



Unit 1

Social Determinants of Health: Values, Approaches and Perspectives

Specific objectives:

Let us start this Introductory Module with the first unit.
Throughout this unit we will help you:

- Become familiar with the rationale of the social determinants of health (SDH) and their potential for designing public policies, taking WHO and PAHO work proposals into consideration.
- Identify the principles of social justice, health equity, human rights and their relationship as key values for SDH interventions.
- Identify structural and intermediary mechanisms underlying health inequities in population groups and territories, as a basis for public policy actions.
- Recognize the need for a comprehensive, intersectoral and participatory approach towards understanding and taking actions on SDH

Topics to be dealt with in this Unit:

- Introduction to the Social Determinants of Health approach.
- Equity, social justice, and human rights in health. Relationship between them.
- Approaches for disclosing health inequities across population groups and territories.
- Mechanisms that cause the persistence of inequity, to deal with social determinants of health.
- An integrated, intersectoral and participatory approach to SDH

Introduction to the Social Determinants of Health.

3.1. Introduction to the “Social Determinants of Health” debate

This topic, though not new, raises debates and controversies.

Some people criticize the term “social determinant” stating that it assumes the existence of a dominant social logic that conditions social actors, who then lose their capacity for collective transformation and weaken their quest for identity.

Others hold the view that “social determination” of the health-disease process is a strongly explanatory expression, entailing strategic elements for compelling social change.

Still others prefer to use the expression “determinants of health” without adding the word “social,” which would restrict determination by excluding any political, environmental, economic, cultural, psychological, spiritual or other determinants. Instead, for others, the word “social” is an umbrella term encompassing all such attributes.

Controversies also arise between the expressions “determinants of health” and “determinants of inequities in health.” For some people, the former refers to the risk factors in classical epidemiology. In distinguishing both expressions, they see in the latter a stronger potential for transformation that would lead to a better understanding of unfair hierarchies in social structures, thus revealing the “true cause” of health inequity.

This discussion is not yet closed. But as you undergo this learning process it is important that you understand how rich and polysemous the concept of “social determinants of health” is and that you wonder whether it would be necessary to find a common language to ensure concerted political actions.

As long as no consensus is reached for a “lingua franca” the concept of “social determinants of health” should be considered in all its bearings. Understanding the health-disease process from this angle will give us a broader and more politicized view and will help us understand the need for more coordinated and integrated public policies designed on consensus by governments, social movements and NGOs aimed at improving life quality



Why is it necessary to focus on the Social Determinants of Health?

The social conditions in which people live have a dramatic impact on their health. In fact, circumstances such as poverty, poor schooling, food insecurity, exclusion, social discrimination, bad housing conditions, deficient sanitation in early childhood and poor occupational skills in adulthood are all major determining factors of inequality both among and within countries in terms of health, disease and mortality rates.

To improve the health conditions of the world population and increase equity in health, new action strategies that address the social factors affecting health are required. This does not mean that equitable health care systems are no longer important. But we must recognize that more often than not health care systems are part of the problem, and therefore, these systems plus new strategies are indispensable to lower or eradicate health inequities.



- The statements above lead us to find answers to three fundamental problems:
- Where do health differences among social groups originate, if we trace them back to their deepest roots?
 - What pathways lead from root causes to the stark differences in health status observed at the population level?
 - In the light of the answers to the first two questions, where and how should we intervene to reduce health inequities?

Social circumstances social stratification and position determine not only social inequities (at the population level) but also health inequities, through intermediary determinants. The institutional, socioeconomic and macroeconomic contexts, the social values adopted by a given society, and inequitable public policies are all key factors in causing social inequities. Individuals and social groups in the lowest social strata run twice the risk of serious illness and premature death. Material and psychological causes contribute to these risks, their effects extending to all causes of disease and death and to all social groups. Social disadvantages may be absolute or relative, and they tend to affect the same social groups, resulting in a lifelong, accumulated impact on health.

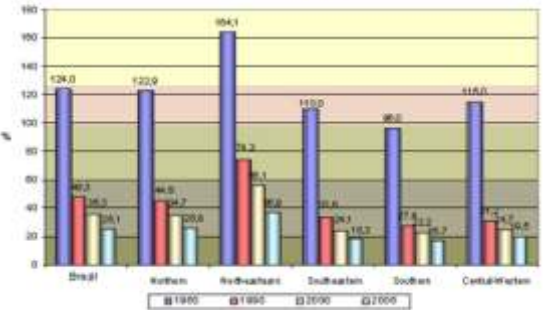


Not only do inequalities appear across countries, but radical differences are found within any given country. Health differences occur along the social ladder and involve socioeconomic, political, cultural and geographical dimensions. One way of measuring inequity is to pay attention to the distance between those at the top and those at the bottom of the social ladder. Nevertheless, all along the social gradient there are unfair inequalities that may well be avoided..

