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Policy Analysis of Institutionalization of the Social Approach to Health in Iran

Ataollah Asadi louyeh[1], Amirhossein Takian[2,3,4,5]*, Batoul Ahmadi[1], Mohammad Arab[1], Ali Davoudi kiakalayeh[6]

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Abstract

Background: The social approach to health (TSATH) is necessary for maintaining and promoting health status in societies toward achieving sustainable development goals (SDGs). Despite various attempts, the health sector in Iran is behind in the meaningful implementation of TSATH. This study analyzed the policy of TSATH in Iran.

Methods: This was a qualitative study. The participants in the research included 36 experts and senior managers of health-related organizations in Iran who were selected using a targeted and snowball method. We used 3 methods for data collection: in-depth interviews, focus group discussions, and document review. Inspired by Walt & Gilson's policy triangle and stage heuristic framework, we conducted a thematic analysis and used MAXQDA software Version 19 for data management.

Results: TSATH was an immediate political decision in Iran. We found insufficient social participation and intersectoral collaboration, conflict of interest, inadequate evidence-based policy-making as well as necessary resources among the most important barriers to implementing the policy of TSATH.

Conclusion: Institutionalizing TSATH requires long-term, evidence-based planning and effective participation of all stakeholders. Providing the necessary resources and infrastructure, appropriate context and good steering, accountability, and creating a sustainable livelihood program, especially for the lowest-income deciles of society, are key measures to improve TSATH.

Keywords: Social Approach to Health, Institutionalization, Policy analysis, Iran

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Introduction

Many health problems are not exclusively of biological origin, but are rooted in social and economic factors, living conditions, and social interactions (1). Marmot demonstrated evidence to conclude that the causal direction is from socioeconomic factors to disease, not the other way around (2). That is, the causal chain of macrosocioeconomic structures can endanger the health of individuals (3). Social factors also account for a significant part of the burden of diseases and a major part of health inequalities (4). Thus, health status is determined not only by behavioral, biological, and genetic factors (5), but also by a wide network of economic, social, and environmental factors (6, 7). Therefore, the social approach to health can be considered a necessity for providing, maintaining, and promoting health in societies. In this regard, the main discussion of the Alma-Ata conference (1978) was to recognize that the root cause of health problems lies outside the health system, and there is a need to shift from a biomedical approach to a social one to explain health and disease while emphasizing social justice (8). Inattention to factors affecting health, not

Corresponding authors: *Dr Amirhossein Takian, takian@tums.ac.ir*

1. Department of Health Management, Policy and Economics, School of Public Health, Tehran University of Medical Sciences, Tehran, Iran
2. Department of Health Policy, Management & Economics, School of Public Health, Tehran University of Medical Sciences, Tehran, Iran
3. Centre of Excellence for Global Health, School of Public Health, Tehran University of Medical Sciences, Tehran, Iran
4. Health Equity Research Center, Tehran University of Medical Sciences, Tehran, Iran
5. World Health Summit
6. Department of Community Medicine, School of Medicine, Road Trauma Research Center, Trauma Institute, Guilan University of Medical Sciences, Rasht, Iran

↑What is "already known" in this topic:
The social approach to health (TSATH) is necessary for maintaining and promoting health status in societies toward achieving sustainable development goals (SDGs).

→What this article adds:
Iran, despite its various health sector reforms, has a long way to go for a meaningful implementation of TSATH.
Factors such as centralized governance of the health system, lack of evidence-based policy-making, inadequate resources, little social participation and inadequate intersectoral collaboration, and conflict of interest are among the most important barriers to TSATH.

only endangers the realization of health in society but also causes the loss of various resources (9). Researchers believe that, considering the multifaceted nature of health, any health-promotion intervention requires the implementation of comprehensive programs that include all the health determinants and lead to broad social participation and intersectoral collaboration (10). The complexity and multidimensionality of health and the impact and influence of various social and economic factors have led many health systems to be unable to maintain and promote health status and meet the growing needs of their citizens, despite the great scientific and technological advances (11). The Ottawa Charter also emphasized the inability of various health systems to resolve health problems and the need for public participation in decision-making and implementation of plans (12).

Definitive evidence suggests that TSATH is necessary for providing, maintaining, and promoting health status in societies toward achieving the SDGs. Socialization is a mechanism through which societies establish behavioral patterns according to their economic, social, and cultural context. TSATH means measures that aim to empower society to promote health-oriented behaviors and create healthier environments (13). TSATH increases the authority of individuals in determining social destiny (14) and is thus considered a symbol of democracy and its connection with social health (15). It can indicate the successful role of just political practices in improving public health (16) by internalizing health-oriented attitudes, ideas, behaviors, and appropriate social choices (17). Despite heavy, unfair, and unprecedented international sanctions and the resulting problems (18), Iran's health indices have reached among the best in the region (19). Nevertheless, health socialization and sustainable health development look far from being reached. The Ministry of Health and Medical Education (MOHME) approved health socialization plan in 2017 in line with the National Action Plan for the Prevention and Control of Non-Communicable Diseases (NCDs) (20), as well as Fourth and Fifth National Development Plans and facilitated its implementation by establishing Social Health Deputy at the MOHME. Despite the necessity and importance of TSATH in achieving health development, it has not achieved its goals in Iran (21). The purpose of this study was to establish TSATH as a policy in Iran and to offer evidence-based policy suggestions for enhancing TSATH implementation as part of Iran's journey toward sustainable health development.

Methods

This study was qualitative, and 3 methods were used to gather the data: document examination, focus groups, and in-depth interviews.

A mixed deductive-inductive approach was used for data analysis (22). MAXQDA Version 19 was used to facilitate thematic (content) analysis. The health policy triangle (23, 24) was used to illustrate the role that 4 components of actors, context, content, and process played in formulating the TSATH policy in Iran. In addition, we used the stages of the heuristic model (24) to explain the nonlinearity of practical decision-making processes (25) in the context of Iran. The study participants were 36 key informants, that is, experts and senior managers, policy makers, and other stakeholders from a variety of health-related organizations (Table 1), who were purposively selected through the snowball method (26). Purposeful sampling means selecting participants who provide more information related to the research topic. In this stage of sampling, senior managers, experts, informed and knowledgeable people about the social approach to health, and people who have management skills or experience in the field of health programs and promoting health and social welfare were selected. In snowball sampling, the people involved in a study introduce other potential sources that can be used in research. The sample we selected may not be representative of the entire population. Therefore, the chance of bias in the sample is increased, and it is difficult to generalize the results to other populations. To ensure that the study sample population reflects the true distribution of the entire population, correct calculation and interpretation of data, minimizing the margin of error, and

