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Investigation of Health Socialization Status in Iran: A Qualitative Study in 2020

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ABSTRACT

Introduction: There are significant differences in the health status of different social groups, despite governments' commitment to improving health indicators, which can be avoided by intervening appropriately. In this regard, it can be mentioned that the formation of the social deputy in the Ministry of Health of Iran in 2016, which was dissolved in 1998, and the socialization of health were ignored. Due to the ambiguity in the new process of socialization of health, this study aimed to investigate the status of health socialization in the current structure of the country.

Methods: The present study as a qualitative study carried out through documentation analysis and two in-depth semi-structured interviews with social deputies of two medical universities of Iran. Data were analyzed using the contractual content analysis method**.** Two in-depth semi-structured interviews were conducted with the social deputies of the universities of Tehran and Ilam, who were selected using convenience sampling to complete the findings.

Results: According to the results of content analysis and 23 extracted codes, the socialization of health in Iran is debatable in two main areas, namely strategies and pillars of socializing health which consisted of three and five sub-themes, respectively. At present, the structure and pillars of socializing health and coordination among these pillars are vague and uncertain due to the distribution of responsibilities of the social deputy in other departments of the Ministry of Health and universities.

Conclusion: For achieving equity in the socialization of health goals, it is better to clarify the socialization of health stewardship, strategies, and policies in the whole country concerning social issues and dimensions of the health system.

Keywords: Health, Socialization of health, social determinants of health

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Introduction

The World Health Organization (WHO) stated that "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." (1). For the first time, in addition to the health of the body and soul, this definition considers social welfare as an integral part of health and emphasizes the direct impact of health on one's social conditions and life and employment (2). Hence, the enjoyment of the highest attainable level of health is a fundamental right of every human being regardless of race, religion, and economic status. Governments have a responsibility for their people's health and establishing justice in health, which is one of the examples of social justice. Socio-political-economic conditions in society must be provided in such a way that its citizens benefit from a desirable level of social resources such as educational opportunities, a healthy environment, proper nutrition, health care, and employment, which require proper and correct distribution of these resources because the quantity and quality of available resources play a determinant role in the health and well-being of citizens (3).

Nowadays, The issue of health injustice has become a global challenge in and between countries.

Over the past two decades due to the large gap that exists between developing and rich countries or different regions of a country in terms of premature mortality and child mortality (4), the health injustice within and between countries has become a global challenge in the last two decades (5). Its examples can be observed in the goals of millennium development and sustainable development (6). These factors have led to forming a concept called socialization of health, and effective social factors on health that have been increasingly considered by health systems (7).

WHO defined Social Determinants Of Health (SDH) as "the conditions in which people are born, grow and live," and these conditions are shaped by political, social, and economic forces (4). Any changes in one of them make a change in other forces. Thus, intersectoral coordination and social participation are critical to achieving the highest desirable level of health in the community, which in turn will increase labor productivity and economic prosperity (8). Thus, the socialization of health means a set of activities with an emphasis on community participation that strengthens intersectoral and intrasectoral coordination which is achieved by focusing on the determinants of social health, responsibility, and accountability of medical education and health and research systems which are all appropriate and necessary for the country (9). The WHO has divided these components into three levels in its conceptual framework for (SDH) that influence health justice in interacting with each other. These levels include 1. Structural components (economic structure, tax system, environmental and social support, macro-policies, political system, norms, and social values) 2. Social status and classification variables of individuals in society (social class, gender, race, ethnicity, level of education, job status, income) 3. Intermediate determinants (biological and behavioral factors and health systems) (6). The social determinants of health show the effect of injustice on health by using a strong logic based on statistics and epidemiology and emphasize that policymaking plays an important role in reducing inequality in health (10). Many countries, including Latin American countries, such as Brazil and Cuba, have had valuable experiences in social health determinants and have benefited from participatory decision-making mechanisms and interdisciplinary coordination to promote community health (6). For several years, attention to the social dimensions of health has been on the agenda of Iranian policymakers which has been emphasized in the country's macro-plans, including development programs and vision documents, namely National Health Attachment Standards, health referral system service leveling, and family physician, formation of High Council of Health and Nutrition Security, etc. In this regard, in 2016, the Ministry of Health and Medical Education has formed a social deputy at the level of ministries and universities of medical sciences in different

