




Patterns of the Social Approach to Health in Selected Countries and Iran: A Comparative Study

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Abstract

Background: The complexity of health and the role of its relevant socioeconomic factors have led countries to adopt new approaches to promote health, including the socialization of health. This comparative study aimed at examining the patterns of the social approach to health in 9 selected countries.

Methods: Using the scoping review method, we collected the data by searching published articles in databases and the websites of the World Health Organization, the United Nations, and the World Bank. A total of 66 articles were included in the study based on the PRISMA protocol.

Results: The thematic analysis showed that the most efficient model among middle-income countries was the one that consisted of good governance, effective social participation, and empowerment of mothers and children. The study findings also revealed that considering social welfare, governance, social participation, empowerment, and health literacy, Ecuador, Bulgaria, Egypt, and Cuba had the highest scores among the selected countries, respectively.

We define socialization of health as public engagement in maintaining and promoting individual and social and psychological health in the society, a part of which is achieved through community-based medical education.

Conclusion: In Iran, the centralized structure of the health system and inadequate transparency and accountability of the government have led to restricted public participation and poor intersectoral collaboration. We propose empowering civil society, setting up free political parties, and implementing the family medicine project as an effective policy for improving the socialization of health to achieve sustainable development goals in Iran.

Keywords: Social Approach to Health, Health Promotion, Health Socialization, Iran

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Introduction

Despite the tremendous advances in science and technology in the third millennium, the complexity of the

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↑What is “already known” in this topic:

Many health problems and diseases are not exclusively of biological origin, but are rooted in social and economic factors, living conditions, and social interactions. Therefore, nowadays, the social approach to health is an undeniable necessity for providing, maintaining, and promoting health status in societies and moving toward achieving sustainable development goals (SDGs).

→What this article adds:

Different countries, according to their socioeconomic, cultural, and political characteristic, have incorporated various models and approaches toward health socialization. Now more than ever, empowering individuals, strengthening public participation, and intrasectoral and intersectoral collaboration with greater accountability to rebuilding societies and moving toward achieving the SDGs is crucial.

health (1) and the impact of socioeconomic factors (2) have made it impossible for health systems in various countries to maintain and improve health (3). Although increasing access to health services and providing the highest quality of services are among the effective measures in ensuring the health of the people, such initiatives are not comprehensive enough to deal with the ongoing health threats (4). Since 1978, through the Alma Ata Declaration on Primary Health care (PHC), the World Health Organization (WHO) has been emphasizing the crucial role of community participation to improve health and well-being for all, in addition to considering the role of social and environmental issues (5). An environment that enables citizens to abandon unhealthy behaviours and endorses a healthy lifestyle is pivotal to achieve health by providing healthy social contexts for all (6). Creating such an environment has been challenging for many countries, as it requires not only health promotion programs but also comprehensive multisectoral cooperation and responsible social participation (7), which are fundamental for achieving sustainable development goals (8). The ongoing coronavirus-2019 (COVID-19) pandemic and the underlying impact of environmental and socioeconomic factors on its prevalence, severity, morbidity, and mortality among populations worldwide are recent examples of how health inequalities and nonbiological factors, including socialization, can influence health outcomes (9). Socialization is the mechanism through which societies shape behavioural and existential patterns that might affect health (10). Although socialization of health is not a new concept per se, it has been recently reemphasized as an undeniable, necessary approach to health promotion in societies (11). According to their characteristics, different countries may adopt various approaches and models for the socialization of health (12). A policy may have a different level of desirability in various countries (13). This study reports the findings of a comparative analysis of various models of health socialization and their social well-being consequences in 9 selected middle-income countries from across different continents. Finally, we drew evidence-based policy recommendations for improvement of health socialization to achieve sustainable development goals (SDGs) in Iran.