Table 1. Study Participants

Row	Organization or place of sampling	Number	Row	Organization or place of sampling	Number
1	Ministry of Health and Medical Education	3	17	Head Office of Standards and Industrial Production	1
2	The Iranian Medical Association	1	18	Center for the Study and Development of Medical Education	1
3	The Iranian Nursing Organization	1	19	Head Office of Water and Sewerage	1
4	The Iranian Health Insurance Organization	1	20	Chancellor of the University of Medical Sciences	2
5	Islamic Consultative Assembly Health Commission	1	21	Member of the Islamic Consultative Assembly	1
6	Management and Planning Organization	1	22	Food Industry Organization	1
7	Medical Charity Organization	1	23	Social Security Organization	1
8	Sports and Youth Organization	1	24	Armed Forces Insurance Organization	1
9	Tehran Municipality	1	25	Researcher and health activist	2
10	Provincial Governor's general office	1	26	Koodak-pad NGO	1
11	Department of Education	1	27	Fatemiyoun NGO	1
12	Agriculture Organization	1	28	Broadcasting Organization	1
13	Islamic Development Organization -	1	29	Department of Environmental Protection	1
14	The Office of Local Imam	1	30	Ministry of Industry, Mining and Trade	1
15	State Welfare Organization	1	31	Social Determinants of Health Research Center of MOHME	1
16	Imam Khomeini Relief Foundation	1	32	Iranian Diabetes Association	1

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protecting the privacy of individuals from noncooperation bias were performed. Data collection continued until data saturation.

Data Collection

In-depth Interviews

Interviewing is one of the most common methods of data collection in health care research (27). We prepared an interview guide based on the research objectives. The questions were related to social participation, intersectoral collaboration, good governance, health literacy, empowerment, and social well-being, and the components of Walt and Gilson's policy analysis triangle model. These factors were the indicators of the World Bank in the evaluation of countries on the path to achieving sustainable development goals, which were emphasized in various statements of the World Health Organization, especially in the Shanghai Declaration in 2016. We obtained written consent to record the interview and ensured confidentiality; all interviews were recorded and transcribed verbatim. Transcripts were read several times, and then coded thematically based on their meaning.

Document Review

We obtained and reviewed all available policy documents related to the social approach to health, including upstream documents, instructions and circular letters, laws and regulations, bylaws, and approvals made by health officials. Documents were identified by reviewing published internal sources, studies and reports, and interviewing key informants. Table 2 describes the details of the documents.

Focus Group Discussion

We also conducted 3 focus group discussion sessions using the Jigsaw technique (28-30) to gather data on the role of contextual factors in health socialization. We divided 36 stakeholders into 6 groups, each with 6 people, called basic or home groups according to their level of knowledge, expertise, and interest. After being justified by the facilitator and reviewing information related to the discussion topic, they were divided into Jigsaw groups as expert groups. The topics were discussed with the new members of other groups, and finally, they returned to their basic groups to gather information. At this stage, one person was selected as the group leader in each basic or home group to record the results while controlling the meeting time and guiding the topics. The topics discussed in the focus group discussion are summarized in Table 3.

Strengths

The most important strength of the present study is its accurate method. Based on its conceptual framework, we used the views of a wide range of stakeholders, experts, nonprofit organizations (NGOs), and institutions regarding the implementation and institutionalization of TSATH. We also increased the reliability of the study by reviewing data from various resources and triangulating.

Weaknesses

The main limitation of the present study was the political, institutional, and social commitments and considerations of the interviewees while expressing their views and initiatives regarding the implementation of the policy. We anticipated that they did not disclose their real positions, therefore, we recommend exercising caution while interpreting the study results. To reduce the limitation in expressing the views and initiatives of the participants due to political, institutional, and social commitments and ethical considerations, the interviewer first provided an oral explanation about the study and its objectives and measures to keep information confidential. The researcher also obtained informed consent from the participants. Also, the participants were assured about the anonymity and confidentiality of the information and the right to withdraw from the study at any stage of the project.

Table 2. Details of Documents

Number of documents	Type of Document	Issuer of the Document	Audience Organization	General Objectives	Document Number and Date
2	announcement	Cabinet	universities of medical sciences	General population policies	1544/100 (March 97)
4	Circular Letter	The Cabinet and the Ministry of Health	universities of medical sciences	Social Health Approach Document Framework	787/100 and 341/100 November 96), 1165/114 and 1023/114 (June 97),
4	Instructions	Deputy of Social Affairs of the Ministry of Health	universities of medical sciences	Guide to forming a neighborhood health association	1120/114 and 2433/114 (July 97) 1675/114 and 2231/114 (November 97)
4	Legal approval	Islamic Consultative Assembly and Cabinet	Cabinet, Minister of Health	General health policies, general science and technology policies	1395 - 1396
1	Regulations	Supreme Council for Health and Food Security	universities of medical sciences	Executive regulations of health assemblies at the national, provincial, and local levels	2783/114 (December 96)
23	Press conferences	Minister and Deputy of Social Affairs of the Ministry of Health	Conferences, congresses, and seminars	Institutionalizing the social approach to health	1395 – 1396

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Table 3. Contextual Factors (Micro and Macro) Examined in Focus Group Discussion

Micro-contextual factors	Management and Leadership	Organizational Structure	Sources	Organizational Performance	Processes and Systems
	Managerial stability in achieving goals and plans Social Responsibility Systemic approach Participatory Management Strategic planning	Flexible organizational structure Effective communications Organizational hierarchy Participatory culture and teamwork	Human resources Funds Information Sources Physical sources Technological sources	Job satisfaction and the quality of work life of employees Improving service quality Customer and community satisfaction Social Responsibility	Quality management Standardization Quality auditing and feedback Creativity and innovation
Macro-contextual factors	Economic factors GDP Per capita income of the people Inflation and bank interest rates Production of goods and services Fair distribution of wealth in society	Sociocultural factors Population growth Birth rate Age distribution of society Employment and unemployment rate People's lifestyle Life expectancy Family structure	Technological factors Technology growth and development Internet e-commerce access Social Networks	Environmental factors Geographical location Weather Environmental pollutants Waste disposal energy consumption People's attitude towards the environment	Political and legal factors Type of government International sanctions Administrative and financial corruption in the government Transparency and accountability Free political parties, civil societies, and NGOs Meritocracy

Data Coding and Analysis

In this study, a combined deductive-inductive approach was used. In a part of this research, the main elements of the social approach to health, such as social participation, intersectoral cooperation, good governance, health literacy, empowerment, and social welfare, have been discussed as a general framework. Therefore, in this section, data analysis using deductive reasoning from general concepts to components has been used. In the other part, due to the variety and breadth of data related to the institutionalization of the social approach to health, inductive reasoning and the free coding method have been used. The new data were classified based on the semantic load and from subconcepts to general concepts.