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provinces and identified its subset structures to facilitate intersectoral coordination in the policies of different sectors of the country concerning reducing health injustice, but in 2018, this deputy was dissolved and its subordinate departments were either under the direct supervision of the Minister of Health or were transferred to other deputies of the Ministry of Health. This issue has led to the disruption of intersectoral coordination or the cessation of some of the activities of this deputy. So far, many studies have been conducted on the social determinants of health in Iran and abroad. For example, Kamaliah etl, has conducted a study that examined Malaysia's experience of socializing and the policy mechanism implementing and evaluating the socialization of health in that country (11). Valle, in another study, has evaluated two policies of the Mexican government to socialize health (12). However, no study has been conducted in Iran on the structure and policies of the country in the field of implementing policies to socialize health and effective social factors on health. Therefore, the present study was carried out to investigate the socialization of health and its dimensions, the current structure of the country in the field of socialization of health, and the study of the relationship between its various elements.

Methods

This study is considered as a qualitative study conducted in 2019 to examine the available documents in Iran in the field of socialization of health. Also, the views of experts have been studied to complete the data, and documents were reviewed and semi-structured interviews were conducted to collect data. All upstream documents related to social factors determining health and socialization of health were extracted from the website of the Ministry of Health and the Universities of Medical Sciences and the Islamic Consultative Assembly to review the documents. Documents were analyzed using the contractual content analysis method. In-depth interviews were conducted with two social deputies of the two Universities of Medical Sciences (one type-I university and one type-II university) due to the lack of official notification of the new structure after the dissolution of the deputy and to complete the data obtained by reviewing the documents because of the limited life of this deputy and experienced people in this field. The convenience sampling method was used to select the interviewees among those who had a history of executive activity in the field of socialization of health in the social deputies of the universities. The participants in the interview were faculty members with at least three years of experience in the position of social deputy of these universities. The interviews were conducted by telephone and in person, and each interview lasted about 45 minutes. The following guide was used to conduct the interviews:

1.Currently, what are the departments and subsets related to health socialization?

2.What is the role of each department in realizing the socialization of health?

3.What mechanism is used to coordinate the activities of these departments with each other?

Audio recorder and note-taking were used to record the interview data, and contractual content analysis was used to analyze the data obtained from the interview. The drowning in data and composition methods were used to increase its validity. The recorded text was implemented immediately after each interview to perform the drowning in the data method, and for deep understanding, the subject of the interview texts was read several times and preliminary codes were extracted. In the composition method, the final extracted codes were sent to the interviewee to confirm and coding was done by two independent researchers to increase the reliability of the study and the classes (how to achieve the goals of socializing health) were formed after the agreement of coding and extracting the main themes based on them. Finally, an image of the structure and process of socialization of health was achieved in its previous and current form.

Results

According to the upstream documents and other available documents, Figure 1 and Table 1 show the

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structure of the social deputy in the form of the organizational structure of the Ministry of Health and Medical Education and medical universities at the time of establishment and also the macro goals of country in line with social determinants of health.

After thematic interviews, the themes (strategies and pillars) and their classes in the field of socialization of health and the role of each of these pillars in achieving the goals of socializing health were determined. Subsequently, qualitative content analysis was used. After reviewing and the integration of similar codes, two themes and eight classes were identified.

