16).

SDH Policy Options

Taking action to intervene in the Social Determinants of Health (SDH)—with the aim of promoting health equity and eliminating or reducing inequalities—is a multisectoral process. It encompasses both immediate and long-term government actions across all sectors, requiring the active cooperation of governmental and non-governmental actors, social organizations, private and international agencies, health sector personnel, and ultimately, the citizens themselves. Below are policy options for Iran (Table 17).

orientation toward reducing health disparities. The evolution from a focus on communicable diseases in the 1980s to the current sophisticated 69-indicator monitoring system reflects a growing recognition of the "causes of the causes".

However, the findings also highlight critical operational challenges. The existence of over 31 supreme councils, while indicative of a commitment to intersectoral action, has historically been marred by overlapping mandates, conflicting stakeholder interests, and a lack of executive enforcement authority. In many instances, decisions reached at the council level have remained mere recommendations due to resource constraints or legislative barriers. For instance, despite issuing 102 directives over a

Table 16. Existing SDH challenges and roots of health inequalities

SDH Zone	Challenges
Macro Policies & Socioeconomic Status	Inequality is often the result of factors outside the health sector (e.g., economic sanctions, GDP, inflation, unclear reference values for decision-making).
Unemployment & Occupation	High unemployment, insurance coverage differences based on employment, high percentage of informal jobs.
Poverty & Income Inequality	Inverse relationship between poverty and health equity; poor health outcomes for low-income groups; Gini coefficient issues.
Education Level	Educational injustice and differences in parental education affect health literacy.
Geography	Significant inequality between urbanization rates and life expectancy across provinces; lack of facilities in slum areas (water/sewage).
Health System	Unequal financial participation, lack of tiered services, and unbalanced hospital bed distribution.
Traffic Accidents	Individual risk factors (alcohol, speed), vehicle standards, and road quality.
Malnutrition	Food insecurity for deprived strata, incorrect dietary habits, and limited physical activity.
Environment	Air pollution, unsafe drinking water in low-income areas, and noise pollution.
Social Capital / Social Health	Addiction, child labor, and divorce are affecting geographical health inequality.
Early Childhood Development	Lack of a national program for early development, poverty, and toxic environmental stressors.
Vulnerable Groups	Child labor, the aging process, and challenges for women-headed households.
Lifestyle	Tobacco, alcohol, unhealthy diet, and lack of physical activity; low per-capita green space.

Table 17. Policy options for improving SDH in Iran

SDH Zone	Policy Options / Actions
Unemployment & Occupation	Improving income distribution, job security, and reducing unemployment rates to mitigate negative impacts on income distribution.
Poverty & Income Inequality	Strengthening the insurance structure for lower social classes; progressive taxation; income redistribution through monetary and fiscal policies.
Health System	Improving financial participation, designing a tiered referral system (family doctor), and defining equitable health service packages.
Traffic Accidents	Improving road safety, vehicle safety standards, and pre-hospital emergency services.
Malnutrition	Establishing intersectoral coordination for food security and enhancing nutritional literacy in deprived regions.
Environment	Increasing public commitment to environmental health through education and community empowerment in pollution control.
Social Capital / Social Health	Social mobilization for reducing social harm and supporting community-based local development centers.
Early Childhood Development	Implementing child development monitoring and ensuring equitable opportunities for growth, especially in deprived areas.
Vulnerable Groups	Promoting the health of child laborers, refugees, the elderly, the disabled, and women-headed households.
Lifestyle	Strengthening public participation in self-care and improving health literacy, particularly among the deprived strata.

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decade, the Supreme Council of Health and Food Safety saw only about 50% implementation due to budget limitations and limited law enforcement (33).

To achieve the goals outlined in the 20-Year Vision and reach Universal Health Coverage (UHC), structural reform is required.

• ***Institutionalizing HiAP:*** The integration of "Health in All Policies" (HiAP) must be legally institutionalized rather than treated as a suggestion to ensure that health impacts are a primary consideration in non-health sector decision-making.

• ***Addressing Economic Barriers:*** Expanding social safety nets to cover informal sector workers is essential to reduce the financial burden of healthcare on low-income families, especially given that out-of-pocket health expenditures remain high at 39%.