Results

The results of the study indicate that, despite the importance and necessity of the social approach to health in maintaining and promoting the health of communities, this approach was not properly implemented in Iran and did not achieve its goals. We categorized our findings based on the stages heuristic policy process as follows:

Problem Identification and Agenda Setting

Our findings indicate that the process of entering policies for the agenda and policy-making in Iran is complex and chaotic so that many good policies that are based on the social problems due to obstacles such as centralized governance of the health system, severe conflict of interests, lack of accountability and responsibility of government institutions, rent-seeking and corruption in the legislative system and public distrust of the government are not on the policy agenda or are not properly implemented after approval. The results show that only 28% of the policies approved during the Fifth Development Plan have been implemented in Iran. Recent issues such as shifting disease trends, not meeting health needs, dealing with new diseases like the coronavirus disease 2019 (COVID 19) pandemic, concentrating on treatment planning rather than public health and prevention strategies, disparities in access to healthcare across regions, income and employment inequality, and public discontent all point to Iran's distance from health development indicators.

Definitive effect of socioeconomic factors on health and the need to change from the traditional biomedical approach to the social approach in explaining health and diseases, with emphasis on social justice as a prerequisite for health, and given the successful experience of many developed countries, TSATH entered the policy agenda in 2017 as a priority.

"*Despite efforts to apply PHC principles in Iran through the expansion of the health care system, which has succeeded in greatly improving health indicators, disparities in employment and income have resulted in glaring disparities in health status and access to healthcare across the nation*." (PM1).

Policy Formulation

Evidence showed that health interventions on the socialization of health care are cost-effective, and especially after recognizing that the main cause of health problems lies outside the health system, the TSATH policy was approved and improving health education and public empowerment were set as the basis for social participation to increase awareness of social, political, and environmental determinants of health. The MOHME approved TSATH in 2017 as a necessity in maintaining and promoting health by holding 3 sessions for health experts and 2 sessions for the heads and directors of medical universities. This policy was approved based on Paragraph 11 of the general policies of the health system and the National Action Plan for Prevention and Control of NCDs, in line with the provisions of the Fourth and Fifth National Economic, Social and Cultural Development Plans.

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The most important factor in accepting the formulated policies by stakeholders is their participation in designing and formulating the policy, which can lead to improvement and selection of more important policies. The results of the study showed that the decision-making process of the TSATH policy was not participatory and transparent, but an immediate decision without the participation of stakeholders; thus, many key stakeholders lacked sufficient knowledge and readiness to accept the policy.

"*Since many stakeholders were not involved in formulating the TSATH policy, they were not only unaware of the TSATH policy but also resisted it*." (PM29).

Comprehensive information and deep understanding of policy makers in formulating appropriate policies is one of the most important factors in achieving health policy goals. Managers must have a deep understanding of the TSATH policy and develop appropriate guidelines and rules for institutionalizing the TSATH policy. However, the results of the study indicate that the managers and experts of the Ministry of Health and health-related organizations did not have a deep understanding of the TSATH policy; thus, the proper framework was not developed to implement the social approach to health.

"*In my opinion, for the successful implementation of TSATH, in addition to the involvement of officials, managers, and experts of the Ministry of Health and health-related organizations in policy-making, they must also have sufficient knowledge, a deep understanding, and a correct attitude towards TSATH*." (PM35).

Also, data analysis revealed that the formulation of the TSATH policy has been done only based on scientific data and in the direction of global health, and not based on the results of studies and evidence. Therefore, more than 3 years after the implementation of health socialization in Iran, there were no clear consequences in social health indicators. The findings suggest that policymakers need to be aware of the important role of evidence in informing public policy and the need for capacity building to develop, implement, and evaluate policies.

"*Since the policy-making and approval of the social approach to health in the country was not based on evidence and the results of studies, therefore, there was no clear and step-by-step planning for implementation and evaluation*." (PM23).

Policy Implementation

The social deputy was appointed by the MOHME to oversee the health socialization plan in the first step.

Then, it developed an organizational structure and job description of the social deputy by convening a meeting for experts and managers. In the second step, the National Health Assembly (NHA) was set up at the national, provincial (universities of medical sciences), local (cities and villages), and instructions for monitoring the formation of health assemblies, and their performance were developed and submitted.

The third step aimed at setting up a CBO with public participation. From the participants' point of view, one of the manifestations of public participation in the social development process is informal institutions, including CBOs, which are targeted and established based on local capabilities. Our thematic analysis also showed that public participation and intersectoral collaboration are the most important components of TSATH in Iran.

Table 4 shows the main themes, themes, and subthemes extracted from the thematic analysis of TSATH.

Our findings revealed that the TSATH policy, despite having scientific support, lacked clear goals and programs

Table 4. Thematic Analysis of Data in TSATH in Iran

Main them	Themes	Subthemes
Health socialization	Governance	• Voice and responsiveness • Efficiency • Monitoring and control • Rule of Law • Control of violence and corruption
	Empowerment& Health Literacy	• Knowledge and insight • Attitude • Skills and abilities • Demanding
	Social participation	• Inform • Consult • Strengthen cooperation • Get involved
	Inter-sectoral collaboration	• Information sharing • Cooperation • Coordination • Integration
	Well-being	• Gender equality • Economic opportunities • Education • Health • Safety and security • Citizen participation • Information and communication technology.

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in implementation and was not explicitly informed; thus, stakeholders were reluctant to cooperate. Even though the TSATH policy required full multisectoral and intrasectoral cooperation, weak, unstructured, and ineffective cross-sectoral cooperation occurred because of a lack of teamwork culture, poor steering, inadequate infrastructure, and an independent institution acting as the stewardship.

"*The inflexible structure and major problems caused by severe international sanctions have led organizations to plan solely to achieve the main goals of the organization, and the necessary infrastructure to target and implement health-oriented programs alongside the main goals is not possible*." (PM34).

The results indicate that the implementation of the social health approach relied mainly on education and promotion of health literacy, lifestyle changes, parenting principles, and life skills, while many families suffer from poverty and lack of living expenses. Therefore, the priority of the needs of many unemployed and poor people in society is not in line with government policies; therefore, there was no social participation in health-oriented programs among the poor classes of society.

"*A breadwinner who has to work all day in the most difficult conditions and despite trying hard in different shifts is not able to make a living, or for low-income groups and below the poverty line, lifestyle changes or proper physical activity do not make sense*." (PM26).

