Original Article
http://mjiri.iums.ac.ir
Medical Journal of the Islamic Republic of Iran (MJIRI)

Med J Islam Repub Iran. 2026 (31 Aug);40.93. https://doi.org/10.47176/mjiri.40.93

Social Determinants of Health (SDH) History Taking in Medical Students' Curriculum; Challenges and Opportunities

Kourosh Kabir[1], Seyyed Amir Yasin Ahmadi[2], Sedigheh Yousefzadegan[3], Soheila Mahdavynia[3], Ramin Zare Mahmoudabadi[3], Zahra Rampisheh[1], Neda SoleimanvandiAzar[1], Zahra Sadr[1], Ali Tayebi[4], Maryam Vafapour[3], Ashraf Mousavi[3], Marzieh Nojomi[1]*

Received: 29 May 2026 Revised: 6 Aug 2026 Accepted: 16 Aug 2026 Published: 31 Aug 2026

Abstract

Background: The aim of the current study was to evaluate the feasibility of implementing SDH history taking by medical students using a checklist, as well as to identify the advantages and barriers associated with this implementation. The checklist was developed during the first phase of an action research study, which comprised three phases: development, implementation, and assessment of SDH history taking during the clerkship course of medical education.

Methods: The implementation of history taking of SDH by medical students involved a briefing session on the importance of SDH for medical students, utilizing a developed checklist for taking SDH history, presenting interesting cases during morning reports, conducting community medicine consultations, and establishing connections with community organizations to support cases. Medical students were instructed to take SDH history alongside routine patient history taking in the pediatric ward of a teaching hospital during their clerkship rotation.

Results: One hundred SDH history-taking forms were collected and reviewed following a briefing session conducted by medical students during their pediatrics ward rotation. The briefing session concluded with a question-and-answer segment, providing an opportunity for discussion and clarification. The complex cases identified in the history-taking forms were presented during the morning report. Of these, five cases were referred for community medical counseling. When necessary, patients were referred to a community mental health center.

Conclusion: Despite several implementation challenges, the incorporation of SDH history taking by medical students using the checklist was feasible during the clerkship course. The program supported the integration of education with patient care and enabled students to acquire practical experience in identifying and addressing SDH in clinical settings.

Keywords: Medical education, Social determinants of health (SDH), Curriculum, History taking

This work has been published under CC BY-NC-SA 4.0 license.

Copyright© Iran University of Medical Sciences

Cite this article as: Kabir K, Ahmadi SAY, Yousefzadegan S, Mahdavynia S, Zare Mahmoudabadi R, Rampisheh Z, SoleimanvandiAzar N, Sadr Z, Tayebi A, Vafapour M, Mousavi A, Nojomi M. Social Determinants of Health (SDH) History Taking in Medical Students' Curriculum; Challenges and Opportunities. *Med J Islam Repub Iran.* 2026 (31 Aug);40:93. https://doi.org/10.47176/mjiri.40.93

Introduction

Social determinants of health (SDH) are nonmedical indicators that affect the health of individuals. These factors encompass the conditions in which people are born, grow, work, live, and age. The SDH includes various social

Corresponding author: Dr Marzieh Nojomi, mnojomi@iums.ac.ir

1. Preventive Medicine and Public Health Research Center, Psychosocial Health Research Institute, Department of Community and Family Medicine, School of Medicine, Iran University of Medical Sciences, Tehran, Iran
2. Clinical Cancer Research Center, Milad General Hospital, Tehran, Iran
3. Firoozabadi Clinical Research Development Unit (FACRDU), Department of Pediatrics, School of Medicine, Iran University of Medical Sciences, Tehran, Iran
4. Firoozabadi Clinical Research Development Unit (FACRDU), Department of Surgery, School of Medicine, Iran University of Medical Sciences, Tehran, Iran

Key Messages:

↑What is "already known" in this topic:

Social determinants of health (SDH) strongly influence children's health outcomes, and medical education increasingly acknowledges the necessity of incorporating them into the curriculum. However, the integration of SDH into clinical training remains challenging due to limited curriculum time, inadequate faculty preparation, and institutional barriers. Practical ward-based methods for teaching SDH history-taking remain underused.

→What this article adds:

This study shows that SDH history-taking can be effectively integrated into a pediatric clerkship through the use of a structured checklist, briefing sessions, morning reports, and referrals to community resources. It establishes the feasibility of this approach in real clinical settings, identifies the most and least predictive items on the checklist, and directly links SDH education with patient care.