• ***Mitigating Sanctions:*** The findings reveal that international sanctions have exerted a deteriorating impact on the economy, restricting access to essential medicines and inflating costs for the most vulnerable.

• ***Localized Governance:*** Empowering local governments at the provincial level can help tailor policies to target specific regional inequities in maternal mortality, environmental hazards, and unemployment more effectively.

Conclusion

Overall, Iran has developed a relatively comprehensive policy and institutional architecture for addressing SDH and health equity. The country's PHC network, upstream policy documents, intersectoral councils, SDH Secretariat, research centers, and 69-indicator monitoring framework provide a broad foundation for action. However, the persistence of financial, geographic, environmental, and socioeconomic inequalities shows that institutional architecture alone is insufficient.

The next phase of SDH action in Iran should therefore move from recognition and monitoring toward implementation and accountability. This requires legally supported Health in All Policies, stronger authority for intersectoral coordination, integration of equity indicators into planning and budgeting, targeted interventions for disadvantaged groups, and continuous evaluation of whether policies reduce measurable health disparities.

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Conflict of Interests

The authors declare that they have no competing interests.

Authors' Contributions

The division of labor among the research team was as follows:

• The first and second authors conducted the primary interviews and managed the qualitative data collection. The second author drafted the primary manuscript.

• The third author performed the required analyses and revised the primary manuscript.

• The fourth through the final authors facilitated access to authorities, provided institutional data, and contributed descriptive context throughout the research process.

Ethical Considerations

This study did not involve patients, clinical interventions, biological samples, or personal health information. The qualitative component consisted of voluntary key-informant interviews with officials and subject-matter experts in their professional capacity, conducted after explaining the study's purpose. The identities, positions, institutional identifiers, and non-public information of interviewees and document providers were kept confidential. Interview notes, transcripts, and administrative documents were stored securely and were accessible only to the research team..

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Data Availability

The data supporting the findings of this review are included in the article and its appendix. Interview transcripts and non-public administrative documents are not publicly available due to confidentiality commitments made to interviewees and document providers.

AI Use Statement

A generative AI tool was used only to assist in redrawing Figure 1 for visual clarity. The conceptual content, interpretation, citations, and final approval of the figure and manuscript were completed by the authors. No AI tool was used in the preparation of this work, and the authors take full responsibility for the accuracy and integrity of the submitted work.

References

1. World Health Organization, Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health: final report of the Commission on Social Determinants of Health. Geneva: World Health Organization; 2008.
2. Potvin L, Jones CM. Twenty-five years after the Ottawa Charter: the critical role of health promotion for public health. Can J Public Health. 2011;102(4):244-8. doi:10.1007/BF03404041.
3. World Health Organization. Promoting health: guide to national implementation of the Shanghai Declaration. Geneva: World Health Organization; 2018.
4. World Health Organization. Promoting health in the SDGs: report on the 9th Global Conference for Health Promotion, Shanghai, China, 21-24 November 2016: all for health, health for all. Geneva: World Health Organization; 2017.
5. Marmot M. Social determinants of health inequalities. Lancet. 2005;365(9464):1099-104. doi:10.1016/S0140-6736(05)71146-6.
6. Marmot MG, Davey Smith G, Stansfeld S, Patel C, North F, Head J, et al. Health inequalities among British civil servants: the Whitehall II study. Lancet. 1991;337(8754):1387-1393. doi:10.1016/0140-6736(91)93068-K.

[DOI: 10.47176/mjiri.40.33] [Downloaded from mjiri.iums.ac.ir on 2026-06-25]