According to the results of the study, conflict of interest, weak political commitment, insufficient support, and lack of sufficient resources were other important obstacles to the implementation of the plan.

"*Senior health officials are clinicians who have a clinical perspective, so health promotion programs are mainly treatment-oriented, and the majority of them are employed in the private sector, so they lack the strong political will to implement the plan and do not provide the necessary resources and support*." (PM6).

In order to implement TSATH, policymakers had to deal with several issues, such as a lack of infrastructure, a lack of cooperation among pertinent organizations, concurrent activities with the public health deputy-MOHME, uncertainties regarding the nature of intrasectoral and intersectoral collaboration, and legal forces.

"*The MOHME, as a policy maker and steward of the health system, should provide the necessary infrastructure to implement TSATH in the country and sensitize other organizations and institutions regarding health-oriented policies*." (PM19).

Policy Monitoring and Evaluation

Monitoring and evaluation structures are designed to ensure the effective and efficient implementation of health socialization in society. Involvement of independent organizations in the monitoring and evaluation system can improve the outcomes.

Some interviewees pointed out that similarities between the activities of CBOs with the primary healthcare network PHC level caused experts and policy-makers to express concerns about the socialization approach as a parallel project to PHC activities and rapid policy implementation.

"*Many managers, because of a lack of sufficient knowledge and deep understanding of TSATH or political considerations or conflicts of interest, carried out the same programs as the Deputy Minister of Health. Therefore, the social deputy acted in parallel with the Deputy Minister of Health after a short time*." (PM2).

One of the most important challenges for health policymakers is to provide and allocate the necessary resources. These resources can include financial, manpower, intelligence, physical, equipment, and technological resources. The results showed that not only were the necessary resources not provided in the policy-making process of TSATH, but due to the general policy of the governing system, that is, shrinking the size of the government, the use of resources of other organizations and government units was taken into account.

"*In my view, creating a social deputy with a small workforce and facilities to carry out part of the health deputy's responsibilities is a parallel effort that merely expands the government*." (PM23).

The most important monitoring system to achieve the goals of TSATH was the NHA, which was the symbol of social participation and intersectoral collaboration consisting of representatives of the public sector (Table 5).

Table 5. Members and Committees for Monitoring and Evaluating TSATH

Row	Title / Supervising representative	Scope of supervision	Row	Title / Supervising Representative	Scope of supervision
1	Secretary or Deputy Secretary of the CBO	CBO performance	10	Village Islamic councils	Development of village services
2	CBO officials	Social participation	11	Education	Health Ambassadors
3	Trustees	Inter-sectoral collaboration	12	Cooperatives, Labor, and Social Welfare	Entrepreneurship and employment
4	Police	Security of places	13	Member of Parliament	Health rules
5	Representative of the Ministry of Interior	Inter-sectoral collaboration	14	Health and food security	Performance report
6	Representative of benefactors	Budget and expenses	15	General Department of Welfare	Social work
7	CBO, NGOs	Empowerment	16	Healthcare	Health committees
8	Neighborhood professors and academics	Empowerment	17	Environment	Environmental adjustment
9	Islamic City Council	Development of city services	18	Municipality/governance of a rural district	City Services

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Table 6. Sample Measures of Social Approach to Health in Iran

Location of the project	Project title	Goal
Tehran, Gilan, Mazandaran, North and Central Khorasan, Kermanshah, Kohkiluyeh and Boyer-Ahmad, Yazd, Qazvin, Zanjan	Setting up CBOs with the participation of the people	Promoting health literacy and empowering society to perform self-care and improve their place of residence and the environment
Provinces of the country	Setting up the project of student health ambassadors in the education department of the provinces of the country, and student health ambassadors and family health ambassadors, and neighborhood health ambassadors in collaboration with health volunteers	Peer education approach in schools and compensation of manpower shortage to create a comprehensive education network on methods of providing and promoting health and self-care methods by covering 70% of families at the end of the Sixth Development Plan
Tehran, Gilan, Qazvin, Yazd, Kermanshah, Isfahan, Tabriz ...	Setting up a participatory system in 354 CBOs	Providing municipal social health service packages to promote health justice in the urban health management center
Gilan	Setting up a comprehensive center for the elderly and an elderly-friendly pharmacy	Teaching a healthy lifestyle and self-care, and keeping the elderly active by producing handicrafts and entertainment programs, as well as providing all medical needs, all care, and medical advice for the elderly
Provinces of the country	Setting up 3540 community-based centers in the form of centers for the elderly, diabetics, mothers and children, the disabled	Lifestyle education and care for the elderly, disabled, diabetics, and vulnerable groups, especially mothers and children
Tehran, Gilan, Mazandaran, and Kerman	Offering the idea of each family as a helper by the Department of Education in all junior high schools for girls and boys	Teaching students about rescue items and earthquake and natural disaster response approaches, and teaching skills such as: first aid, transporting the injured people, quickly finding a safe place, triage, and cardiopulmonary resuscitation to them
Tehran, Gilan, Qazvin, Yazd, Kermanshah, Isfahan, Tabriz, Shiraz, Kerman, Khorasan, Mazandaran ...	Setting up and operating 800 non-governmental organizations active in the health sector	Health care training, empowerment of foster mothers and orphans and abused children, and training in technical skills and crafts to generate income
Tehran	Child development monitoring and home health monitoring plan with the participation of parents and caregivers	Control of health, height, and weight, oral health, and nutrition of children, and improvement of the growth curve
Qazvin	Comprehensive health plan with the approach of social health factors in Qazvin province	Prevention and reduction of disease risk using the approach of social components of health and inter-sectoral collaboration
Tehran	Empowerment plan for social workers to carefully examine the situation and conditions of clients	Investigating social factors threatening the health of clients and performing interventions in collaboration with the Welfare Department, Relief Committee, NGOs, and benefactors in Tehran
Gilan	Identification plan for high-risk elderly in Gilan province, as the oldest province in the country	Performing health-oriented interventions and disease prevention in collaboration with the Welfare Office, NGOs, and benefactors
Provinces of the country	Health Promoting Hospital (HPH) for diabetes screening	Identification and screening of diabetic and diabetes-prone patients and education for prevention and control of the disease in collaboration with the Iranian Diabetes Society

It should be noted that 16 months after the approval of the plan, the minister resigned, and the new minister appointed the deputy for social affairs, which led to most activities being put on hold at both national and local levels.

However, in Iran, several activities were conducted for the initial implementation of the health socialization plan, some of which are briefly mentioned in Table 6.