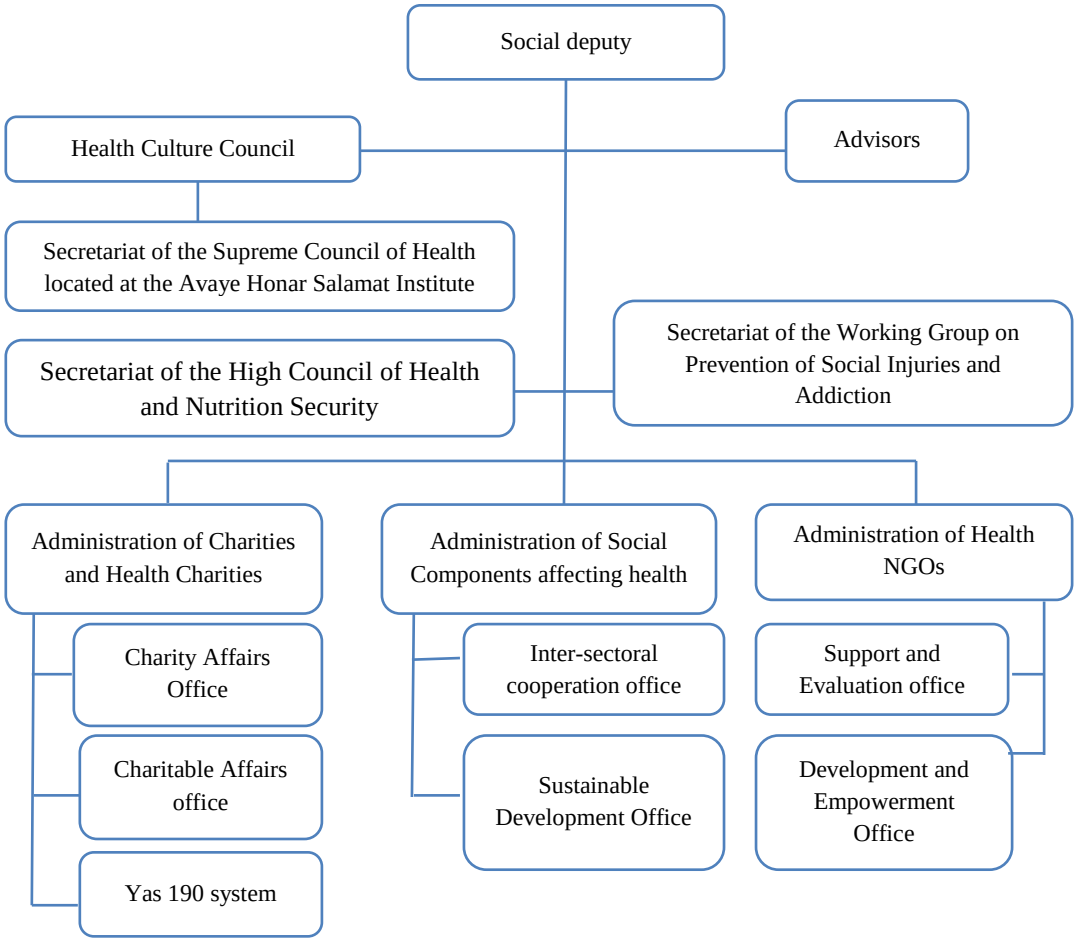

Figure 1. The structure of the social deputy of the Ministry of Health and Education

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Table 1. Content emphasized by the socialization of health in health-related upstream documents

Cases containing socializing health	Upstream document
1. Principle 3, paying attention to housing and nutrition and eliminating any kind of deprivation in the field of health and insurance generalization 2. Principle 29, the government must meet health needs as a public right 3. Principle 43, education, food, and health care clothing have also been recognized as a fundamental right alongside housing	Constitution of the Islamic Republic of Iran
1. Characteristics of Iranian society from the perspective of 1404 including having health, welfare, nutrition security, social security, equal opportunities, proper income distribution, strong family institution away from poverty and corruption, discrimination, and benefiting from the desired environment	Twenty-year perspective
1. Article 2: The General Health Policies emphasize health-oriented laws, executive policies, and regulations (the realization of comprehensive health and human health approach in all laws, executive policies, and regulations). 2. Article 11: "Increasing awareness, responsibility, ability and structured and active participation of the individual, family, and society in providing, maintaining and promoting health by using the capacity of cultural, educational and media institutions and organizations under the supervision of the Ministry of Health, treatment and medical education."	General health policies
1. Article 6: "Promoting life expectancy, health and healthy nutrition of the population and prevention of social harms, especially addiction, accidents, environmental pollution, and disease".	General population policies
2. Article 10: "Ensuring food security and treatment and creating strategic reserves with emphasis on increasing the quantity and quality of production (raw materials and goods)".	Resistance Economy Policies
1. Paying attention to the living environment of the society. 2. Nutrition security, 3. Complete insurance coverage, 4. Public access to health care services, 5. Attention to sports and physical education, 6. Control of pesticides used in agriculture, 7. Reduction of road accidents. 8. National standards of health attachment. 9. Promoting education, leveling health care services and referral system	Fourth, fifth, and sixth development plans