7. Gómez CA, Kleinman DV, Pronk N, Gordon GLW, Ochiai E, Blakey C, et al. Addressing health equity and social determinants of health through Healthy People 2030. J Public Health Manag Pract. 2021;27(Suppl 6):S249-57. doi:10.1097/PHH.0000000000001297.
8. Herb JN, Hu CY, Giordano SH, Chang GJ, Snyder RA. Association of social determinants of health diagnosis codes with overall survival in Medicare-insured patients with cancer. J Natl Cancer Inst. 2026:djag079. doi:10.1093/jnci/djag079.
9. World Health Organization. World report on social determinants of health equity [Internet]. Geneva: World Health Organization; 2025 [cited 2025 Jun 12]. Available from: https://www.who.int/teams/social-determinants-of-health/equity-and-health/world-report-on-social-determinants-of-health-equity.
10. Renzi P, Franci A. Inequalities in health: definitions, concepts and measurements-an application in the regional health authority in Italy. Soc Indic Res. 2023;169(1):599-627. doi:10.1007/s11205-023-03170-1.
11. Enelamah NV, Lombe M, Yu M, Villodas ML, Foell A, Newransky C, et al. Structural and intermediary social determinants of health and the emotional and behavioral health of US children. Children (Basel). 2023;10(7):1100. doi:10.3390/children10071100.
12. Mbau R, Musiega A, Nyawira L, Tsofa B, Mulwa A, Molyneux S, et al. Analyzing the efficiency of health systems: a systematic review of the literature. Appl Health Econ Health Policy. 2023;21(2):205-24. doi:10.1007/s40258-022-00785-2.
13. Solar O, Irwin A. A conceptual framework for action on the social determinants of health. Geneva: World Health Organization; 2010.
14. Naderimagham S, Jamshidi H, Khajavi A, Pishgar F, Ardam A, Larijani B, et al. Impact of rural family physician program on child mortality rates in Iran: a time-series study. Popul Health Metr. 2017;15(1):21. doi:10.1186/s12963-017-0138-0.
15. Doshmangir L, Moshiri E, Farzadfar F. Seven decades of primary healthcare during various development plans in Iran: a historical review. Arch Iran Med. 2020;23(5):338-52. doi:10.34172/aim.2020.24.
16. Hosseini SH, Zarei M, Ghodrati H. Built environment determinants of mental health in Mashhad metropolis, Iran. Cities Health. 2026;10(2):319-37. doi:10.1080/23748834.2025.2589638.
17. Abiyat M, Abiyat M. Resilience for rural sustainable development in Iran: challenges and approaches. In: Li Y, editor. Global Perspectives on Building Resilience for Sustainable Rural Development: Institutional Innovation and Policy. Singapore: Springer; 2025. p. 63-190. doi:10.1007/978-981-96-6149-7_5.
18. Alipour P. Healthcare reform in Iran: a market-driven path to quality and affordability. Iran Prosperity Project; 2025.
19. Farzadfar F, Naghavi M, Sepanlou SG, Saeedi Moghaddam S, Dangel WJ, Davis Weaver N, et al. Health system performance in Iran: a systematic analysis for the Global Burden of Disease Study 2019. Lancet. 2022;399(10335):1625-45. doi:10.1016/S0140-6736(21)02751-3.