"*But I must admit that TSATH is not implemented systematically in Iran, although programs such as the national health forum of provinces and cities, CBOs, and family medicine, et cetera, were launched. If there are programs in rare cases, they are quite theatrical and, in many cases, have a research or political aspect*." (PM24).

Discussion

Even though Iran has implemented several programs in accordance with TSATH, the results of the health socialization plan's implementation and acceptance in terms of health promotion remain unclear several years later.

It appears that the TSATH policy had significant issues from the start, which prevented it from accomplishing its intended objectives. Iran lacks a comprehensive and systematic plan for TSATH, even though there are a few dispersed and inconsistent relevant programs, research projects, and occasionally pilot studies conducted by researchers, institutions, NGOs, health professionals, and charity groups.

The result showed that the development of a comprehensive plan is the basis for institutionalizing TSATH. In this regard, we can refer to the environmental-social model of health socialization in the United States, which is based on

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3 pillars: social and structural factors (businesses), individual characteristics and living environment (family, school, peers, and habitat), and social communication and media (social networks, Internet, television and newspapers). The realization of health socialization goals depends on integrated and systematic planning in each sector and the coordinated implementation of programs (31). For health-related organizations in Iran, a comprehensive program and integrated document that outlines societal obligations, tasks, and ways to collaborate and participate are required.

However, the degree to which an initiative is supported by evidence determines how stable it will be (32, 33). The TSATH policy was a hasty political choice rather than an evidence-based policy, and has produced no observable results.

The importance of evidence-based health policies in improving health, reducing health inequalities, and contributing to economic development is increasingly recognized (34). A successful example of evidence-based policymaking is the policy of setting up a regulatory body to control corruption and mismanagement of public health expenditures in Ugandan schools, following the World Bank study in that country (35).

Evidence-based policy-making helps in understanding the policy being established or developed in response to a social problem (36) as well as identifying the elements determining the success or failure of certain policies (37), as well as the contribution of research to policy-making.

For example, we can refer to the successful model of Thailand's social approach to health by creating a health promotion fund based on the tax on harmful goods and creating a universal health coverage system (38), passing the National Health Law, institutionalizing the National Assembly, which is planned to achieve socioeconomic development, improve family and community health, and promote a healthy lifestyle (39), with an emphasis on health equity.

Our findings revealed that there was no comprehensive program to implement the policy of a social approach to health. For example, there was no accountable organization, nor an official policy in this regard to address problems in education and child care, employment, income inequality, cheap housing, social support, and well-being, and a suitable living environment, which have the greatest impact on social factors and health inequality (40).

In TSATH, effective content is characterized by well-defined objectives and appropriate preparation to reach the objectives.

In this regard, the model of the British health socialization approach, which is targeted at 4 strategies: community-based medicine, preventive medicine, community health and social care, and universal health coverage, can be exemplified (41). Systematic and integrated implementation of health-oriented programs in this model is the key to its success.

In Iran, despite the relative success of universal health coverage, health policies are mainly treatment-oriented, and the content of the TSATH policy, except for community-based medical education, lacked clear goals and programs and was not explicitly informed. Results of a study referred to a lack of transparency and a clear definition of policy decisions and the role of actors as the most important challenge facing the internationalization plan for higher education in Iran (42).

The health socialization policy is a fundamental approach and an undeniable necessity (43). However, because of the government's weakness, corruption, and lack of accountability, it was not appealing to organizations and individuals experiencing poverty and economic difficulties, nor was it a priority for them. As a result, they were not sufficiently motivated to participate in the implementation phase (44).

Empirical evidence shows that addressing health problems is impossible without simultaneous attempts to address economic problems and eliminate poverty and income inequality (45). The most basic result of public participation is the acquisition of social benefits, health promotion, and well-being (1, 46). It also helps to create opportunities for the distribution of health knowledge in society, provides appropriate conditions for organizing scattered resources, and ensures equitable access to these resources (47, 48). Therefore, public participation is essential in all aspects of health policy-making and implementation (24).

For instance, Egypt's social approach to health has been centered on 3 pillars: empowering society, particularly women and children, through the establishment of CBOs and the utilization of private sector and NGO capacity; reducing poverty; eradicating illiteracy; and fostering health literacy. Comprehensive initiatives have been put in place to teach individuals how to take care of themselves and to train women and orphans how to make money (49).

Our findings showed that a selected proportion of existing evidence was used to guide, develop, and implement TSATH, rather than a comprehensive approach to utilize all available evidence. The TSATH policy's implementation was hampered not only by a lack of scientific evidence but also by the political environment, individual interests, and resource constraints. Obtaining the resources needed and allocating them is one of the greatest problems faced by health officials. Inadequate resource allocation in health projects was identified as a barrier to "good practice" in the findings of research conducted in Alberta, Canada (50).

Informed policy strengthening, public institution capacity building, accountability, and the use of integrated and evidence-based knowledge at the organizational level have all proven to be successful strategies, according to a study on the implementation of Lebanon's voluntary health insurance system (51). The Ministry of Health and Long-Term Care in Ontario, Canada, was also noted as a successful example of systematic integration and the application of evidence in policymaking (52).

Stakeholder Analysis

Recognizing the role of stakeholders, including groups and individuals with political and economic influence, helps to develop and implement policies (13, 53, 54). Many health policymakers mistakenly concentrate on the reform content and overlook the influence of actors during the decision-making process, even though actors can negatively

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affect the policy process or reject any policy effort to protect their interests (55, 56). Politicians might choose to concentrate on projects that yield results right away (57), such as appointing a social representative to the MOHME without making sure the right arrangements are in place.

In order to meet the objectives of TSATH, both directorates could collaborate rather than compete in order to benefit from the position of deputy of public health (58, 59). Health care may be impacted by the political players' current structure (60). However, because stakeholders, NGOs, and civil society were not included in the policy-making process, the health socialization decision-making process was neither transparent or participatory. Because of this, they were not well-versed in or prepared for intersectoral collaboration, which resulted in a top-down strategy during the planning and implementation stages and poor stakeholder collaboration during the policy implementation stage.

Other barriers included a lack of evidence-based policy-making, conflict of interest, poor political commitment, and insufficient support for the plan's implementation from the senior officials. To present good policies, the availability of relevant evidence alone is not enough; however, the political commitment and support play an important role in the formulation and implementation of policies.

The interests of stakeholders might affect their professional judgment and impede evidence-based decision-making, resulting in flawed policies and incorrect policy enforcement, according to statistical evidence (61). Even professionals who are aware of conflicts of interest often underestimate how much they influence their conduct and judgment (62). As personal interests become more important, political commitment decreases. Even when policymakers are aware of the data, they may choose to disregard it because it contradicts their objectives and interests (51).