Methods

This comparative study was conducted using the available data from 9 countries that were purposefully selected from the middle-income countries according to the World Bank's ranking in 2018 (given that Iran is also classed as a middle-income country) and based on experience in socializing health. The countries included Ecuador and Cuba from America; Nigeria and Egypt from Africa; Turkey, India, and Iran from Asia; Bulgaria and the Russian Federation from Europe. We used the scoping review approach based on the 6-step framework presented by Arkesy and O'Malley (14), as described below:

1. Identifying the Research Question

This study was designed to compare the various models of health socialization and related socioeconomic policies in

9 selected middle-income countries from across different continents. To do so, we examined the health consequences associated with these models of health socialization in these countries and evidence-based policy recommendations to be proposed for improving health in Iran.

2. Identifying Relevant Studies

(A) *Searching for Relevant Studies*: All published articles related to the social approach to health and the components of health socialization in middle-income countries were collected from 2000 to 2020. MEDLINE/PubMed, EMBASE, Elsevier, ISI/Web of Science, Scopus, CI-NAHL, IranMedex, the WHO, the United Nations, and the World Bank databases were searched using Google and Google Scholar.

(B) *Selecting Appropriate Keywords*: The search was done using appropriate keywords, including social approach to health, health promotion, governance in health care, social participation, intersectoral collaboration, empowerment and health literacy, well-being, social mobilization, multisectoral collaboration, community participation, health socialization, socialized health care, and community-based organization.

3. Study Selection

All observational, descriptive, survey, qualitative, retrospective, or prospective studies, which provided a successful experience of a social approach to health in middle-income countries or one of the components of health socialization in these countries were selected and analyzed. The criterion for inclusion in the study was the presentation of health socialization models in the articles (Table 1).

To determine the suitability of the selected articles, the following steps were taken:

1. In the first stage, the initial screening was done by reviewing the titles of the articles and then reviewing the abstracts.

2. If reviewing the abstract could not determine whether the article was appropriate or not, the full-text of the article was reviewed.

3. All steps were taken by the first author and each step was reviewed by other authors.

After determining the suitable articles, the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) protocol was used to adjust the articles that met the inclusion criteria (15).

By reviewing the full articles, 217 items were identified, of which 202 were extracted from the mentioned databases and 15 items were obtained from various web pages. Out of a total of 217 articles, 15 duplicate articles, 8 inaccessible articles, and 87 unrelated articles were excluded from the study. At this stage, 107 articles were reviewed, of which 8 and 2 were excluded because of duplication non-English language, respectively. In the next step, 97 full-text articles were reviewed, 15 articles were related to countries that were in the low- and high-income countries according to the World Bank ranking at the time of the study, and thus were excluded. Seven articles had examined other aspects of health in the middle-income coun-

Table 1. Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
1. The articles that provide a successful experience of a social approach to health in middle-income countries.	1. The articles published before 2000 that provide a social approach to health and its components in countries.
2. The articles on the role of social participation, intersectoral collaboration, governance, well-being, health literacy, and empowerment in health socialization among middle-income countries	2. The articles on the role of social determinants of health in middle-income countries.
3. The articles that examine the role of community-based organizations on health socialization in middle-income countries.	3. The articles published in languages other than English.
4. The articles that present the pattern of health socialization in one of the middle-income countries.	4. The articles that examine social harms in countries.
5. The articles published between 2000 and 2020 that provide a social approach to health and its components in one of the middle-income countries.	5. The articles that present the pattern of health socialization in high and low-income countries.
	6. The articles that provide other aspects of health in middle-income countries.

tries, which were also excluded from the study and 9 were excluded because they were only related to the impact of social determinants of health in countries. Finally, 66 eligible articles were included in the study and sorted for analysis (Fig. 1).

4. Charting the Data

(A) *Data Mapping*: Articles were categorized based on the country's approach to health, health socialization mod-

el, and its main components, type of policy interventions, health consequences, and social welfare as a result of policy interventions, year of study and publication, methodology, study population, conclusions, and policy recommendations.