20. Danaei G, Farzadfar F, Kelishadi R, Rashidian A, Rouhani OM, Ahmadnia S, et al. Iran in transition. Lancet. 2019;393(10184):1984-2005. doi:10.1016/S0140-6736(18)33197-0.
21. Haghdoost A, Dehnavieh R, Mehrolhssan MH, Abolhallaje M, Fazaeli AA, Ramezanian M. Future financing scenarios for Iran's healthcare system. Arch Iran Med. 2022;25(2):85-90. doi:10.34172/aim.2022.14.
22. Moradi-Lakeh M, Majdzadeh R, Farzanegan MR, Naghavi M. Iran and beyond: perilous threats to population health. Lancet. 2025;406(10507):1001-2. doi:10.1016/S0140-6736(25)01387-X.
23. Takian A, Doshmangir L, Rashidian A. Implementing family physician programme in rural Iran: exploring the role of an existing primary health care network. Fam Pract. 2013;30(5):551-9. doi:10.1093/fampra/cmt025.
24. Emami M, Haghdoost AA, Yazdi-Feyzabadi V, Ahmadi-Gohari M, Mehrolhassani MH. Developing scenarios for the Iranian health system using system dynamics methodology. Health Scope. 2025;14(3):e161473. doi:10.5812/healthscope-161473.
25. Shams L, Mobinizadeh M, Nasiri T, Mohammadi F. Prioritizing implementation solutions for the urban family physician policy in Iran: a multi-criteria decision-making study. BMC Health Serv Res. 2025;25(1):143. doi:10.1186/s12913-025-12291-x.
26. Negarandeh R, Kamran A, Heydari H. Iran's health system performance in achieving goals based on the World Health Organization's framework: a scoping review. J Res Health. 2022;12(2):65-74. doi:10.32598/JRH.12.2.1932.1.
27. Nasiri A, Amerzadeh M, Yusefzadeh H, Moosavi S, Kalhor R. Inequality in the distribution of resources in the health sector before and after the Health Transformation Plan in Qazvin, Iran. J Health Popul Nutr. 2024;43(1):4. doi:10.1186/s41043-023-00495-y.
28. Bakhtiari A, Mostafavi H, Mohamadi E, Yaftian F, Kargar S, Ahmady Tabatabaei SV, et al. Identifying knowledge gaps in social determinants of health and related challenges in Iran; 2023. Health Res Policy Syst. 2025;23(1):63. doi:10.1186/s12961-025-01300-4.
29. Shariati JAD, Seifpanahi Shabani J, Khosromanesh R. Identify and study the status of trustees and the desired consequences of sports in Iran. J Sport Manag. 2022;14(2):148-61. doi:10.22059/JSM.2021.320478.2696. Persian.
30. Rezaee M, Effatpanah M, Ghamkhar M, Namazi Shabestari A, Ghamkhar L. Comparing the billing cost of global childbirth surgeries (natural, cesarean section) with the tariff approved by the Supreme Insurance Council: a descriptive study. J Health Adm. 2023;26(2):84-97.
31. Rezaei N, Saeedi Moghaddam S, Farzadfar F, Larijani B. Social determinants of health inequity in Iran: a narrative review. J Diabetes Metab Disord. 2023;22(1):5-12. doi:10.1007/s40200-022-01141-w.
32. Ghiasvand H, Mohamadi E, Olyaeemanesh A, Kiani MM, Armoon B, Takian A. Health equity in Iran: a systematic review. Med J Islam Repub Iran. 2021;35:51. doi:10.47176/mjiri.35.51.
33. Keshavarz Moahmmadi N. Social determinants of health, health promotion, and sustainable development goals: rising opportunities in Iran to address SDH and achieve SDGs. Soc Behav Res Health. 2017;1(1):1-2.