Table 2. The main themes and classes extracted from the interviews

Main themes	main themes
1. Management and organization of charity institutes and Health NGOs (Saman) 2. Increasing health literacy and promoting people's participation in promoting community health. 3. Increasing inter-sectoral cooperation between private and public organizations and institutions to achieve the goal of promoting community health.	Health socialization strategies in Iran
1. Administration of Non-Governmental Organizations and Health Donors at the level of the Ministry of Health and Medical Sciences Universities 2. Health Donors Assembly 3. National Health Assembly, Provincial Health Assembly, County Health Assembly, and Neighborhood 4. The Supreme Council for Health and Nutrition security, and the Council for Health and Food Security of the province and county 5. Social component affecting health office	Pillars and structures of socialization of health

1.Socialization of health strategies

❖ **Management and organization of charity institutes and Health NGOs (Saman)**

Two administrations were defined for implementation of this strategy at the level of the Ministry of Health, which are the Administration of Non-Governmental Organizations and the Administration of Charitable Affairs and Health Charities. Such a structure was found at the university level. These departments had

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responsibility for policy-making and planning regarding the activities of charitable organizations and, establishing coordination between charitable organizations, and allocating charitable donations to the country's priority projects. According to the interviewees, "the issuance of licenses for the establishment of charitable organizations in hospitals was one of the activities that took place during that period, hospitals did not have such a license before. After the changes, two offices have been integrated and became non-governmental organizations and health charities under the supervision of the Ministery of Health at the national level and the President of the University at the university level.

The two offices have been integrated after changes and have been placed under the supervision of NGOs and health donors under the supervision of the Minister of Health at the national level and the President of the University at the university level.

❖ **Increasing health literacy and promoting people's participation in promoting community health:** The following structures have been formed to achieve this goal.

A. **Council of Public Participation:** The council was formed at three provincial, county, and district levels to increase public participation in health plans with the participation of representatives. It is responsible for conveying the health demands of the people to the managers and officials, teaching and conveying health messages to the people, and paving the way for the people's participation in planning, implementation, and evaluation of health-oriented projects. According to the interviewees, "This was one of our strategies for engaging more people in their health, in both social and political aspects. Activity in these councils was voluntary, and their activity has become much less after the changes and they have become practically passive".

B. Health Messenger Council: The "Health Messenger Council" was formed to provide information continuously, educate people of the province and promote their health literacy, which the university's public relations department was chaired by the council and its members, included health messengers, the province's media representative, the province's policy-making secretariat, and the governor's public relations office. This council was responsible for designing, implementing, and evaluating a plan to transfer knowledge, attitudes, and health skills to all public groups. According to the interviewees, "In fact, they were planning to educate people and they had a kind of planning role rather than an executive role".

C. **Health Assemblies:** According to the interviewees, "Health assemblies were held at four levels of national, provincial, county and neighborhood, which were held at the provincial and national levels, annually. These assemblies are considered as a bridge between the specialized working group on health and food security and the people. The neighborhood health assembly was held in the neighborhood centers every month and reflected the health problems and demands of the people concerning health to the working group, as well as provided health-related education to the people. And according to another quote " it has become practically passive after changing the structure and there is no news of holding its meetings ".

❖ **Increasing inter-sectoral cooperation between private and public organizations and institutions to achieve the goal of promoting community health:** The active commitment of all elements and levels of society is necessary to improve the level of comprehensive health and eliminate the roots of injustice in health which will not be achieved except through cooperation and coordination between various institutions and organizations. The following structures were created to attract cooperation and coordination between all sectors of the country:

A. The Supreme Council for Health and Food Security: According to the quote of one interviewee: "The Supreme Council for Health and Food Security has a policy-making role and responsibility for planning to facilitate inter-sectoral cooperation, increase people's participation in health and monitor the

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implementation of these policies as well". Besides, its role is more supportive and supervisory, and it is the responsibility of the specialized working group on health and food security at the provincial level. The Office of Social Components Affecting Health also was established to facilitate inter-sectoral cooperation, even though, its duties were similar and parallel with the specialized working group to some extent**.**

2.Health and Food Safety Working Group of the province: The Planning and **Pillars and structures of health socialization**

❖ **The Secretariat of Health Policy-Making of the province (secretariat of the specialized working group on health and food security):** The secretariat of health policy of the province is responsible for coordinating the formulation and implementation of provincial health development policies and programs and evaluating their implementation. According to the interviewees, the secretariat is at the university and is under the supervision of the president of the university (as the secretary of the specialized working group on health and food security of the province and the vice president of the minister of health, treatment and medical education in the province). The university's deputy of social affairs is the head of the secretariat by order of the university's president, and at the county level, this is the responsibility of the network's director.