(B) *Data collection*: The data of all articles after extraction and determination of semantic load were analyzed based on deductive thematic analysis. Then, all studies on social approaches to the health of countries were reviewed

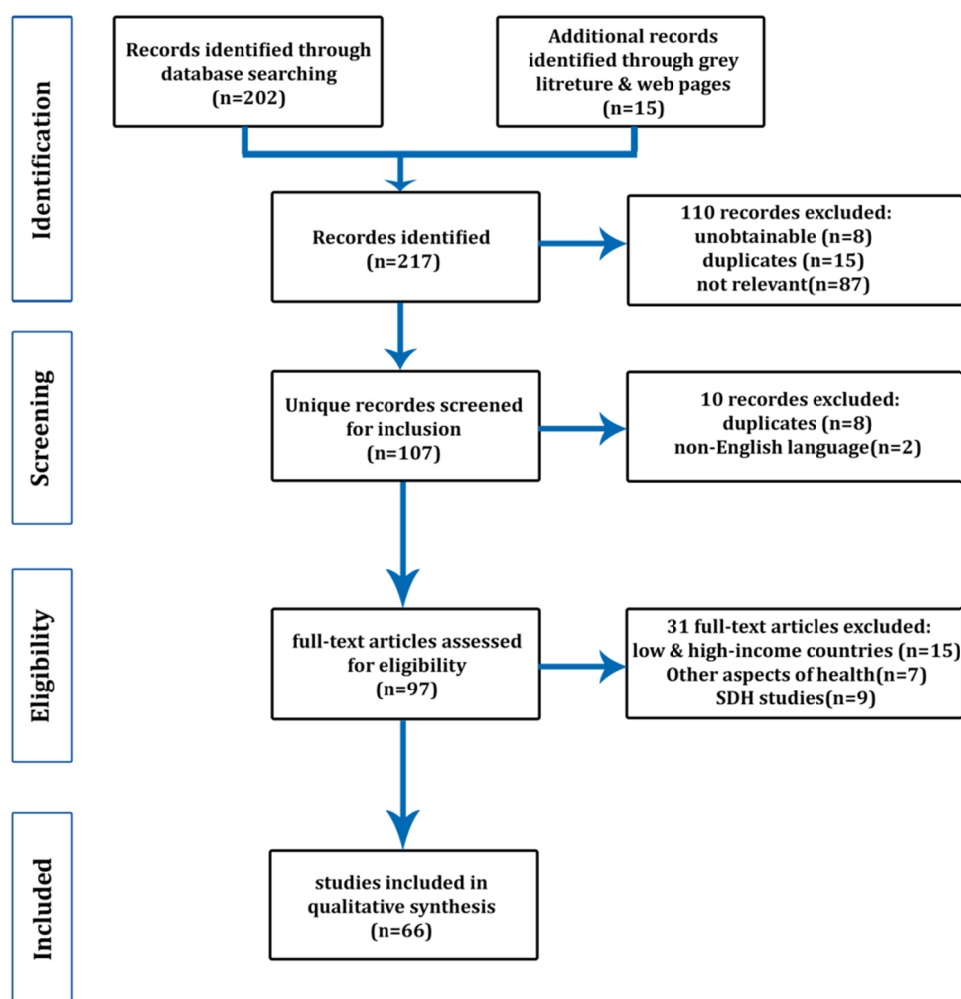


Fig. 1. PRISMA flowchart of the study selection process

by the first author several times and then by 2 other authors. We observed the ethical considerations during all stages of the research, especially the commitment to interpret the obtained information without any bias.

Theoretical Framework of the Study

There is a growing acceptance that health is determined not only by behavioral, biological, and genetic factors but also by a wide range of biological, economic, social, and environmental factors (16). Indeed, a significant part of the burden of disease and health inequalities is because of social factors (17). It is a well-established fact that many health problems are rooted in social factors, social relationships, and environmental conditions. Also, many diseases are not exclusively biological in origin, but their onset and course are often due to living conditions, social factors, behaviors, and social interactions (18). Therefore, the health of communities is affected by a complex network of social, political, economic, and environmental factors (19) and the definite role of these factors on health is well known (20). Furthermore, One study showed that 50% of health determinants are outside the scope of health system and are related to socioeconomic factors (21). Health is a multifaceted issue and communities need to use comprehensive programs that include all the factors that affect it and lead to broad social participation and intersectoral cooperation (22). Keys emphasize the inevitable role of social criteria in individual and social health and believes that a person's health, quality of life, and personal performance cannot be assessed without considering social criteria (23). Therefore, nowadays, the social approach to health is considered as an undeniable necessity with the aim of providing and promoting health and moving toward achieving the sustainable development goals in societies. The social approach to health means taking actions for empowering individuals, organizations, and communities to promote health-oriented behaviors and create a healthy environment, or a comprehensive systematic approach consistent with long-term impact on health. It aims to influence community norms through educating and organizing the community (24).