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Appendix 1. The 69 SDH indicators

No.	Domain	Indicator Name	Definition	Numerator	Denominator / Coefficient	Inequality Disaggregation Variables	Responsible Organization	Update Frequency
1	Health	Neonatal Mortality Rate	Probability of death among live-born infants from birth to 4 weeks of age.	Number of deaths among live-born infants aged 4 weeks or less during one year	Live births in the same year ×1000	Sex, economic status, mother's education, mother's age, residence (urban/suburban/informal settlement/rural), by county and province	National Civil Registration Organization; MoHME	Annual
2	Health	Infant Mortality Rate (<1 year)	Probability of death among live-born children from birth to one year of age.	Number of deaths among children under one year during one year	Live births in the same year ×1000	Sex, economic status, mother's education, mother's age, residence, by county and province	National Civil Registration Organization; MoHME	Annual
3	Health	Under-5 Mortality Rate	Probability of death among live-born children before age 5.	Number of deaths among children under 5 during one year	Live births in the same year ×1000	Sex, economic status, mother's education, mother's age, residence, by county and province	National Civil Registration Organization; MoHME	Annual
4	Health	Maternal Mortality Rate	Probability of death of mothers during pregnancy, childbirth, or within 42 days postpartum due to pregnancy-related causes.	The number of maternal deaths due to pregnancy and childbirth complications during one year	Live births in the same year ×100000	Economic status, residence, mother's age, mother's education, by province	Civil Registration Organization; MoHME	Annual
5	Health	Mortality Rate Ages 30–70 Due to Four Major Diseases	Mortality rate among people aged 30–70 due to diabetes, cardiovascular disease, cancer, and chronic respiratory diseases.	Number of deaths due to the four disease groups among ages 30–70 during one year	Mid-year population aged 30–70 ×10000	Age groups, sex, residence, economic status, education, by county and province	MoHME; Civil Registration Organization	Annual
6	Health	Life Expectancy at Birth	Expected number of years a newborn is projected to live if current age-specific mortality rates remain constant.	Life table completion based on population and mortality data	-	Sex, economic status, education, residence, by county and province	Statistical Center of Iran; Civil Registration Organization; MoHME	Annual
7	Health	Diabetes Incidence Rate	New diabetes cases during one year.	New diabetes cases reported during the year	Mid-year national population ×100	Age, sex, economic status, education, residence, by county and province	MoHME	Annual
8	Health	Proportion of Diabetic Patients Under Care	Percentage of diabetic patients receiving care according to defined protocols in healthcare units.	Patients under care in healthcare units	Total patients ×100	Age, sex, economic status, education, residence, by county and province	MoHME	Annual
9	Health	Effectiveness of Diabetes Care Program	Percentage of diabetic patients under care whose diabetes is controlled according to the definition.	Patients whose diabetes is controlled	Total patients under care ×100	Age, sex, economic status, education, residence, by county and province	MoHME	Annual
10	Health	Prevalence of High Blood Pressure	Prevalence of hypertension among individuals aged 30 years and older.	Number of hypertension cases among the population aged 30+	Mid-year population aged 30+ ×100	Age, sex, economic status, education, residence, by county and province	MoHME	Annual
11	Health	Hypertension Patients Under Care	Percentage of hypertension patients under standardized care.	Hypertension patients covered by the program	Total hypertension patients ×100	Age, sex, economic status, education, and residence	MoHME	Annual
12	Health	Effectiveness of Hypertension Care	Percentage of patients with controlled hypertension.	Controlled hypertension patients	Total covered patients ×100	Age, sex, economic status, and education	MoHME	Annual
13	Health	Tuberculosis Incidence	New reported TB cases.	Reported TB cases	Mid-year population ×100000	Sex, education, occupation, economic status	MoHME	Annual
14	Health	Traffic Accident Incidence	Traffic injuries causing hospitalization or death.	Traffic accident victims	Population ×100000	Sex, age, residence, inside/outside city	MoHME; Legal Medicine Org.	Annual
15	Health	Non-Traffic Injury Incidence	Falls, burns, violence, and similar injuries.	Non-traffic injury victims	Population ×100000	Sex, age, education, and economic status	MoHME; Legal Medicine Org.	Annual
16	Health	Occupational Injury Incidence	Fatal and non-fatal occupational injuries.	Injured workers	Worker population ×100000	Sex, age, job type, education	Ministry of Labor; MoHME	Annual
17	Health	Prevalence of Top 10 Cancers	Cancer prevalence by cancer type.	Registered cancer cases	Mid-year population ×100000	Age, sex, education, residence	MoHME	Annual

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Appendix 1. Cont.