[Downloaded from mjiri.iums.ac.ir on 2026-11-07]

[DOI: 10.47176/mjiri.40.93]

norms, economic systems and policies, development plans, social policies, and political systems. The interaction of these factors can affect health outcomes (1, 2). The World Health Organization (WHO) defines health as a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity (3).

Social health is defined as the ability to interact and form essential relationships with others (4). Social relationships can affect mental health, physical health, and the risk of death (5). Therefore, for physicians to effectively approach patients, it is necessary to consider all aspects of health. Focusing solely on the physical and mental aspects of health cannot ensure the overall well-being of the patient. Patient care includes understanding the individual and the world and environment in which he or she lives (6). Information about a patient's context is essential, not only for establishing an accurate diagnosis but also for selecting the most appropriate approach (7).

Rudolf Virchow highlighted the social responsibilities of physicians by famously stating that "physicians are the natural attorneys of the poor" and that social problems should largely be resolved by them. He identified social inequality as a cause of diseases, emphasizing that political action is necessary to address this issue (8). If the primary task of medicine is to improve the health of individuals, then political and social topics should be incorporated into the medical education curriculum (9). One of the most effective ways to include these topics is by addressing SDH within the curriculum. It appears that, in addition to addressing the physical and mental health issues of patients during bedside education, SDH can be integrated alongside these subjects.

Despite broad consensus on the importance of SDH in medical education, the integration of SDH into the formal curriculum remains challenging. Common obstacles include resistance to curricular change, inadequate faculty preparedness for teaching SDH-related concepts and skills, limited space within the formal curriculum, and insufficient support from institutional leadership. In the Iranian context, although SDH has garnered increasing attention at both the policy and academic levels, evidence regarding practical and theory-informed models for incorporating SDH education into undergraduate medical training is still limited. In particular, there is a lack of knowledge about how SDH-related competencies can be taught and implemented during the clerkship period.

The implementation of SDH in the curriculum faces several challenges. These include general resistance to curricular change, a lack of knowledge and skills regarding SDH among faculty members, insufficient space within the curriculum, and inadequate support from administration and leadership (10). In this context, we previously conducted research on the training of SDH in the pediatric ward of a teaching hospital in Iran, reporting on the design phase of this action research (11). In the present paper, we discuss the implementation phase of this action research. Therefore, the aim of the current study was to identify the advantages and obstacles associated with the implementation of SDH in the medical education curriculum during the clinical phase.

Methods

Study Design

This study represents the second phase of an action research initiative comprising three sequential stages: the development of a Social Determinants of Health (SDH) checklist, SDH history taking in medical education, and the evaluation of these activities during the clerkship stage of medical education (11). This action research was based on Kemmis and McTaggart's framework, which includes planning, acting, observing, and reflecting. In the current phase, in addition to qualitative action research, a quantitative report was employed in which one hundred medical students, under structured observation and guidance, utilized the SDH history-taking forms with patients. The project for this study was approved by the ethics committee of the National Agency for Strategic Research in Medical Education (NASR) (No: IR.NASRME.REC.1402.133).

Setting

The first phase of the action research focused on developing SDH history-taking forms, which included a rapid scoping review of the literature and consultation with an expert panel to create the form for use in the clerkship stage of medical education (11).

This study was conducted in the pediatric ward of a teaching hospital affiliated with the Iran University of Medical Sciences (IUMS) in Tehran, Iran. Situated in the southern part of Tehran, the hospital primarily serves a population with relatively low socioeconomic status. Medical students at IUMS typically spend one month of their pediatric rotation during the clerkship stage at this hospital, which provides them with exposure to the social health challenges that affect patient care.

Implementation Phase

In the current phase of the study, the program was implemented through three key processes:

1. Briefing Session – A meeting was conducted to introduce the program to medical students. During this session, students received instructions on completing the SDH history-taking form. The briefing included a film presentation and a lecture that covered the definition and domains of SDH, its significance in hospital settings, and practical examples. The instructor subsequently reviewed the history-taking form and provided detailed guidelines for its completion.

2. History-Taking Form – In collaboration with the hospital's education director, medical students collected SDH histories from hospitalized pediatric patients using the designated history-taking form alongside the standard medical history-taking process. Each student was required to complete at least two forms, either individually or in small groups of 5–6 students. Confidentiality was strictly maintained as students documented patients' social concerns, prioritized the identified issues, and, with guidance from mentors, determined which problems could be addressed through targeted interventions.