Such components as governance, social participation, intersectoral collaboration, citizen empowerment, health literacy, and social welfare have a fundamental role in the process of socialization of health, which were emphasized in different WHO Declarations (5, 25), especially in the Shanghai Declaration of 2016 (26).

Results

Two groups of researchers selected the articles separately and summarized them after reviewing the data. The perceptions of the 2 groups of researchers were quite similar.

Descriptive Analysis: From a total of 66 articles included in the study published from 2000 to 2020, the year of publication and the country are as shown in Table 2.

Thematic Analysis

Considering the general framework of the social approach to health and its main components, data were collected and classified based on semantic load and analyzed by deductive thematic analysis (27). The classification of these concepts underlying the social approach to health is summarized in Table 3.

The highest frequency of codes dedicated to health literacy and empowerment and their components (approximately 90%), followed by social participation and its components (approximately 80%) and governance and its components (about 60%), respectively, which were introduced as the main pillars of institutionalization of the social approach to health.

Our findings revealed that Ecuador, Bulgaria, Egypt, and Cuba had the highest scores among the selected countries in terms of social welfare, governance, social participation, empowerment, and literacy, respectively.

Based on the indicators proposed by the WHO in 2018, the score of the subbranches of the governance components was determined between at least -2.5 to a maximum of +2.5 (28) and between a minimum of 0 and a maximum of 1 for health and social welfare (29) (Table 4).

Table 5 shows the health socialization models in selected countries, separated for each component.

Table 2. Number of Articles, Year of Publication, and Country

Number of Articles	Year of Publication	Country
1	2001	Ecuador
1	2002	Cuba
1	2004	United States
1	2005	UK
3	2006	Sweden, Iran (n=2)
2	2007	Ecuador, Iran
1	2008	WHO
2	2009	Iran, UK
3	2010	WHO, Nigeria, United States
3	2011	Iran (n=2), Egypt, Cuba
4	2013	Nigeria, India, Iran, Bulgaria
6	2014	United States (n=2), India, Canada (n=2), Ecuador
2	2015	United States, UK
7	2016	WHO, Australia, Egypt, Lebanon, Iran, Malawi, Iran
11	2017	Ecuador (n=2), Turkey, India, Iran (n=2), WHO, Denmark, Cuba, United States (n=2)
9	2018	Ghana, United States (n=3), Brazil, Bulgaria, Australia, Iran, Ecuador
5	2019	Iran, UK, World Bank, Turkey, Ecuador,
3	2020	Iran (n=2), Denmark

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Table 3. The Results of the Thematic Analysis of Data in the Models of Social Approach to Health

Main Them	Themes	Subthemes
Health socialization	Governance	<ul style="list-style-type: none"> • Voice and responsiveness • Efficiency • Monitoring and control • Rule of Law • Control of violence and corruption
	Empowerment and health literacy	<ul style="list-style-type: none"> • Knowledge and insight • Attitude • Skills and abilities • Demanding
	Social participation	<ul style="list-style-type: none"> • Inform • Consult • Strengthen cooperation • Get involved
	Intersectoral collaboration	<ul style="list-style-type: none"> • Information sharing • Cooperation • Coordination • Integration
	Well-being	<ul style="list-style-type: none"> • Gender equality • Economic opportunities • Education • Health • Safety and security • Citizen participation • Information and communication technology.