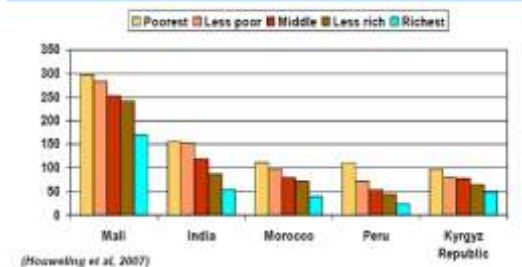


The influence of social determinants becomes evident not only when comparing the distance between those at the top and those at the bottom of the social ladder, but also when health indicators are checked against other variables along the social scale. In Bangladesh and Thailand, low-income young women having completed their secondary education have better health indicators than other girls with only primary education or no schooling at all. No analysis should focus only on the situation of those living in poverty; the poorest among the poor (see the Final Report of the Women and Gender Equity Knowledge Networks available in Links, Full texts). When we analyze the social distribution of health along the entire social ladder, it is clear that we are all involved.

Evolution of infant mortality Brazil and Regions – 1960-2006
Source: IBCE



Under 5 mortality (per 1000 live births) by wealth group



Food-for-Thought Activity

Some questions to trigger reflection:

- What is the incidence of poverty on health in your region's or country's population? To what extent has such incidence changed over time? What population groups are the most vulnerable? To what factors are they more vulnerable?
- Considering all the social gradient and not only the gaps between those at the top and those at the bottom of the distribution scale, what factors influence on the different social groups?
- Do you see any differences within your own country or district, when considering different geographical areas, labor conditions, age, gender or ethnicity groups, schooling level, etc.?
- How do these gaps impact on the way to address public health policies?

Defining core values: Equity, Social Justice, and Health as a Human Right

The framework of core values below is based on the paper written by Solar and Irwin (2007,¹) which can be downloaded from Links, [Full texts](#). Its major concepts are outlined here to help you reflect upon SDH.

¹A first draft of this paper was prepared for the May 2005 Cairo meeting of the Commission on Social Determinants of Health by the Commission secretariat, based in the Department of Equity, Poverty and Social Determinants of Health, Evidence and Information for Policy Cluster, WHO Geneva. The principal writers were Orielle Solar and Alec Irwin. Valuable input to the original draft was provided by other members of the Commission secretariat, in particular Jeanette Vega. In the course of discussions in Cairo, Commissioners and the Chair contributed substantive insights. Commissioners recommended the preparation of a revised draft paper, which was completed in January 2007. It is planned that the current version of the paper will be submitted to CSDH Commissioners at their June 2007 meeting in Vancouver. In addition to the Chair and Commissioners of the CSDH, many colleagues have offered valuable comments and suggestions in the course of the revision process.



Equity in Health is an ethic founding concept of the SDH approach. The WHO Department of Ethics, Poverty, Trade and Human Rights defines health equity as 'the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically.' In essence, health inequities are health differences which are: *socially produced*, systematic in their distribution across the population, and *unfair*. Identifying a health difference as inequitable is not an objective or material description, but necessarily implies an appeal to *ethical norms*.

Primary responsibility for protecting and enhancing health equity rests in the first instance with national governments, as explained by renowned figures of contemporary political thought. According to Amartya Sen (2002), "health equity cannot only be concerned with inequality of either health or health care, and must take into account how resource allocation and social arrangements link health with other features of states of affairs." Anand (2004) points out that health is a special good, whose equitable distribution merits the particular concern of political authorities. There are two principal reasons for this: health is directly constitutive of a person's well-being and health enables a person to function as a social agent.

Basically, inequities in health compromise *freedom*, *social justice* and *human rights*, and when there is inequity; governance has failed in one of its prime responsibilities. But the causal linkages between health and social agency are not unidirectional: equity in health is the result of public policies and it is also a pre-requisite for social groups to participate in the strengthening of their own rights and the control over their work and lives.

The international human rights framework, based on the 1948 Universal Declaration of Human Rights, is the appropriate conceptual structure within which to advance towards health equity. It holds that the right to health must be interpreted broadly, including (but not limited to) medical care, food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment. It also comprises the responsibility for the social determinants with a view to fulfilling the citizens' right to the highest attainable standard of health.