3. Morning Report Presentations – Students were responsible for presenting their SDH histories during designated morning report sessions in the pediatric department.

[Downloaded from mjiri.iums.ac.ir on 2026-11-07]

[DOI: 10.47176/mjiri.40.93]

Professors from the departments of pediatrics and community medicine provided mentorship, guiding students in history-taking techniques and facilitating discussions on patients' SDH histories and potential interventions.

After implementing the program for 2-3 months, the research team identified cases that required more extensive assessment, long-term care, or external support beyond hospital resources. Consequently, two additional processes were introduced to strengthen the implementation:

4. Community Medicine Consultation: The research team integrated routine consultations with the Department of Community Medicine for patients requiring detailed assessments or specialized interventions.

5. Collaboration with Community Organizations: Efforts were made to engage with community organizations. Meetings were conducted with selected groups to establish more effective collaboration and improve patient support services.

Statistical Analysis

The frequency of unfavorable findings (social risk) for each item in the SDH history-taking form was calculated among 100 patients. Item-response theory (IRT) analysis was conducted using the ltm package in R programming (version 4.4.3) to assess item difficulty. The one-parameter logistic method of item-response theory was applied to assess the predictive capacity of the items in the SDH history-taking form.

Results

Briefing Session

The meeting was conducted as a briefing session. Initially, the program was introduced to the medical students, followed by a presentation on the topic of SDH, which was an integral component of the educational program. Subsequently, instructions on completing the history-taking form were provided to the students. The session concluded with a question-and-answer session.

The meeting was structured as a briefing session, beginning with an introduction to the program for medical students. The primary focus was a lesson on Social Determinants of Health (SDH), which was presented as the central concept. Students were then guided through the process of completing the history-taking form. The session concluded with a question-and-answer segment, offering an opportunity for discussion and clarification. Throughout the study period, from October 2024 to April 2025, seven sessions were conducted, with a total of 147 medical students participating. The attendance rate was 100%.

History Taking by Students

Medical students visited hospitalized pediatric patients and completed history-taking forms under the supervision of their attending professors. Over a seven-month period, approximately 100 forms were filled out and incorporated into each patient's medical record.

The descriptive analysis of determinants recorded in the forms for 100 pediatric patients is presented in Table 1. The most prevalent responses were related to Q6 (“Is there security in the residence?”) and Q14 (“Is there smoking in one of the patient’s parents?”). In the IRT analysis, items were evaluated based on their Item Information Function, which indicates each item’s capacity to discriminate between students with varying levels of SDH history-taking competency. Items such as Q6 and Q14, despite their high endorsement frequencies, were categorized as “least predictors” because they provided the lowest amount of information across the latent trait spectrum. These items were endorsed at a relatively constant rate regardless of student performance, thereby offering minimal utility in distinguishing between higher- and lower-performing students compared to items with higher information content.

The median number of positive responses per patient was 3, with an interquartile range (IQR) of 1–5 (minimum 0, maximum 11). Higher difficulty levels indicated that a more severe SDH status was necessary to yield an unfavorable result (social risk) for an item.

Morning Report

The complex cases identified through the history-taking forms were presented during the morning report. One of the cases discussed was as follows.

Case 1: A 4.5-year-old girl was referred with complaints of fever, nausea, and jaundice. Her parents reported a recent trip to a neighboring country and the consumption of non-potable water. She was admitted for the evaluation of hepatitis A. Regarding her Social Determinants of Health (SDH) history, the family, originally from a neighboring country, had migrated to Iran approximately 5 years ago. The mother, now 35 years old, had married at the age of 12. The family had three children and reported several high-risk behaviors, including alcohol consumption. Their socioeconomic status revealed that while their nutritional status was adequate, the mother was illiterate, and the father had only elementary-level literacy. Their health literacy was acceptable given their education levels. They had access to potable water, gas, and electricity. However, their living environment was unsafe, characterized by frequent theft and a high population of individuals with substance use disorders. In terms of healthcare access, the child's vaccinations were complete, and the family had easy access to a health house, but they lacked health insurance and struggled with hospital expenses. There was no evidence of physical violence within the household. The father smoked and consumed alcohol excessively, which affected the child's family relationships; she had a good bond with her mother but a strained relationship with her father. The patient had a history of antidepressant medication use. Despite their circumstances, the family had access to parks, recreational areas, and the internet.