❖ **Health Strategic Documentation Center:** The center is responsible for collecting and maintaining strategic health documents in the province to make access to these documents possible by principals, experts, students, and researchers.

❖ **Health Monitoring Committee:** This committee is responsible for presenting an analytical report on the status of the main health indicators of the province on an annual basis and it has been formed in the Secretariat of Health and Food Security (13).

❖ **Health Messengers Council:** Creating sensitivity in organizations to maintain the health of employees, and the environment’s health for their customers is necessary to achieve the goals of socializing health. Health messengers were used to create such sensitivity and keep it stable. According to one interviewee: To persuade other organizations to corporate in achieving health goals by the secretariat, it must be able to interact with them properly, and communicate its programs and policies with them, while engaging them in planning and policy-making. For this purpose, health messengers were used to ask various organizations to introduce their representatives to the secretariat, and they were appointed after the announcement of the president of the university. "This was one of the strategies of the Working Group on Health and Nutrition Security for inter-sectoral cooperation".

❖ **Health Attachment Committee**: This committee was responsible for the examination of the effects of macro-policies and plans on public health and presenting corrective proposals to the provincial decision-making council.

❖ **Province's Health System Research Council:** The council determined the province's health research priorities with the participation of the Health Policy Secretariat and the Specialized Working Group on Health and Food Security, and health messengers to make evidence-based decisions, and the results of its annual evaluation were presented to the Specialized Working Group on Health and Food Security.

❖ **Health think tank:** Utilizing scientific capacities, experts, and specialists in various fields of science were the goal of forming the health think tank. According to the interviewees, the "health think tank" was managed under the supervision of the secretariat of the specialized working group on health and food security. It was expected that a platform would be provided for the presentation of new ideas and modern thoughts, and interdisciplinary interactions would be strengthened in this regard".

A. Affecting Social Components Health Office: The office is responsible for policy-making, planning and evaluating the plan, and health socialization policies, and determining the priorities of effective social determinants for health at the provincial and national levels, as well as

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strengthening inter-sectoral cooperation. According to one interviewee, "The office was integrated with the secretariat after the changes due to its parallel duties with the Secretariat for Health and Food Security."

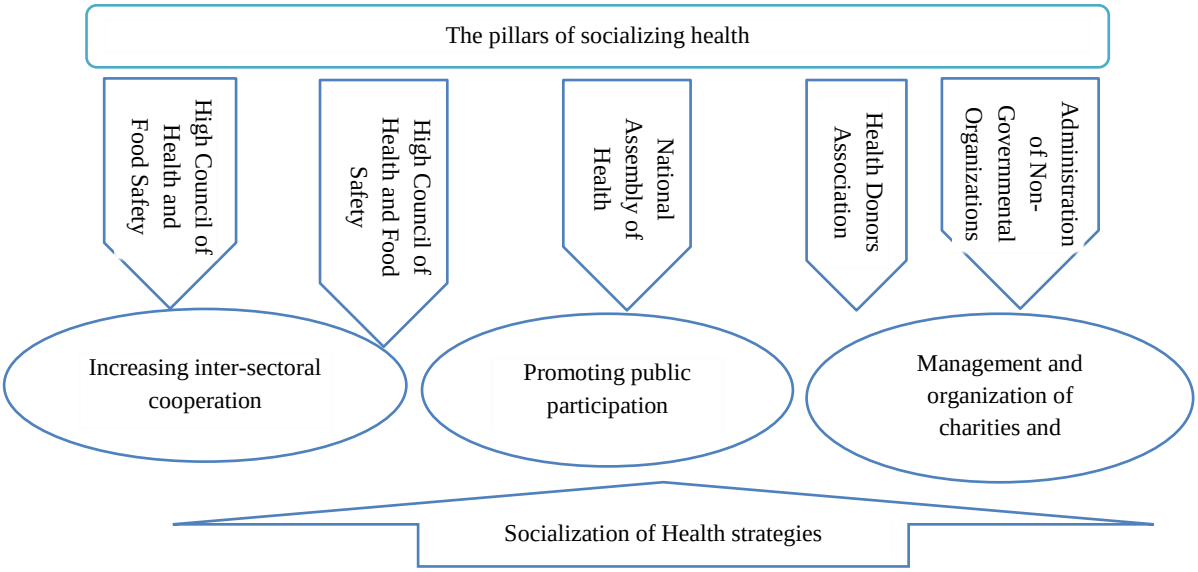

Figure 2. The relationship between the socialization of health strategies and its structure and pillars