Human rights offer a conceptual armature connecting health, social conditions and the principles of civilian participation in political rights. As Braveman and Gruskin (2003) argue, the human rights perspective removes actions to relieve poverty from the realm of charity to the domain of law. Over recent years, the work of the UN Special Rapporteur on the Right to Health has been instrumental in advancing the political agenda around the right to health at national and global levels.

Life expectancy of Indigenous Peoples

Country	Indigenous (male)	Total (male)	Gap (years)
Australia (1996–2001)	59.4	76.6	17.2
Canada (2000)	68.9	76.3	7.4
New Zealand (2000–2002)	69.0	76.3	7.3

(Bramley et al, 2005)

Food-for-Thought Activity

Based on these analyses, we invite you to reflect upon the following:

Why are Equity and Social Justice in Health ethical guidelines to account for and guide the development of public policies?

Why does the Human Rights framework provide a foundation for addressing the social determinants of health?

To what extent have globalization and State reforms contributed to linking Equity and Social Justice in Health outcomes among the population in your country?

What is the relevance of empowering the least advantaged social groups for the exercise of their rights in the control of the factors that affect their health?



Reviewing approaches and building a comprehensive reference framework for an improved analysis and action on the Social Determinants of Health

When different analyses on SDH are reviewed, three main approaches may be identified, including complementary contributions (Solar & Irwin, 2007)²:

- The psychosocial approach;
- The social production of health /disease approach;
- The multilevel ecosocial approach.

These three approaches attempt at accounting for health inequities. Even though all of them are based on the analysis of the social distribution of disease, their interpretations are not restricted to the biological aspects, but integrate them with social explanations, with varying emphasis on the population health perspective.

The psychosocial approach focuses on the weight assigned to the individual's perception of his/her own status within unequal societies, which leads to stress and worse health conditions. According to these theorists, the experience of living in social settings of inequality forces people constantly to compare their status, possessions and other life circumstances with those of others, engendering feelings of shame and worthlessness in the disadvantaged, along with chronic stress that undermines health. At the level of society as a whole, steep hierarchies in income and social status weaken social cohesion. This research has inspired a substantial literature on the relationship between perceptions of social inequality, psychobiological mechanisms, and health status

The social production of health /disease approach explicitly addresses economic and political determinants of health. Its advocates do not deny negative psychosocial consequences of income inequality, but stress the need to begin with the structural causes of inequalities. Under this interpretation, the effect of income inequality on health reflects both lack of resources held by individuals and groups, and systematic under-investments in infrastructure (education, health services, environmental controls, availability of food, quality of housing, occupational health regulations, transportation, etc.). Political decisions and economic processes shape a cluster of material conditions that have an impact on the health of the population.

More recently, the multilevel ecosocial approach has sought to interpret inequities in health as the cause and the result of a dynamic, historical and ecological relationship. This approach seeks to develop analysis of the population patterns of health, disease and well-being as biological expressions of social relations, and grasp how social relations influence our most basic understandings of biology and our societal constructions of disease. More than simply adding biology to social analysis, this approach seeks to envision a more integrated and complex view of the changing population patterns of health.

²Solar, Orielle & Irwin, Alec. Discussion paper for de Commission of Social Determinants of Health, Ginebra, Abril de 2007.



But, what is the contribution of these approaches?

These approaches provide a deeper insight into the **mechanisms** through which social determinants influence health, by recognizing a series of complementary, non-mutually-excluding explanations:

- *Social selection*: This perspective implies that health determines a person's socioeconomic position and not the other way around. Health exerts a strong effect on the attainment of social position, through social mobility, through which the healthier are in better conditions to move up the social ladder than the ill or disabled.
- *Social position*: By complementing the mechanism above, in this perspective social position determines health through intermediary factors. Health problems are more likely to develop in the lower socioeconomic groups, in an indirect manner. Socioeconomic health differences occur when the quality of these intermediary factors is unevenly distributed between the different socioeconomic classes.
- *Life course perspective*: Within an individual life course, across generations and at the population level, this perspective helps identify critical periods in the life of an individual, paying attention to the timing of exposure to risk as well as to the accumulation of risks over time. It particularly facilitates the understanding of the concept of “timely” intervention in the lifelong process (early childhood, childhood, adolescence, adulthood).