Contextual Factors

Contextual factors can affect the policy-making process and its implementation (63). Analyzing the contextual factors to understand the policy process is invaluable (64). Leadership and infrastructure were the most important micro factors influencing the implementation of TSATH. Evidence shows that managerial changes in Iran have generally led to the non-implementation of policies or their incomplete implementation (65). In this regard, health socialization plans were carried out very rarely and almost abandoned with the change of the Minister of Health. The results of the present study showed no necessary infrastructure for intra- and intersectoral collaboration, while multilateral and intersectoral collaboration is necessary to promote health and social well-being and achieve the SDGs (66, 67). In this regard, a successful implementation of the family physician plan along with public health coverage occurred in Turkey by providing appropriate conditions and necessary infrastructure (68).

In the Finnish social health approach model, integrated health care and social services are provided by local municipalities. The Alliance model is for providing health and social care through the collaboration of various service providers from the public and private sectors and local authorities. However, highly decentralized services are provided by state municipalities after decision-making based on citizens' needs, and with poor central government guidance (69). However, the top-down policy-making process and centralized, hierarchical political system in Iran preclude the involvement of NGOs and the private sector in the policy-making process.
Regarding macro aspects, economic issues were the main obstacle to the implementation of TSATH because of the extensive and harsh international sanctions.

Most people in society do not participate in health promotion programs because they do not view health as a priority due to rising inflation, a severe fall in per capita income, declining household purchasing power, poverty, and livelihood issues (70). The creation and execution of anti-poverty policies are crucial for the implementation of health-oriented programs and lifestyle changes for those living in poverty (71).

A shift in the pattern of growth and social well-being in India, for instance, can be attributed to the adoption of a sustainable livelihood strategy that prioritizes antipoverty policies (72).

About sociocultural factors, rising unemployment and employment, and income inequality, especially among women, are among causes of apathy and social non-participationv (73) in government programsv (74). In this regard, we can refer to the model of Russia's social approach, which is based on the elimination of poverty through a targeted and merit-based social protection policy, improving health and quality of life, and Fair employment. In the case of gender equality, we can mention the successful policy of gender responsive budgeting and increasing women's participation in political and economic activities in Russia (75).

In addition to decreasing social involvement (76), ineffective managers, a lack of accountability, rent, and corruption in the government have also led to a severe fall in the nation's social capital (77, 78) and public mistrust of officials. Research points to a connection between high social capital and acceptable levels of social participation in sustainable communities (79). By establishing robust democratic institutions and ensuring accountability and transparency in decision-making, India's social health strategy exemplifies good governance. This methodology promotes health literacy, implements a sustainable livelihood plan, and uses a social support strategy (80). A coordinated, multidimensional, and participative strategy to addressing potential health hazards is the One Health Master Plan, which is founded on the positive interactions between humans, animals, and ecosystems (81).

Many programs, notably TSATH, were implemented with less participation because of the Iranian health system's hierarchical and centralized structure (82). Based on national development initiatives, Ecuador's social approach to health prioritizes civil rights, democracy, social welfare, and the advancement of socioeconomic indicators. The Buen Vivir (Good Living) program, which is the cornerstone of this strategy, has advanced societal participation in

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decision-making and suitable lifestyles, such as citizenship and democracy, through creative performing arts like street circuses (83).

Conclusion

Health systems must be sufficiently prepared and resilient to deal with emerging diseases to manage health risks and the growing demands of the population. To maintain global health, community-based and integrated approaches to this problem are needed. TSATH is undoubtedly essential to deliver, maintain and improve health status in communities and work towards the SDGs. Iran has not fully addressed TSATH, a multi-sectoral and multidisciplinary problem with multiple aspects and components.

Despite implementing initial plans, Iran still has a long way to go before implementing TSATH.

Factors such as centralized governance of the health system, lack of evidence-based policymaking, insufficient resources, government incompetence, corruption and lack of accountability, conflict of interest, reduced social capital, low social participation, and insufficient cross-sectoral collaboration are the most important obstacles to TSATH.

In order to create a sustainable livelihood plan, especially for the low-income deciles of society, create jobs, and specify the social and professional obligations of health-related organizations as well as how they collaborate and interact, it is essential to create an integrated document and a comprehensive TSATH plan.

Suggestions for Further Studies

Investigating and determining the necessary infrastructures for full intersectoral cooperation and effective social participation in TSATH.

Authors' Contributions

Conceptualization: Ataollah Asadi louyeh, Amirhossein Takian, Batoul Ahmadi. Methodology/formal analysis/validation: Ataollah Asadi louyeh, Amirhossein Takian, Ali Davoudi Kiakalayeh. Project administration: Ataollah Asadi louyeh, Amirhossein Takian, Mohammad Arab. Writing the original draft: Ataollah Asadi louyeh, Amirhossein Takian, Writing, reviewing & editing: Ataollah Asadi louyeh, Amirhossein Takian, Batoul Ahmadi, Mohammad Arab, Ali Davoudi Kiakalayeh.

Ethical Considerations

This research was performed by the ethical committee of Tehran University of Medical Sciences, under the code IR.TUMS.SPH.REC.1398.166.

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Conflict of Interests

The authors declare that they have no competing interests.