In the new structure, the administration of non-governmental organizations and charitable affairs are integrated with health charitable organizations and was considered as a subset of the minister's organization as NGOs and Health Donors, as well as the Secretariat of the High Council for Health and Food Security. The office of Social Affairs was also integrated with the Council Secretariat. The Secretariat of the Working Group was first responsible for the prevention of Social Harms and Addiction which duty was transferred to the Office of Mental Health, Social Affairs, and Addiction in the Deputy of Health. The duties of the Secretariat of the Council for Health Culture at the network management center were transferred to the Health Education and Promotion Group and in the deputy of health to the health promotion group. The duties of the Social Welfare Office were transferred to the Office of Hospital Management and Excellence of the Clinical Services in the Deputy of Treatment.

However, there is no evidence regarding the connections of these sections with each other and how they interact.

According to one interviewee, "It was decided that the next changes would be officially announced, but this has not happened, yet. According to interviewees "establishing a social deputy was a positive experience, and I believe that such a structure was necessary to integrate the activities carried out to promote health in the community".

Recently, many organizations have established a social deputy in their structure, and the presence of such a structure is essential in the field of health, but no official structure has been announced for leading this and the necessary processes to align the plans of different units. It shows that the Ministry of Health is confused and ambiguous about this issue. Another interviewee said, “The new structure has not been implemented by all universities, such as Shahid Beheshti University, which has not eliminated this deputy. The Ministry of Health itself has not yet made any decisions on how to implement it".

Figure 3 shows the current structure of socialization of health in the country according to the communication instructions and statements of the interviewees.

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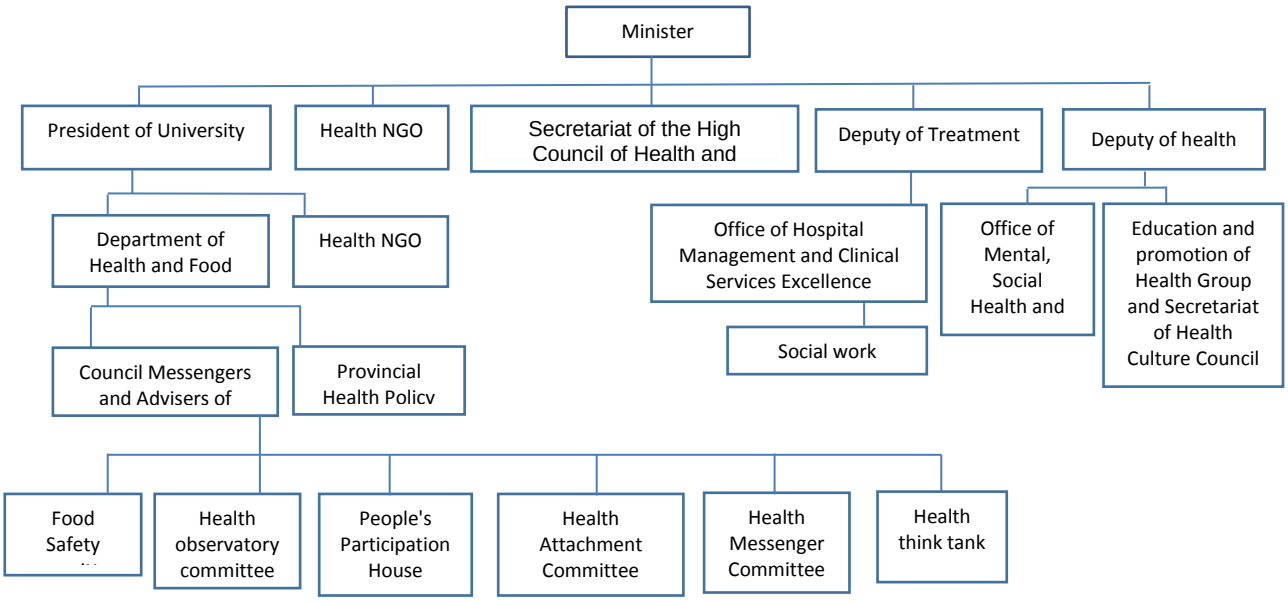