Table 4. Scores Related to Health Socialization Components in Selected Countries (2018)

Health Socialization components	Bulgaria	Russia	India	Turkey	Iran	Egypt	Nigeria	Cuba	Ecuador
Social welfare CGWBI* score	0.562	0.549	0.526	0.563	0.546	0.464	0.519	-	0.587
Human development indicator	0.729	0.750	0.607	0.830	0.656	0.599	0.533	0.778	0.525
Governance	0.23	-0.63	-0.10	-0.47	-1.00	-0.59	-1.07	-0.46	-0.39
Social participation	%6.3	%21	%8	%24	Low	%27	%23	-	%11.4
Health literacy and empowerment	%98	%100	%74	%96	% 86	%71	%62	%100	% 93
Intersectoral collaboration	weak	weak	weak	weak	weak	weak	weak	weak	weak

* CGWBI, composite global well-being index (30).

Table 5. Health Socialization Models in Selected Countries

Country	Health Socialization Model	Policy Action
Ecuador	Governance	<ul style="list-style-type: none"> • Accountability • Control & monitoring Social capitals Civil society
	Empowerment	<ul style="list-style-type: none"> • Health literacy • Changing knowledge & attitude CCL Buen vivir policy
	Social participation	Free political parties
Cuba	Empowerment	Free educational campaign
	Social participation	Public mobilization to deal social problems & disasters
	Well-being	Free social services
Nigeria	Governance	<ul style="list-style-type: none"> • Efficiency CBO
	Empowerment	<ul style="list-style-type: none"> • Health literacy Collaboration with WHO for AIDS control Charitable organization
Egypt	Governance	<ul style="list-style-type: none"> • Rule of law • Efficiency Civil rights Macro-economic & structural reforms
	Empowerment	<ul style="list-style-type: none"> • Health literacy • Women & Children empowerment Launching CBO Gender equality
	Social participation	SMART project Involvement of civil society in policy making

Table 6 shows a summary of the social, economic, and political status of the countries studied and the trend of social developments and consequences related to health

socialization as a result of important policy measures in each country.

Table 5. Ctd

Country	Health Socialization Model	Policy Action
Russia	Governance	• Transparency • Accountability
	Empowerment	• Health literacy
	Social participation	
Bulgaria	Governance	• Efficiency
	Empowerment	• Health literacy
Turkey	Governance	• Efficiency
	Empowerment	• Health literacy
	Social participation	
India	Governance	• Responsiveness • Democracy
	Empowerment	• Health literacy
	Social participation	
Iran	Governance	• Rule of law
	Empowerment	• Health promotion
	Social participation	• NGO & Charitable organization

Table 6. The Status of Countries and the Social Consequences of Policy Measures (up to 2018)

Trend	Existing Conditions	Policy Measures	Social Consequences
Ecuador	<ul style="list-style-type: none"> The neoliberal economic model governing Ecuador during the 1990s to the 21st century and the consequences of rising poverty, unemployment, economic, social, and health problems. Constitution of the Republic of Ecuador, adopted in 2008. 	<ul style="list-style-type: none"> Implementing Buen Vivir policy (good living) as the basis of national development programs. Implementing a social circus program as a socio-cultural intervention for street-involved youth and other marginalized groups. Formation of civil society, a non-governmental organization such as CCI. 	<ul style="list-style-type: none"> Social welfare and promotion of economic and social indicators, citizenship and democracy rights, freedom of expression, creation of political parties, and social participation. Empowering and promoting public health literacy. Introducing "good living". Monitoring state actions and playing a role in the transparency and accountability of the government.
Cuba	<ul style="list-style-type: none"> Establishment of a one-party communist government after the 1959 Cuban revolution. Consolidation of an authoritarian state from top to bottom. 	<ul style="list-style-type: none"> Cuban National Health System Policy, which considers health as a fundamental component of social welfare and a strategic goal of development. The policy of setting up social services. The nature of the socialist revolution and approach. Focused from top-down in policy-making. 	<ul style="list-style-type: none"> One of the most efficient and effective health systems in the world with public and free access to the required health care fairly. Provision of social services, free education, and public and free safety network. Social mobilization and participation to deal with social problems and illiteracy.