Case 2: A one-year-old child was hospitalized due to respiratory distress and seizures. Social history revealed that the family were undocumented migrants from a neighboring country, living in precarious conditions in a temporary shelter on a farm. They endured significant hardships, including a lack of access to healthcare, insurance, and financial resources to cover medical expenses. Their living environment lacked piped water, and they

[Downloaded from mjiri.iums.ac.ir on 2026-11-07]

[DOI: 10.47176/mjiri.40.93]

Table 1. The descriptive frequency of SDH status of the subjects (out of 100)

Category / Item	Number (%) of Positive* responses
Nutrition / food security	
Q1. Are there any suitable types of foods, including protein sources, dairy products, fruits, and vegetables, in your diet? (Identify if at least one of these items is not consumed in sufficient quantity)	20
Education	
Q2. Is the mother literate?	20
Q3. Has the patient dropped out or fallen behind in school?	12
Q4. Is the level of health literacy of the person caring for the patient appropriate? For example, inquire whether she/he knows the address of the health center or if she/he examines the nutritional value label of food products.	21
Environment and living conditions	
Q5. Is there access to safe tap water, city gas, electricity and telephone in the patient's home? If there is no access to at least one of these items, please identify it.	7
Q6. Is there security in the residence? For example, there should not be a significant amount of theft or a congregation of drug addicts in the vicinity of the residence.	41
Access to health services	
Q7. Does the child possess a vaccination card, and were the vaccinations administered on time and in accordance with the schedule?	10
Q8. Is it in proximity to health and treatment centers, and is transportation readily accessible?	10
Q9. Does the child have basic insurance?	29
Q10. Do the parents have a treatment fee?	30
Ethnicity	
Q11. Is the patient a foreign citizen?	23
Social harm and addiction	
Q12. Does the patient help the family financially?	3
Q13. Is there evidence of physical violence in the patient's examination (or sometimes in history)?	6
Q14. Is there smoking among one of the patient's parents?	41
Q15. Does the father, mother, or any family member have a history of incarceration, substance abuse, or alcohol consumption?	19
Q16. Does the patient smoke?	2
Q17. Does the patient use alcohol or drugs?	3
Mental health	
Q18. Does the patient have good social relationships with family and friends?	4
Q19. Does the patient live with someone who has mental health problems?	15
Access to recreational, cultural, and social services	
Q20. Does the patient have access to parks and recreational facilities?	12
Q21. Does the patient's family have access to the Internet to use scientific information and electronic services?	6

* Positive result means unfavorable response.

struggled to obtain adequate, nutritious food. Furthermore, the mother was illiterate and a victim of domestic violence inflicted by her husband.

During the morning report, the case was reviewed by students and their faculty, who carefully analyzed the family's circumstances and their impact on the child's health. The team proposed providing health education to the family and referred them to the hospital's social work unit for comprehensive support, which included cost reduction measures, commodity assistance, and access to a food basket.

Community Medicine Consult

Complicated cases requiring social interventions were referred to the community medicine service for consultation. The flowchart of this process is depicted in Figure 1.

The consultation cases included the following.

Case 1: A 16-year-old girl presented with intentional methadone toxicity due to a suicide attempt. She was referred to the Community Mental Health Center (CMHC), locally known as Seraj.

Case 2: A 10-year-old girl presented with symptoms of hallucinations, weakness, and lethargy, alleging that she had been forced to consume methamphetamine and other drugs. A community medicine consultation was conducted; however, the history provided by the child was fragmented and unreliable. The physical examination revealed no specific abnormalities, although the child appeared anxious and restless. Laboratory tests and toxicology results were within normal limits. The patient was accompanied by her mother, who acted as her caregiver, while the father was reportedly traveling and absent from the hospital. Observations of the mother indicated poor dental hygiene and visible tattoos on various parts of her skin. Attempts to obtain a reliable history from the mother were unsuccessful due to her incoherent and inconsistent speech. Further investigations, coordinated with the Community Mental Health Center (CMHC) and the local healthcare system, revealed that the family had connections to drug trafficking. The child was referred to the CMHC for long-term care and support.

Case 3: A 15-year-old girl presented with pseudo-seizures following a verbal argument with her mother. Further evaluations revealed a strained mother-daughter relationship. She was subsequently referred to CMHC for support.

Case 4: A 3-year-old boy with incidental methadone toxicity. Based on the consultation, and aside from providing safety education to the parents, no social intervention was deemed necessary.