Food-for-Thought Activity

After reviewing these factors and mechanisms, we invite you to analyze the following:

- What are the national characteristics of your country that influence the type and magnitude of inequalities and inequities in health?
- What are the contributions made by the different SDH approaches for their interpretation?
- What are the differential exposures and vulnerability (that damage health) and their consequences (of bad health)?
- What differential health outcomes can be observed in the population and to what extent are they observable?
- To what extent is public spending oriented to closing the gaps in terms of rights and opportunities?
- To what extent are intersectoral policies developed to fight the deepest roots of the social determinants of health?

How to look for a more comprehensive perspective on SDH

An integrated and strategic framework for SDH actions adopts *social position* as the key concept whereby health inequity mechanisms are interpreted as the causes of power, wealth and risk distribution, stratifying health outcomes. From this integrated perspective, the following determinants can be identified:

- *Structural determinants* defined by social stratification and its sustenance mechanisms.
- *Intermediary determinants*, related to specific social factors and circumstances.

Social stratification engenders differential exposure to health-damaging conditions and differential vulnerability, in terms of health conditions and material resource availability, producing differential consequences of ill health for more and less vulnerable groups, including socioeconomic consequences, as well as differential health outcomes *per se*.



The degree of social cohesion cuts across and concerns both structural and intermediary factors. The magnitude of the problem affects the socioeconomic and political context, having an impact on mortality and morbidity rates, while affecting economic and social growth.

An integrated and strategic approach to SDH involves considering:

- **Social stratification** as a key factor for the understanding of SDH. This stratification gives rise to inequalities in power, prestige, income and wealth linked to different socioeconomic positions.
 - That the **mechanisms** that play a role in stratifying health outcomes operate in the following manner:
 - **Social contexts**, which assign individual and groups to different social positions, creating and maintaining hierarchies. Such contexts include the labor market, the educational system, political institutions, and social and cultural values.
 - **Differential exposure** to health-damaging conditions and **differential vulnerability**, in terms of health conditions and material resource availability according to the population group involved.
 - **Differential consequences** of ill health for more and less advantaged groups.
- Based on these determinants and structural mechanisms, **intermediary** determinants develop and operate contributing to the creation of specific situations that shape health outcomes:
- **Material** circumstances, such as housing quality, access to food and physical environment.
 - **Psycho-social** circumstances, involving social stressors (e.g. strain, violence, coercion), gender and ethnic conflicts and changes in or imitation of behavioral patterns and lifestyles vis-à-vis other groups or cultural contexts.
 - **Biological and behavioral** factors, such as nutritional patterns, physical activity, alcohol consumption, and smoking, and genetic factors.

Not to be forgotten, no matter how complex it might be!

In order to build an *integrated and strategic approach* it is important, first of all, to consider that any serious effort to reduce health inequities will involve changing the *distribution of power* within society to the benefit of disadvantaged groups, and changes can take place at various levels. Action on the SDH is a *political process* that engages both the agency of disadvantaged communities and the responsibility of the State, based on collective action. Theorizing the impact of social power on health suggests that the empowerment of vulnerable and disadvantaged social groups will be vital to reducing health inequities.

Implications for policy-making and policy actions:

- The analysis of these factors leads us to the need of:
- Overcoming depoliticized approaches regarding the **role of the State** in promoting equity.
 - Generate **intersectoral actions** to fight the deepest roots of differential vulnerability and exposure to risks



A relevant social determinant of health that cannot be ignored!

Health systems have often not received adequate attention as a SDH.

Much research on health policies has focused its attention on ways to address health problems, mainly on remedial actions and instruments for improving health service efficiency. On the other hand, considerable public health research works mainly draws attention to actions aimed at preventing disease among high-risk groups, prioritizing individual actions concerning lifestyles. Furthermore, within SDH literature, several SDH analytical models have focused on the role played by the organization of health systems in improving health equity. The Final Report of the Health Systems Knowledge Networks* deals specifically with this issue and states that health systems are the result of social and political processes. Consequently, health systems are socially determined and are, in fact, a social determinant of health. The organization and values of any health system may affect people, their exposure and vulnerability. If properly designed, health systems may address the problem of differential exposure and vulnerability among population groups, by improving equity of access, promoting intersectoral actions, encouraging communities to participate in decision-making processes or adopting innovative health-related public policies, among other actions.

Primary health care (PHC) and a focus on the SDH have much in common. Both concepts prioritize the importance of health equity and social justice. PHC is an approach to organizing health systems and broader society with the aim of achieving health equity (as reflected in the “Health for All” target of the Alma-Ata Declaration). SDH provide an analysis of why health inequities exist which encompasses the whole of society. Reducing health inequities provides the most compelling argument for both PHC and for action on SDH. PHC and SDH also share a broad view of health as a human right that traces its roots to the 1948 WHO Constitution. Both concepts place a strong emphasis on health promotion and prevention, and on increasing the ability of people to access the resources required to stay healthy and protect themselves from disease and illness.