Discussion

Currently, the WHO emphasizes the health socialization approach as an undeniable necessity to achieve sustainable health development. Health socialization aims to draw the attention of societies to the role and interaction of all factors in social life that might involve health. The concept highlights the need for comprehensive participation and collaboration of all organizations, social institutions, and individuals (31) in decision-making for health, health

promotion, and provision. Our findings revealed that different countries, according to their socioeconomic, cultural, and political characteristics, incorporated various models and approaches toward health socialization. These include as follows:

1. Health and Social Welfare

Ecuador had the highest score among the countries studied for the Social Welfare Index. It seems that Ecuador

Table 6. Ctd

Trend	Existing Conditions	Policy Measures	Social Consequences
Nigeria	<ul style="list-style-type: none"> • A diverse ethnic and cultural federation with 36 autonomous states with widespread social and economic challenges, extreme poverty, injustice, and extreme social and political unrest. 	<ul style="list-style-type: none"> • Participation of 12 community-based, non-governmental, and charitable organizations as a cost-effective strategy in TB and AIDS care. • Establishment of community-based organizations related to knowledge, attitudes, beliefs, and methods of HIV/AIDS care and prevention. 3) Multi-sectoral crisis recovery project in Nigeria. 	<ul style="list-style-type: none"> • Access to quality services in the prevention of tuberculosis, AIDS, and hepatitis by establishing home care groups. • Strengthening social participation, empowering, and promoting health literacy in dealing with risk factors. • Improving the provision of services and livelihood opportunities and strengthening social cohesion in responding to crises.
Egypt	<ul style="list-style-type: none"> • Authoritarian leadership and stagnant public spheres stifled civil society as a result of widespread repression with severe economic, social, health, and safety challenges, and income and gender inequality. • Egypt is undergoing a dramatic political and economic transformation that began on January 25, 2011. 	<ul style="list-style-type: none"> • Creating a democratic environment and setting up civil society organizations. • SMART community-based initiative program and launching CBOs to strengthen the social participation of citizens. • Implementing Al-Shahab in Ezbet El Hagana as an internal asset and part of the social structure for the implementation of the first wave of macroeconomic and structural reforms. 	<ul style="list-style-type: none"> • The activities of civil societies in social and health decision-making and omitting health inequalities. • Empowering and promoting health literacy, teaching economic activities, and generating income for women and children, and implementing a program to eliminate illiteracy in society. • Focusing on justice and civil rights, striving to improve living conditions and social cohesion, and creating the opportunity for more active participation of the private sectors.
Russia	<ul style="list-style-type: none"> • The Republic of Russia was created after the collapse of the Soviet monopoly and faced social challenges such as poverty, gender injustice, poor health systems, domestic violence against women and children, poor social participation, and low cooperation of the private sector. 	<ul style="list-style-type: none"> • Developing and implementing 12 national projects in line with the vision of 2024 in the field of public health, social support, and free education • Improving governance through greater transparency and accountability, public administration reform, social services, education, and health promotion • Adopting a participatory and gender-responsive budgeting approach by the government 	<ul style="list-style-type: none"> • Reducing poverty, improving education, improving health indicators, empowering, and increasing health literacy • Increasing the level of public trust in the government, activities of the private sector, and social participation. • Gender equality and social development, women's greater participation in economic and social activities, and the active role of women at all levels of government.
Bulgaria	<ul style="list-style-type: none"> • The Republic of Bulgaria is a member of the European Union with challenges such as lack of financial resources, injustice, poverty, population crisis, unemployment, the decline of social capital and human relations, poor health culture, and low quality of life. 	<ul style="list-style-type: none"> • Establishing a comprehensive system of social services and benefits to support vulnerable groups, reduce poverty and social deprivation by municipalities, and developing health policies for the fair access of society to health services. 	<ul style="list-style-type: none"> • Empowering and educating families to generate income and increase public awareness about health risk factors and the risks posed by new technologies. • Implementing a health liaison model to promote a healthy lifestyle and disease prevention, health education, increasing health literacy in families and schools and creating a culture of health from childhood.
Turkey	<ul style="list-style-type: none"> • Turkey was a Eurasian country with a fragmented health care system with three different types of insurance coverage and with challenges such as gender inequality, minimal social participation, and the least civil liberties of women. 	<ul style="list-style-type: none"> • Carrying out reforms and changes in health in 2003 and providing fair health services. • Implementing a targeted green card program for the poor and integrate it into the social security system in 2012 and covering the entire working population and a large part of self-employment in the country. • The community-based approach in mental health and integration with primary health services. 	<ul style="list-style-type: none"> • Implementing the Family medicine program since 2004 and providing primary health. • Implementation of universal health coverage, referral system, and fair access to health services. • Education and research and provision of human resources in the field of mental health with the active participation of stakeholders. • Eliminating the gender gap in higher education and some public and private jobs.