[Downloaded from mjiri.iums.ac.ir on 2026-11-07]

[DOI: 10.47176/mjiri.40.93]

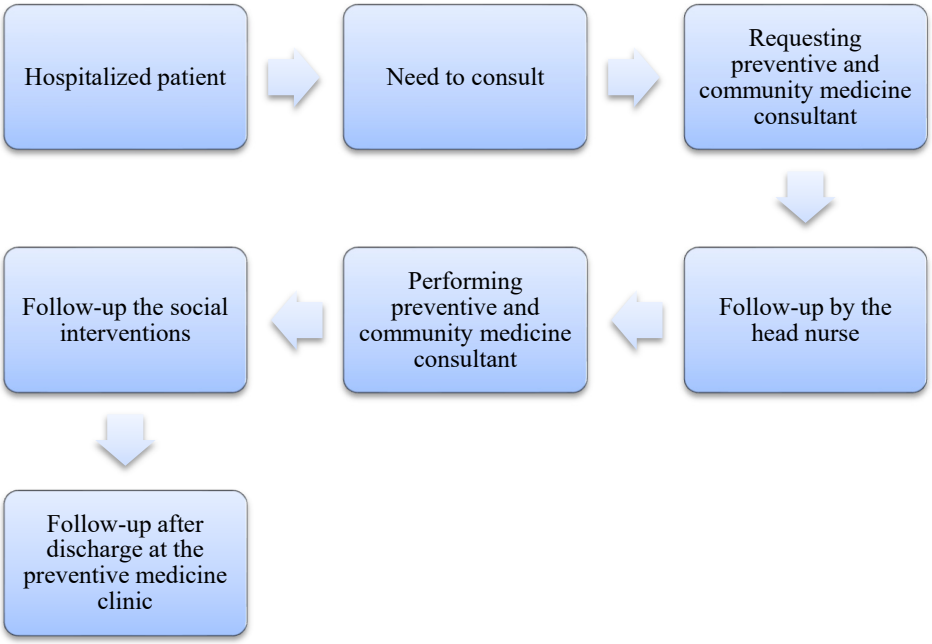

Figure 1. The flowchart of the process of community medicine consultation

Case 5: A 4-year-old child presented with fever and vomiting as the primary complaints, accompanied by a significant history of frequent hospital admissions. Upon further investigation, it was noted that the mother often brought her 9-year-old daughter to the hospital alongside the younger child. A comprehensive medical and social history revealed that both children had spent considerable time in healthcare settings for various complaints and were frequently administered medications and vitamins. These findings raised concerns among the healthcare team regarding Factitious Disorder Imposed on Another (FDIA), previously referred to as Munchausen Syndrome by Proxy, with the mother potentially being the instigator. Factitious Disorder Imposed on Another poses serious physical and psychological risks to dependents due to fabricated or induced medical conditions. Given the severity of these concerns, the consultant recommended evaluations by forensic medicine and psychiatric professionals. Furthermore, the formation of a medical commission was proposed to conduct a thorough review of the case and develop a strategy to work collaboratively with social services (including the Social Emergency Department) to ensure the safety and well-being of the children.

Collaboration with Community Organizations

To implement interventions and monitor patients concerning SDH, researchers organized several meetings with the South Health Center (Shahr-e-Rey), the Welfare Organization, and Social Emergency services.

First Meeting (Nov 4th, 2024): The focus of this meeting was to explore strategies for enhancing collaboration and patient follow-up within the healthcare system, particularly following hospital discharge. Representatives from the health center introduced services available through the healthcare system, including CMHC (Seraj) centers, which were identified as potential resources to support this initiative.

Second Meeting (Jan 6th, 2025): Representatives from the Welfare Organization's Social Emergency Unit were invited to the hospital to discuss work processes, collaboration obstacles, and concerns raised by the medical team regarding this partnership. Colleagues from the Social Emergency Unit elaborated on their activities, highlighting their experienced team and explaining the steps involved in their interventions.

Key Decisions across Both Meetings

- Conduct educational sessions for faculty and hospital staff to enhance awareness of available services.
- Appoint a representative from the health system to facilitate collaboration and streamline processes within the hospital.
- Pilot patient referrals to CMHC (Seraj) centers to establish a practical and effective follow-up system.
- Organize visits to CMHC centers and the Social Emergency Unit by physicians, students, and hospital staff to promote a deeper understanding and collaboration.
- Include representatives from these organizations in morning report discussions regarding patients facing social challenges.