No.	Domain	Indicator Name	Definition	Numerator	Denominator / Coefficient	Inequality Disaggregation Variables	Responsible Organization	Update Frequency
18	Health	Prevalence of Psychiatric Disorders	Prevalence by disorder type.	People with psychiatric disorders	Mid-year population ×100	Age, sex, education, residence	MoHME	Annual
19	Health	Prevalence of Psychiatric Symptoms	Percentage with psychiatric signs and symptoms.	Individuals with symptoms	Mid-year population ×100	Sex, age, marital status, job	MoHME	Annual
20	Health	Suicide Attempt and Death Prevalence	Hospitalization or death due to suicide.	Hospitalized or deceased individuals	Mid-year population ×100000	Age, sex, education, residence	MoHME; Welfare Org.	Annual
21	Health	Average DMFT Index	Average decayed, missing, and filled teeth in children.	Damaged teeth count	Screened children	Sex, economic status, and mother's education	MoHME; Ministry of Education	Annual
22	Health	Drug Use Incidence and Prevalence	Drug use among the population aged 12+.	Drug users	Population aged 12+ ×100000	Type of substance, method of use	Drug Control HQ; MoHME	Annual
23	Health	Alcohol Use Prevalence	Alcohol use among ages 15–64.	Alcohol users	Population 15–64 ×100	Age, sex, education, residence	MoHME	Annual
24	Health	Drug Users Under Treatment	Drug users receiving treatment.	Users under treatment	Total users ×100	Age, sex, education	MoHME	Annual
25	Health	Retention in Addiction Treatment	Patients remaining >12 months in treatment.	Patients retained >12 months	All treatment patients ×100	Sex, age, drug type	MoHME	Annual
26	Health	Tobacco Use Prevalence	Use of tobacco among the population aged 12+.	Current tobacco users	Population group ×100	Age, sex, education	MoHME	Annual
27	Health	Underweight Prevalence Under Age 5	Children under 5 with low weight-for-age.	Underweight children	Total children ×100	Residence, sex, mother's education	MoHME	Annual
28	Health	Stunting Prevalence Under Age 5	Children under 5 with low height for age.	Stunted children	Total children ×100	Residence, sex, mother's education	MoHME	Annual
29	Health	Overweight/Obesity Prevalence	Adults aged 18+ with overweight or obesity.	Overweight/obese adults	Adult population ×100	Sex, age, and education	MoHME	Every 5 years
30	Health	Exclusive Breastfeeding Until 6 Months	Infants exclusively breastfed for 6 months.	Infants breastfed exclusively	Children aged 6–11 months ×100	Mother's education, job	MoHME	Annual
31	Health	Low Birth Weight Ratio	Infants born under 2500g.	Low birth weight newborns	Live births ×100	Mother's education, residence	MoHME	Annual
32	Health	Physical Activity	Adults with recommended physical activity.	Physically active adults	Surveyed adults ×100	Sex, age, and education	MoHME	Annual
33	Health	Infertility Rate	Couples unable to conceive.	Infertile couples	Relevant population ×100	Sex, age, and education	MoHME	Annual
34	Health	Infertile Individuals Receiving Services	Infertile couples accessing fertility services.	Couples receiving services	Infertile couples ×100	Sex, age, and education	Barakat Foundation; MoHME	Annual
35	Health	High-Risk Pregnancies	High-risk pregnancies during one year.	High-risk pregnancies	All pregnancies ×100	Age, education, occupation	MoHME	Annual
36	Health	Household Disaster Preparedness	Households with functional disaster preparedness.	Prepared households	Total households ×100	Economic status, residence	MoHME	Annual
37	Health	HIV Detection Coverage	Identified HIV positive cases.	Detected HIV cases	Estimated HIV cases ×100	Sex, age, transmission route	MoHME	Annual
38	Health	HIV Treatment Coverage	Eligible HIV patients receiving treatment.	HIV cases under treatment	Eligible HIV cases ×100	Sex, age, transmission route	MoHME	Annual
39	Physical Environment & Infrastructure	Access to Drinking Water Network	Households with access to public drinking water.	Households with access	Total households ×100	Urban/rural	Ministry of Energy; Water & Wastewater Co.	Annual
40	Physical Environment & Infrastructure	Acceptable Drinking Water Samples (Bacteriological)	Samples meeting bacteriological standards.	Acceptable samples	Total samples ×100	Residence	MoHME	Annual
41	Physical Environment & Infrastructure	Acceptable Drinking Water Samples (Nitrate)	Samples with nitrate below standard.	Acceptable nitrate samples	Total samples ×100	Residence	MoHME	Annual
42	Physical Environment & Infrastructure	Acceptable Drinking Water Samples (Heavy Metals)	Samples within heavy metal standards.	Acceptable samples	Total samples ×100	Residence	MoHME	Annual
43	Physical Environment & Infrastructure	Acceptable Drinking Water Samples (TDS)	Samples with acceptable dissolved solids.	Acceptable samples	Total samples ×100	Residence	MoHME	Annual