achieved this by implementing the Buen Vivir (Good Living) policy as the cornerstone of national development programs, emphasizing on social welfare and the promo-

tion of socioeconomic indices, civil rights, and democracy (32, 33). The Cuban national health system considers health as an essential component of social welfare (34),

Table 6. Ctd

Trend	Existing Conditions	Policy Measures	Social Consequences
India	<ul style="list-style-type: none"> The Republic of India, the second-most populous country and the third-largest economy in the world. Despite its strong democracy, it experiences challenges in social welfare, health, education, the human development index, economic opportunities, gender equality, poverty, and unemployment. 	<ul style="list-style-type: none"> The formation of strong democratic institutions and the implementation of large-scale elections with the active participation of civil societies. Implementation of a sustainable livelihood strategy with a focus on poverty alleviation. Changing in governance strategy, transparency and accountability in natural resource management, teaching health, providing social support, and developing infrastructure in rural areas and suburbs. 	<ul style="list-style-type: none"> Providing open political space and participation and extensive activities of civil society, 31 NGOs, and people in development programs, social welfare, and the political process in the country. Empowering women in poverty alleviation and social welfare programs, especially after joining self-help groups. Governance flexibility in public mobilization in strengthening safety and social health services. Increasing job opportunities and social support, especially in rural areas and suburbs.
Iran	<ul style="list-style-type: none"> The Islamic Republic of Iran is the second-largest economy in the Middle East and North Africa, in the post-revolutionary years with many serious problems, including the eight-year war with Iraq, unfair economic sanctions, cessation of foreign investment in the country, withdrawal of Assets and experienced human resources from country, and economic, social, welfare and health problems. 	<ul style="list-style-type: none"> Implementation of six laws of social, economic, and cultural development program focusing on the reconstruction of economic infrastructure and improvement of welfare and social health. Expansion of health care networks, especially in rural areas, with the presence of a successful Behvarz model. Carrying out reforms in medical education, including the implementation of the integration plan in medical education and the community-based and responsive medical education program. Developing policies to achieve universal health coverage. 	<ul style="list-style-type: none"> Iran is developing socio-economic conditions and preventive safety measures based on the UL safety index with a score of 65 on a scale of 0-100. The economic growth of 7-8% with the implementation of the law of the first to fourth programs of social and economic development. Continuous improvement and progress of Iran's health indicators and approaching developed countries. Advances in the health care system, including self-sufficiency in labour training, advances in public health and medical sciences, including the production of drugs and medical equipment, and significant expansion of health insurance coverage.

which has been achieved through decentralization and fully systematic participation and collaboration of municipalities (35). It is one of the most efficient health systems in the world (36). The Turkish model in the implementation of the family medicine project, the green card program for the poor and its integration into the social security system in 2012 (37), and the health transformation plan to reach universal health coverage in 2004 can be mentioned (38). We can also point to the implementation of a sustainable livelihood strategy with a focus on poverty alleviation as the pattern of development and social welfare in India (39).

2. Governance

Governance mechanisms have positive effects on the health of societies, and the presence of factors such as empowerment, accountability, and trust are among the initiatives related to governance (40). Expanding health care networks and implementing reforms in medical education are among the government's effective programs (41) to promote health and social welfare in Iran. In Ecuador, the civil society also played a very important role towards greater accountability and transparency in the government and created more opportunities for participation in shaping public policy and oversight of state action (42). Additionally, maintaining its strong democratic institutions, India has a successful governance owing to the extensive electoral processes at the national and state levels (43) and flexibility in implementing governance strate-

gies to eradicate polio, despite cultural and social differences (44).