References

1. Umberson D, Karas Montez J. Social relationships and health: A flashpoint for health policy. J Health Soc Behav. 2010;51(1_suppl):S54-S66.
2. Marmot M, Wilkinson R. Soc Determ Health: OUP Oxford; 2005.
3. Blas E, Gilson L, Kelly MP, Labonté R, Lapitan J, Muntaner C, et al. Addressing social determinants of health inequities: what can the state and civil society do? Lancet. 2008;372(9650):1684-9.
4. McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. Health Aff. 2002;21(2):78-93.
5. Pilkington P. Social capital and health: measuring and understanding social capital at a local level could help to tackle health inequalities more effectively. J Public Health. 2002;24(3):156-9.
6. Rantala R, Bortz M, Armada F. Intersectoral action: local governments promoting health. Health Promot Int. 2014;29(suppl_1):i92-i102.
7. Park K. Text Book of Preventive and Social Medicine. 2007 ed: M. S Banarsidas Bhanot, Jabalpur, India. 2007.
8. Gillam S. Is the declaration of Alma Ata still relevant to primary health care? Bmj. 2008;336(7643):536-8.
9. Azizi Akbar SJ. Social determinants of health status: The effect of socio-economic status on health. Tasvir Salamat. 2014;5(1):15-21.
10. Vahidi R, Kousha A, Kalantari H, Tabrizi J. Social determinants of health and their related organizations in East Azerbaijan. J Public Health. 2013;3(4):20-8.
11. Moradi S. Socialization of health: An undeniable necessity for the formation of responsible medical universities in Iran. Soc Determ Health. 2017;3(4):175-6.
12. Thompson S, Watson M, Tilford S. The Ottawa Charter 30 years on: still an important standard for health promotion. Int. J Health Promot Educ. 2018;56(2):73-84.
13. Laverack G. Health promotion practice: building empowered communities: McGraw-Hill Education (UK); 2007.
14. Sen A. Development as freedom: Oxf. Pap. 2001.
15. Ruger JP. Democracy and health. Qjm. 2005;98(4):299-304.
16. Safaei J. Is democracy good for health? Int J Health Serv. 2006;36(4):767-86.
17. Singh-Manoux A, Marmot M. Role of socialization in explaining social inequalities in health. Soc Sci Med . 2005;60(9):2129-33.
18. Takian A, Raoofi A, Kazempour-Ardebili S. COVID-19 battle during the toughest sanctions against Iran. Lancet (London, England). 2020;395(10229):1035.
19. Doshmangir L, Bazyar M, Majdzadeh R, Takian A. So near, so far: four decades of health policy reforms in Iran, achievements and challenges. Arch Iran Med. 2019;22(10):592-605.
20. Amerzadeh M, Salavati S, Takian A, Namaki S, Asadi-Lari M, Delpisheh A, et al. Proactive agenda setting in creation and approval of national action plan for prevention and control of non-communicable diseases in Iran: The use of multiple streams model. J Diabetes Metab Disord. 2020:1-12.
21. O'Brien GL, Sinnott S-J, Walshe V, Mulcahy M, Byrne S. Health Policy Triangle Framework: Narrative Review of the Recent Literature. Health Policy OPEN. 2020:100016.
22. Gale NK, Heath G, Cameron E, Rashid S, Redwood S. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. BMC Med Res Method. 2013;13(1):1-8.
23. Doshmangir L, Bazyar M, Najafi B, Haghparast-Bidgoli H. Health financing consequences of implementing health transformation plan in Iran: achievements and challenges. International journal of health policy and management(IJHPM) . 2019;8(6):384.
24. Buse K, Mays N, Walt G. Making health policy: McGraw-hill education (UK); 2012.
25. Nogueira-Jr C, Padoveze MC. Public policies on healthcare associated infections: a case study of three countries. Health Policy. 2018;122(9):991-1000.
26. Baltar F, Brunet I. Social research 2.0: virtual snowball sampling method using Facebook. INTR. 2012.
27. Mitchell G. Use of interviews in nursing research. Nursing Standard (2014+). 2015;29(43):44.
28. Goolsarran N, Hamo CE, Lu W-H. Using the jigsaw technique to teach patient safety. Med Educ Online . 2020;25(1):1710325.
29. Van Wyk MM. Using the Jigsaw Teaching Strategy for the advance of economics teachers' acquisition of knowledge. Int J Educ Sci. 2015;10(2):338-46.

[DOI: 10.47176/mjiri.39.66]