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No.	Domain	Indicator Name	Definition	Numerator	Denominator / Coefficient	Inequality Disaggregation Variables	Responsible Organization	Update Frequency
44	Physical Environment & Infrastructure	Households with Hygienic Toilets	Households with sanitary toilets.	Households with sanitary toilets	Total households ×100	Rural	MoHME	Annual
45	Physical Environment & Infrastructure	Sanitary Wastewater Disposal	Use of hygienic wastewater disposal systems.	Households using systems	Total households ×100	Urban/rural	MoHME	Every 5 years
46	Physical Environment & Infrastructure	Household Waste Collection Coverage	Households covered by waste collection.	Covered households	Total households ×100	Urban/rural	Municipalities	Annual
47	Physical Environment & Infrastructure	Sanitary Waste Disposal	Use of sanitary disposal/recycling.	Households using sanitary disposal	Total households ×100	Urban/rural	Municipalities	Annual
48	Physical Environment & Infrastructure	Urban Green Space per Capita	Public green area per urban resident.	Green area	Urban population	Urban/rural	Municipalities Org.	Annual
49	Physical Environment & Infrastructure	Healthy Air Days	Days with healthy air quality.	Healthy air days	Measured days	Cities with monitoring stations	Environment Org.; MoHME	Quarterly
50	Physical Environment & Infrastructure	Agricultural Pollutant Residues	Products exceeding pesticide/nitrate/heavy metal limits.	Unacceptable samples	Total samples ×100	Urban/suburban	Ministry of Agriculture	Annual
51	Social & Human Development	Age-Specific Fertility Rate	Fertility rates under 18, 18–35, and above 35.	Live births by age group	Women population	Mother's education, residence	Statistics Center; MoHME	Every 5 years
52	Social & Human Development	Net Enrollment Rate Grade 1	Six-year-olds are enrolled in first grade.	First-grade students	Population age 6	Sex, city/village	Ministry of Education	Annual
53	Social & Human Development	Expected Completion of Primary/Secondary Education	Probability of completing school.	Calculated via the life table	-	Age, sex, residence	Ministry of Education	Annual
54	Social & Human Development	First-Graders with Preschool Experience	Children who attended preschool.	Children in preschool	First-grade students ×100	Sex, economic status	Ministry of Education	Annual
55	Social & Human Development	Elderly Receiving Social Support	The elderly benefiting from welfare support.	Supported elderly	Total elderly	Sex, age, and education	Welfare Org.; Relief Committee	Annual
56	Social & Human Development	Disability Prevalence	Prevalence by severity.	People with disabilities	Mid-year population ×100	Sex, age, severity	Welfare Organization	Annual
57	Social & Human Development	Access to Rehabilitation Services	Disabled individuals receiving rehab services.	Users of rehab services	People needing services ×100	Severity, sex, age	Welfare Organization	Annual
58	Social & Human Development	Female-Headed Households Receiving Support	Women heads of household receiving aid.	Supported women	Needy female-headed households ×100	Age, education	Welfare Organization	Annual
59	Social & Human Development	Mosques/Tekyehs per 1000 Population	Religious centers per 1000 population.	Number of centers	Population ×1000	Urban/rural	Religious Organizations	Annual
60	Social & Human Development	Literacy Rate Ages 10–49	Population able to read and write.	Literate population	Population 10–49 ×100	Sex, province	Education Ministry	Five-year
61	Economic Development	Unemployment Rate	According to the labor definition.	Unemployed individuals	Economically active population	Sex, age, and education	Labor Force Survey	Annual
62	Economic Development	Health Expenditure Share	Health spending share in non-food household expenditure.	Health expenditures	Non-food expenditure ×100	Economic level, urban/rural	MoHME	Five-year
63	Economic Development	Absolute Poverty Line	Population below the national poverty line.	Population below the poverty line	Total population ×100	Household head age/sex	Welfare Ministry	Five-year
64	Economic Development	Extreme Poverty Line	Population below severe poverty line.	Population below severe poverty	Total population ×100	Head characteristics	Welfare Ministry	Five-year
65	Governance	Basic Insurance Coverage	Population covered by basic insurance.	Covered population	Total population	Sex, age, residence	Welfare Ministry	Annual
66	Governance	Supplementary Insurance Coverage	Population with supplementary insurance.	Covered population	Total population	Sex, education	Welfare Ministry; Central Insurance	Annual
67	Governance	Active NGO/Charity Members in Health	Active NGO members in the health sector.	Active members	Population ×1000	Urban/rural	Ministry of Interior	Annual
68	Governance	Health Budget Supported by Donations	Share of health budget funded by donations.	Charitable contributions	Total health budget	Urban/rural	MoHME	Annual
69	Governance	Households per Community Health Liaison	Urban households covered per active health liaison.	Covered households	Active health liaisons	County	MoHME	Annual

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