3. Social Participation

Social participation has been recognized as an underlying principle in the provision of PHC (45). Promoting social identity (46), it is potentially a beneficial strategy to reduce inequalities (47) and to improve the quality of life (48), mental health (49), social welfare (50), and other positive health outcomes (51). Our findings indicated that Egypt implemented SMART community-based initiatives for a healthy life, launched CBOs, and implemented the Al-Shahab project to improve social participation and women empowerment (52). In Iran, social participation is not embedded in the majority of the policy-makings due to the centralized and hierarchical structure of the health system (53), low social capital, and insufficient transparency, and accountability of the government (54). Acceptable levels of social participation has been linked to the high social capital (55). Lack of trust and interaction between citizens and government agencies was associated with low social interaction and social participation in Tehran (56). Some researchers considered unemployment (57) and poverty (58), as factors contributing to the lack of social participation. Accordingly, low social participation in Iran can be attributed to the relatively high unemployment rate (59).

4. Multilateral and Intersectoral Collaboration

The WHO describes the intersectoral collaboration in low- and middle-income countries as weak to moderate. The goals of PHC might be compromised as a result of poor intersectoral collaboration (3). Essentially, elimination of health inequalities requires the active participation of different sections of the society (60). In Ecuador, Causes for Change International is a nongovernmental organization collaborating in improving self-care and educating women and vulnerable and disabled people through community-based rehabilitation (61). Another example is the intersectional convergence in maternal and child nutrition interventions in Odisha, India (62). In Iran, the Supreme Council of Health and Food Security is politically and technically responsible for intersectoral measures related to health (63). The results of a study in Iran revealed that there is a need for planning and implementing governing policies for intersectoral measures related to health in addition to monitoring the performance of organizations (63).

5. Empowerment and Health Literacy

Ecuador implemented the circus art as a sociocultural intervention for street-involved youth and other marginalized groups, through which people became aware of "good living" (33). In Nigeria, 12 community-based, nongovernmental and charitable organizations empowered the society through promoting knowledge, attitudes, beliefs, and methods of care and prevention against tuberculosis, acquired immunodeficiency syndrome, and hepatitis (64).

Another example is the implementation of SMART community-based initiatives and the launch of community-based organizations to teach healthy lifestyle in families, make-money for women and children, and hold classes to eliminate illiteracy in Egypt (65).

In Bulgaria, the government selected and educated motivated youth, as health liaisons, to teach healthy lifestyles, highlight disease prevention, and increase health literacy at various levels (66).

Iran has introduced its tailored model of socialization of health, public participation in maintaining and promoting individual, social, and psychological health through community-based medical education. The initiative aims to both educate skilled and qualified human resources as well as empower them to achieve community health literacy promotion. Meanwhile, the integration of medical education and research into health care services has played an important role in the provision of health services by forming universities of medical sciences and health care services. As a result of the unique structure of the health system in Iran, where medical universities are under the Ministry of Health & Medical Education, socialization of the health system would go through the socialization of the universities (4).

Limitations

The data on the social and cultural context of countries are very limited and insufficient. In addition, selection of the low- and middle-income countries with successful experience in implementing health socialization approach

was difficult, as most successful countries are among high-income settings.

Conclusion

Countries may adopt different methods to implement socialization of health, depending on their socioeconomic, cultural, and political contexts. Despite its community-based medical education model, extensive health care network system, and reasonably acceptable health indices, Iran has a long way to reach optimal health socialization on the way of achieving sustainable development goals. The role of active civil societies, the establishment of free political parties and strong democratic institutions, and enhancing social capital can lead to greater accountability and transparency of the government and provide more opportunities for building trust between the people and the state towards improving social participation in Iran. Health is a political choice. While the burden of noncommunicable diseases is at the highest and the COVID-19 pandemic is hindering all human achievements, it is crucial, now more than ever, to strengthen public participation in rebuilding the societies with greater accountability and more meaningful responsiveness, in Iran and anywhere else.

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Conflict of Interests

The authors declare that they have no competing interests.

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