PHC and SDH also both focus on the role of communities in ensuring health. PHC emphasizes the importance of health services responding to community need and facilitating community participation -in both service provision and health policy-making. The SDH analysis considers the impact on health of community factors such as social inclusion and exclusion, relative social status and community resiliency and support. Action on the SDH also requires empowerment of marginalized communities and governance structures that genuinely allow a voice for all.

As a result, implementing both PHC and action on SDH requires a strong focus on intersectoral action for health - policies and initiatives beyond the health sector that are required to protect and promote health. Intersectoral action was a key principle of the Alma Ata Declaration, and has been reconfigured more recently as “health in all policies” in the European region. PHC thus recognizes that the health sector is not the only contributor to improving health. The SDH discourse clearly shows how most health inequities are not caused by a lack of access to health services, but by the influence of inequities in other sectors such as housing, occupation, education or income. Action on the SDH thus involves the whole of society, with the health sector being only a single, but important focus, among many other sectors where action is required if health inequities are to be reduced.

In conclusion, PHC needs to be informed by an analysis of SDH and guide action on SDH to achieve its aims of health equity. This requires public policies across all sectors that act on SDH with the specific aim of promoting and protecting health. Furthermore, under a PHC approach, health systems need to be informed and champion action on SDH across the whole of society, while also promoting social participation in policy-making to protect health.



To learn more

You are encouraged to read the following reference material:

□ Whitehead, M., “The concepts and principles of equity in health”, *Int J. Health Serv* 1992; 22, 429-445. disponible en <http://www.euro.who.int/document/PAE/conceptsrpd414.pdf>

WHO and PHAC. Improving health equity through intersectoral action. World Health Organization and Public Health Agency of Canada Collaborative Project, 2008 <http://www.phac-aspc.gc.ca/publicat/2008/hetia18-esgai18/pdf/hetia18-esgai18-eng.pdf>

Databank of social inequality cases

“Inequalities” or “Social inequity in Health” and “Social Equity in Health”

Social inequalities (inequities) in health refer to health disparities within and between countries. Inequities that are judged to be unfair, unjust, avoidable, and unnecessary (meaning: are neither inevitable nor irremediable and that systematically burden populations rendered vulnerable by underlying social structures and political, economic and legal institutions. As such, social inequalities (or inequities) in health are not synonymous with “health inequalities,” as this latter term can be interpreted to refer to any difference and not specifically to unjust disparities. For example, recently proposed measures of “health inequalities” deliberately quantify distributions of health in populations without reference to either social groups and/or social inequalities in health.⁴

Reviewing some cases, whose characteristics may reappear in other contexts

Read the following cases, preferably in the order suggested and write down your ideas in your SDH Reflection Notebook, in answer to the following questions:

- Are these situations similar or different in your country, region or location?
- What can you tell us about your country, region or location as to what is done to fight social inequities?

⁴-Krieger, N (2002) Glosario de Epidemiología Social, *Rev Panam Salud Publica* vol.11 no.5-6 Washington May/June http://www.paho.org/english/sha/be_v23n1-glossary.htm - Part 1 http://www.paho.org/english/sha/be_v23n2-glossary.htm - Part 2 Accessed in September 2008.



Maternal Mortality Inequities in Urban Areas

It is well known that socioeconomically disadvantaged groups, even in developed countries, have a shorter life expectancy and are more prone to suffer from diseases than the rich. In the city of Sao Paulo (Brazil), maternal mortality rates were close to 40/100,000 in 2003. In the urban suburbs of the same city, the maternal mortality ratio reached 65/100,000, and was even worse among black women(200/100,000).⁵

Life Expectancy Inequities in Different Countries

At the global level, differences as to the extent to which people can lead healthy lives are simply radical. Health levels are crucial in measuring such differences. A woman in Botswana has a life expectancy of 34 years, while a woman living in Japan is expected to live 86 years. The rest of the world falls somewhere in between, with differences within each country according to socioeconomic strata.