Discussion

The present study was conducted as the second phase of an action research project (11), specifically the implementation phase. The findings indicate that in the realm of SDH, treatment and education are not distinct entities.

[Downloaded from mjiri.iums.ac.ir on 2026-11-07]

[DOI: 10.47176/mjiri.40.93]

This integration of education and treatment is referred to as "social accountability." The Social Determinant of Health is a crucial component for realizing social accountability (12). The connection between SDH and social accountability lies in the fact that appropriately addressing SDH is essential for improving health outcomes and reducing health inequalities, necessitating action from all sectors and civil society. Mechanisms for social accountability can enhance intersectoral plans for health service delivery. The WHO has advocated for socially responsive medical education, defining it as a commitment by medical schools to align their teaching, research, and service activities with the priority health concerns of the community, region, and/or country they are mandated to serve. The "AIDER" model (Assess, Inquire, Deliver, Educate, Respond) provides a framework for social accountability in medical education and practice (13).

David et al. (2021) implemented an SDH screening program for children during the COVID-19 pandemic. They conducted a 12-month single-center study that reviewed pediatricians' experiences with screening and referring families for unmet social needs in the context of financial resource pressures, transportation needs, and food insecurity, which inadvertently coincided with the COVID-19 pandemic. This pilot study, which introduced SDH screenings and resource referrals in a primary care clinic, faced challenges, including low compliance and the unexpected impact of the COVID-19 pandemic. Despite these challenges, the pilot study demonstrated the feasibility of introducing SDH screening and increasing resource referrals (14). Jetelina et al. (2020) investigated the factors affecting the implementation of SDH screening in pediatric wards. These factors included the adaptability of the SDH screener into electronic health record workflows, staff training, patient needs, resources and staffing, coordination and consent, and the acknowledgment of family strengths. They concluded that implementing SDH screening for medically complex pediatric patients was complicated and depended on many factors. To make these screenings more widespread and effective, it is necessary to study how well patients connect with community resources (15).

Medical students should receive training on this crucial aspect of health during their education. If we neglect to teach about the social determinants of health (SDH) and their significance in patient care throughout medical training, there may not be an opportunity to address these issues later. In the current study, we demonstrate the importance of taking a history of SDH in our approach to patients. In the final phase of the current study, we will evaluate and critique the process with input from stakeholders.

Although our findings suggest that this program may enhance the social accountability of medical education by increasing attention to patients' social contexts, this implication should be interpreted with caution. For broader implementation, institutions require faculty development, structured teaching tools, curricular time, and administrative support. Scaling up SDH education may face challenges due to limited faculty expertise, competing curricular priorities, and variations across clinical settings. Therefore, SDH education should be integrated longitudinally throughout the medical curriculum rather than being limited to a single clerkship. Future studies should evaluate its effects on students' clinical practice and patient-centered care.

The present study had several strengths and limitations. We selected the pediatric ward of a teaching hospital due to the supportive collaboration of the faculty in that area. However, there were constraints in collecting histories related to social determinants of health (SDH), including issues concerning rights and confidentiality. Additionally, we had limited time to educate the students about SDH.

Conclusion

Despite the existing barriers and limitations, the implementation of SDH education in the medical education curriculum is crucial. Future investigations should assess the feasibility of incorporating SDH education into this curriculum. This program has led to the integration of education and treatment, thereby enhancing the social accountability of medical education. Future research should evaluate this intervention using pre/post designs, follow students longitudinally, validate the SDH history-taking form, and examine its scalability and impact across multiple settings.

Acknowledgment

Not applicable.

Conflict of Interests

The authors declare that they have no competing interests.

Authors' Contributions

Kourosh Kabir: Conceptualization, Data Curation, Writing – Original Draft Preparation. Seyyed Amir Yasin Ahmadi: Data Curation, Formal Analysis, Writing – Original Draft Preparation. Sedigheh Yousefzadegan: Conceptualization, Data Curation, Writing – Review & Editing. Soheila Mahdavynia: Conceptualization, Data Curation, Writing – Review & Editing. Ramin Zare Mahmoudabadi: Conceptualization, Data Curation, Writing – Review & Editing. Zahra Rampisheh: Conceptualization, Writing – Review & Editing. Neda SoleimanvandiAzar: Conceptualization, Writing – Review & Editing. Zahra Sadr: Conceptualization, Data Curation, Writing – Review & Editing. Ali Tayebi: Conceptualization, Data Curation, Writing – Review & Editing. Maryam Vafapour: Conceptualization, Data Curation, Writing – Review & Editing. Ashraf Mousavi: Conceptualization, Data Curation, Writing – Review & Editing. Marzieh Nojomi: Conceptualization, Supervision, Writing – Original Draft Preparation, Writing – Review & Editing.