30.Kumar V, Kalasuramath S, Patil S, Kumar R, Taj S, Jayasimha V, et al. Effect of jigsaw co-operative learning method in improving cognitive skills among medical students. Int J Curr Microbiol. 2017;6(3):164-73.
31.Paek H-J, Reber BH, Lariscy RW. Roles of interpersonal and media socialization agents in adolescent self-reported health literacy: a health socialization perspective. Health Educ Res.2011;26(1):131-49.
32.Lavis JN, Ross SE, Hurley JE. Examining the role of health services research in public policymaking. Milbank Q. 2002;80(1):125-54.
33.Campbell DM, Redman S, Rychentnik L, Cooke M, Zwi AB, Jorm L. Increasing the use of evidence in health policy: practice and views of policy makers and researchers. Aust N Z Health Policy.
2009;6(1).
34.Hanney SR, Gonzalez-Block MA, Buxton MJ, Kogan M. The utilisation of health research in policy-making: concepts, examples and methods of assessment. Health Res. 2003;1(1):1-28.
35.Scott C, editor Measuring up to the measurement problem. The role of statistics in evidence-based policy making CBMS Network Meeting Available online on: http://www pep-net org/fileadmin/medias/pdf/files_events/4th_colombo/proceed/scott pdf (accessed 12 April 2015); 2005.
36.Coveney J. Analyzing public health policy: three approaches. Health Promot. Pract. 2010;11(4):515-21.
37.Buse K, Dickinson C, Gilson L, Murray S. How can the analysis of process and power improve health outcomes? Moving the agenda forward. Odi Brf Pap. 2007;25.
38.Sumriddetchkajorn K, Shimazaki K, Ono T, Kusaba T, Sato K, Kobayashi N. Universal health coverage and primary care, Thailand. Bull. World Health Organ. 2019;97(6):415.
39.Phulkerd S, Thapsuwan S, Chamratrithirong A, Gray RS. Influence of healthy lifestyle behaviors on life satisfaction in the aging population of Thailand: a national population-based survey. BMC Public Health 2021;21(1):43.
40.Saunders M, Barr B, McHale P, Hamelmann C. WHO Health Evidence Network Synthesis Reports. Key policies for addressing the social determinants of health and health inequities. Copenhagen: WHO Regional Office for Europe (WHO/EURO). © World Health Organization 2017.; 2017.
41.Light DW. Universal health care: lessons from the British experience. Am J Public Health. 2003;93(1):25-30.
42.Asghari F. Internationalization of higher education - in Iran with emphasis on the role of actors. J Manag Tomorrow. 2019;18:243-60.
43.Ashoorkhani M, Rajabi F, Majdzadeh R. The meaning of" socialization of health" to Iranian policymakers and how it can be implemented. Med J Islam Repub Iran. 2019;33:6.
44.Rasanathan K, Atkins V, Mwansambo C, Soucat A, Bennett S. Governing multisectoral action for health in low-income and middle-income countries: an agenda for the way forward. BMJ Glob Health. 2018;3(Suppl 4).
45.Worku EB, Woldesenbet SA. Poverty and inequality–but of what-as social determinants of health in Africa? Afr. Health Sci. 2015;15(4):1330-8.
46.Heritage Z, Dooris M. Community participation and empowerment in Healthy Cities. Health Promot Int. 2009;24(suppl_1):i45-i55.
47.Gatewood JG, Litchfield RE, Ryan SJ, Geadelmann JDM, Pendergast JF, Ullom KK. Perceived barriers to community-based health promotion program participation. Am J Health Behav 2008;32(3):260-71.
48.Rifkin SB. Lessons from community participation in health programmes: a review of the post Alma-Ata experience. Int Health. 2009;1(1):31-6.
49.El Razak A, El Ela A, editors. Social participation in Egypt: Civil Society's former experience and new opportunities (Draft Background Paper 11). World Conference on Social Determinants of Health, Rio De Janeiro, Brazil; 2011.
50.Smith N, Mitton C, Bryan S, Davidson A, Urquhart B, Gibson JL, et al. Decision maker perceptions of resource allocation processes in Canadian health care organizations: a national survey. BMC Health Serv. Res 2013;13(1):247.
51.El-Jardali F, Bou-Karroum L, Ataya N, El-Ghali HA, Hammoud R. A retrospective health policy analysis of the development and implementation of the voluntary health insurance system in Lebanon: learning from failure. Soc Sci Med. 2014;123:45-54.
52.Wilson M, Lavis J, Grimshaw J. Supporting the use of research evidence in the Canadian health sector. J Healthc Qual. 2012;15:58-62.
53.Taylor D, Balloch S. The politics of evaluation: Participation and policy implementation: Pol Press; 2005.
54.Pawson R. Evidence-based policy: a realist perspective: sage; 2006.
55.Gilson L, Schneider H, Orgill M. Practice and power: a review and interpretive synthesis focused on the exercise of discretionary power in policy implementation by front-line providers and managers. Health Policy Plan. 2014;29(suppl_3):iii51-iii69.
56.Walt G, Gilson L. Reforming the health sector in developing countries: the central role of policy analysis. Health Policy Plan. 1994;9(4):353-70.
57.Exworthy M. Policy to tackle the social determinants of health: using conceptual models to understand the policy process. Health Policy Plan. 2008;23(5):318-27.
58.Zhang X, Xiong Y, Ye J, Deng Z, Zhang X. Analysis of government investment in primary healthcare institutions to promote equity during the three-year health reform program in China. BMC Health Serv Res. 2013;13(1):1-6.
59.Travis P, Bennett S, Haines A, Pang T, Bhutta Z, Hyder AA, et al. Overcoming health-systems constraints to achieve the Millennium Development Goals. Lancet. 2004;364(9437):900-6.
60.Van De Bovenkamp HM, De Mul M, Quartz JG, JWM WEGGELAAR-JANSEN AM, Bal R. Institutional layering in governing healthcare quality. Public Adm. 2014;92(1):208-23.
61.Subiabre MS. Conflict of interest disclosure as a tool to improve the reliability of research. Rev Med Chile. 2016;144(8):1067-72.
62.Richter J. COI and policy making: reflections from the fields of health and infant nutrition2005.
63.Pisani E, Olivier Kok M, Nugroho K. Indonesia's road to universal health coverage: a political journey. Health Policy Plan. 2017;32(2):267-76.
64.Organization Wh. Health Serv and policy-making: a toolkit for nurses and midwives. Manila: WHO Regional Office for the Western Pacific; 2005.
65.Doshmangir L, Bazyar M, Doshmangir P, Mostafavi H, Takian A. Infrastructures required for the expansion of family physician program to urban settings in Iran. Arch Iran Med. 2017;20(9):-.
66.Ratzan SC, Gillian Christie M, Sidibe M. Guiding Principles for Multisector Engagement for Sustainable Health. MESH. 2019.
67.Cech DJ, Alvarado ZJ. Collaborating with Communities and Higher education to address the Health-care needs of individuals with disabilities in ecuador. Front Public Health. 2017;5:91.
68.Cesur R, Güneş PM, Tekin E, Ulker A. The value of socialized medicine: The impact of universal primary healthcare provision on mortality rates in Turkey. J Public Econ. 2017; 150:75-93.
69.Keskimäki I, Sinervo T, Koivisto J, Organization WH. Integrating health and social services in Finland: regional and local initiatives to coordinate care. Public Health Pan. 2018;4(04):679-87.
70.Rock A, Barrington C, Abdoulayi S, Tsoka M, Mvula P, Handa S. Social networks, social participation, and health among youth living in extreme poverty in rural Malawi. Soc Sci Med. 2016;170:55-62.
71.Levin J. An antipoverty agenda for public health: background and recommendations. Public Health Rep. 2017;132(4):431-5.
72. Dutta S, Kumar L. Poverty dynamics in rural India: An asset-based approach. Margin. J Appl Econ Res. 2013 Nov;7(4):475-506.
73.Keyes CL, Shapiro AD. Social well-being in the United States: A descriptive epidemiology. How healthy are we. 2004:350-72.
74.Tajeddin MB. Determinants of Social Health of Citizens in District 12 of. Soc Dev Wel Plan. 2017;8(32):61-96.
75.Zakirova V. Gender inequality in Russia: the perspective of participatory gender budgeting: "[Russian woman] can stop a runaway horse and will go into a burning house."(from: N. Nekrasov poem, Death of a peasant 1862–1863). Reprod Health Matters. 2014;22(44):202-12.
76.Dieleman, M., Shaw, D.M. & Zwanikken, P. Improving the implementation of health workforce policies through governance: a review of case studies. Hum Resour Health. 2011;9(10).
77.Mohammadi F, Foruzan A. Facilitating and hindering factors of community participation for health promotion in residents of the second region of Tehran. J Qazvin Univ Med Sci. 2013;17(4):24-31.
78.Borji M, Moradi M, Mahdian K, Bahman Pour K, Navkhasi S, Salimi E. Comparison of Social Participation Level Between Older Adults With Assistive Mobility Devices and Those Without These Devices. Iran J Rehabil Res Nurs. 2017; 3 (2) :38-44
79.Lindström M, Group MS-NS. Psychosocial work conditions, social participation and social capital: A causal pathway investigated in a longitudinal study. Soc Sci Med. 2006;62(2):280-91.

[DOI: 10.47176/mjiri.39.66]

80.Sharma R, Henneman L, Qadri A, Sharma R, Vignoles L. Global youth wellbeing index. Baltimore, MD: IYF. 2017.
81.Yasobant S, Bruchhausen W, Saxena D, Falkenberg T. One health collaboration for a resilient health system in India: Learnings from global initiatives. One Health. 2019;8:100096.
82.Organization WH. Building foundations for eHealth: progress of Member States: WHO Global Observ eHealth: World Health Organization; 2006.
83.Spiegel JB, Ortiz Choukroun B, Campaña A, Boydell K, Breilh J, Yassi A. Social transformation, collective health and community-based arts:'Buen Vivir'and Ecuador's social circus programme. Glob Public Health. 2019;14(6-7):899-922.

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