Inequities in the Evolution of Health Gains

Let us take three children: a sub-Saharan African, a south-Asian and a European. In 1970, the life expectancy of the first two was less than 50 years. The European child, depending on his/her country average, had the same life expectancy in 1901. In the last century, life expectancy for the European child increased by about 30 years, whereas between 1970 and 2000 life expectancy for the south Asian child improved by 13 years, and only 4 months for the sub-Saharan African child.⁶

Inequities in Education-related Health Outcomes

In El Salvador, for example, if a mother has no schooling, her babies are 10% more likely to die in their first year of life (100 every 1000 cases). Instead, if a mother has completed her secondary education, infant death rate is reduced to one fourth

Poverty, Migration, Gender, Labor and Social Protection Conditions, Culture

Maria Alvarez, an 18 year-old woman living in a rural town, moved to the capital city in search of better opportunities for herself and her three-year old daughter. Maria can only read and write. She dropped out of school to work out in the fields and raise her daughter after her partner left her. The rural establishment where she worked closed when a competitive free trade zone was created in the area, and Maria decided to migrate to the city, since she could not get another job in the free trade area due to her poor schooling. Upon arriving in the city, some relatives of hers who lived in a suburban slum got her a job as a maid, and she was offered a basic salary and no social security benefits.

⁵ -Secretaría Municipal de Salud de Sao Paulo, Brasil. Datos de 2004.

⁶ -Duarte et alli Gravidez na adolescência e exclusão social: análise de disparidades intra-urbanas. Rev Panam Salud Publica. 2006; 19(4): 236-243



One month later, her little daughter contracted hepatitis and Maria had to take her to the emergency ward of a public hospital. In addition to hepatitis, she was diagnosed malnutrition. Although this was a public hospital offering free medical services, she was informed that she would have to pay for the laboratory tests and some medicines that were not included in the “basic coverage” list. Maria’s bosses told her she could not continue working for them for fear of contagion and the risk posed to all family members, particularly their son. With the money earned in that month, she could only afford the costs of one-week hospitalization costs. Ten days after being admitted to the hospital, her little daughter died of fulminant hepatitis complicated by a malnutrition history. Maria currently works as a waitress and sometimes as a prostitute.”

Differential Quality of Health Care Services

Maria, a 42-year old woman from the city of Masaya, went to the nearest health care service looking for medical assistance for her 6-month son. Her son's symptoms included vomiting, 39.7°C fever and diarrhea lasting for 24 hours. Maria arrived with her baby at 7.30 a.m., asking for assistance. She was given number 68 for the general medicine ward. After a half-hour wait, the child's temperature was taken, and mother and child were guided to the URO unit, where a file was prepared, taking 15 minutes more. The boy continued with vomiting and diarrhea and his fever was getting worse. At that moment, the boy had a convulsion and was taken to the nearest hospital. Eventually, they arrived at the hospital's emergency ward, and a new administrative process was initiated for admission purposes, but the child died while he was being prepared for intravenous therapy.

Ethnicity, Origin, Access to Health Care, Gender, Culture, Poverty, Vulnerability

Amerindians were the first human beings in southern Central America. It is said that indigenous peoples who kept their ancestors' habits had good health and high life expectancy rates. At present, changes resulting from globalization have triggered a demographic, epidemiological and cultural transition with negative impact on health conditions. Today, Amerindians are an ethnic minority and the worst marginalized community despite their long tradition of resistance to domination. Their civilian rights are still very limited in the fields of education, effective political participation and access to health services. They are mainly engaged in agricultural activities. Women's access to health services depends on geographical location and language barriers. Some peoples still speak their own language (Bribri and Cabecar). Unlike men, many women are not bilingual. Medical care during pregnancy, labor and delivery in the case of indigenous women living in Bratsi, in the south-east of Costa Rica near the border with Panamá, is highly deficient. This is a place inhabited by many Amerindian ethnic groups speaking Chibcha. The canton of Talamanca has the lowest human development index (HDI) in the country.



According to their geographical location, districts are classified into: those located before crossing rivers (no bridges are available), those located on the other side of the rivers (the Talamanca valley) and those located on top of the mountains. The last two groups have scattered populations, where huts may be more than one kilometer apart.

Infant death risk at Salamanca doubles the national risk, while child malnutrition in the third year of life (24-35 months) is attributed to poverty and insufficient coverage of nutrition needs by local programs.

Wrap-up Activity

Re-read your notes and analyze the following questions::

What do you see in your location as far as health inequities are concerned? What social groups are the most affected?

How does the government respond to this situation? To what extent and in what context does the community participate to improve its living conditions?

Identify the strengths and weaknesses of the health sector to address social problems having an impact on the population health

We wish you good luck! Let us pass on to Unit 2.!