All authors approved the final version of the manuscript. All authors agree to be accountable for the research presented.

Ethical Considerations

The project of this study was approved by the ethics committee of the National Agency for Strategic Research

[Downloaded from mjiri.iums.ac.ir on 2026-11-07]

[DOI: 10.47176/mjiri.40.93]

in Medical Education (NASR) (No: IR.NASRME.REC.1402.133).

Funding Support

National Agency for Strategic Research in Medical Education (NASR) with grant number 4010381.

Data Availability

Data available on request from the authors.

AI Use Statement

No AI model was used in this study.

References

1. Social Determinants of Health, World Health Organization [Available from: https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1.
2. Karimi SE, Ahmadi S, SoleimanvandiAzar N. Inequities as a social determinant of health: Responsibility in paying attention to the poor and vulnerable at risk of COVID-19. J Public Health Res. 2021 Feb 2;10(1):1904. doi: 10.4081/jphr.2021.1904
3. Health definition by World Health Organization [Available from: https://www.who.int/about/governance/constitution.
4. Ponticiello M, Nuwagira E, Tayebwa M, Mugerwa J, Nahabwe H, Nakasita C, et al. "If you have light, your heart will be at peace": A qualitative study of household lighting and social integration in southwestern Uganda. J Glob Health. 2023;13. doi: 10.7189/jogh.13.04026
5. Richman LS. Relational health: How social connection impacts our physical and mental wellbeing: Cambridge University Press; 2023.
6. Stewart M, Brown JB, Weston WW, Freeman T, Ryan BL, McWilliam CL, McWhinney IR. Patient-centered medicine: transforming the clinical method: CRC press; 2024.
7. McWhinney IR, Freeman T. Textbook of family medicine: Oxford University Press; 2009.
8. Mackenbach JP. Politics is nothing but medicine at a larger scale: reflections on public health's biggest idea. J Epidemiol Commun Health. 2009;63(3):181-4. doi: 10.1136/jech.2008.077032
9. Wittern-Sterzel R. " Politics is nothing else than large scale medicine"--Rudolf Virchow and his role in the development of social medicine. Verh Dtsch Ges Pathol. 2003;87:150-7.
10. Lewis JH, Lage OG, Grant BK, Rajasekaran SK, Gemeda M, Like RC, et al. Addressing the social determinants of health in undergraduate medical education curricula: a survey report. Adv Med Edu Pract. 2020:369-77. doi: 10.2147/AMEP.S243827
11. Sadr Z, Ahmadi SAY, Tayefi B, Yousefzadegan S, Mahdavynia S, Mahmoudabadi RZ, et al. Integration of social determinant of health in patient's history-taking in medical education: an educational scholarship and action research study: phase I. BMC Med Edu. 2024;24(1):1175. doi: 10.1186/s12909-024-06172-w
12. Buchman S, Woollard R, Meili R, Goel R. Practising social accountability: From theory to action. Can Fam Physician. 2016;62(1):15-8.
13. Sandhu G, Garcha I, Sleeth J, Yeates K, Walker GR. AIDER: a model for social accountability in medical education and practice. Med Teach. 2013;35(8):e1403-e8. doi: 10.3109/0142159X.2013.770134
14. David P, Qureshi NK, Ha L, Goldberg V, McCune E, Wojtowicz J, et al. Social determinants of health screening at well child visits: a pilot program implemented during the COVID-19 pandemic. Glob Pediat Health. 2021;8:2333794X211060971. doi: 10.1177/2333794X211060971
15. Jetelina KK, Rodriguez P, Oke OK, Mathew MS, Schoppa S, Booker-Nubie Q, Messiah SE. Factors influencing the implementation of social determinants of health screening and referral processes in pediatric settings serving medically complex patients. J Appl Res Child. 2020;11(1):1. doi: 10.58464/2155-5834.1410

[Downloaded from mjiri.iums.ac.ir on 2026-11-07]

[DOI: 10.47176/mjiri.40.93]