Figure 3. The current structure of socialization of health in Iran

Discussion

This study has identified two main issues and themes and eight sub-categories, the main themes included the strategies of the Ministry of Health to socialize health and the other was the pillars of socialization of health in Iran. The following strategies were implemented by the Ministry of Health regarding the socialization of health: 1. Managing and organizing charitable organizations and non-governmental organizations for the socialization of health, 2. Improving health literacy and promoting people's participation in promoting community health, 3. Increasing inter-sectoral cooperation between private and public organizations and institutions to achieve the goal of promoting community health.

There is a very close relationship between social and economic conditions and justice in health measures that reduces economic and social differences, which must be taken to reduce health inequality and many of these measures are out of range of health sector activity, so there is a need for cross-sectoral cooperation. It is necessary to identify the grounds for inequality and then take serious measures to attract public participation to improve them. Therefore, all policymakers at all levels and sectors must be committed to it, because they all have a significant and important impact (14). In the last decade, countries have paid attention to this issue and are pursuing policies that can reduce inequality and injustice in health, but many of these policies have not been formulated and designed in a proper way (15). Besides, few number of these policies are monitored and evaluated (12). The basic strategy for achieving the goals of socializing health in Vietnam was to mobilize all available resources in the community for health purposes which means paying attention to the issue of health in the policies of all levels and sections of the society. All available resources in the community must focus on financial policies, including equitable participation in health care financing, the use of private sector potential, hospital autonomous hospitals, and insurance coverage (16).

In Mexico, supportive policies have been implemented, and some of the most important ones include financial support for very poor or insurance coverage policies that have had a direct and positive impact on health care outputs. In this regard, the Social Development Law has been developed and an institution called the National Association for the Evaluation of Social Policies has been established to monitor the implementation of social plans and policies and their effectiveness (12). It has also been reported that in Malaysia, the

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socialization of the health approach is considered as an umbrella that encompasses all of the country's policies. In this country, a general approach has been determined and all ministries are required to move within this framework. Centralized planning is done at the highest political levels of the country, which leads to create commitment and interest at other policy-making and executive levels and facilitate inter-sectoral coordination (11, 17).

Another main related theme was to realize the socialization of health in Iran, which had eight subclasses. These classes of tools and pillars were defined as a subset of the social deputy, which was established in 2016 in the country and the universities of medical sciences and their sub-organizations, each of which was responsible for the implementation of one of the strategies including Administration of Social Components Affecting Health, Administration of Charitable Affairs and Health Charities, Administration of Non-Governmental Organizations, the Secretariat of the High Council of Health and Food Security. The Secretariat of the High Council for Health and Food Security and Office of Social Components of Health have responsibility for planning and policy-making in this field, facilitating and enhancing inter-sectoral cooperation and evaluating the implementation of defined policies. Also, a similar structure was established with similar tasks at the provincial level: a specialized working group on health and food security to implement national policies and plans, as well as planning at the provincial level. The secretariat of this working group chaired by the university's vice chancellor for social affairs has used the public participation house and the Health Messengers Council to increase public participation in improving public health and promoting public health literacy. They also used the health messengers council for inter-sectoral cooperation at the county level. It should be mentioned that a working group with the same name and mission was formed at the county level. Also, the Administration of Charitable Organizations had responsibility for managing and organizing the activities of charitable organizations. In a country like Mexico, there was a need to establish an independent institute called the National Association for Social Policy Evaluation which was established to determine the social policies' effectiveness to monitor and evaluate them as well (12). All policy-making related fields are involved in this process in Malaysia, just like in Iran (a combination similar to the Supreme Council for Health and Food Security), but it has a different and interesting approach for evaluating plans and policies(11) . In this country, a government-independent institution has the responsibility for evaluating the performance of various ministries based on key performance indicators (KPIs) in the field of socialization of health policies (11). Whereas, in Iran, a single system is responsible for policy-making and evaluation. Lack of effective assessments of health socialization policies in promoting community health and reducing injustice shows its deficiency in the previous and current structure. Health assemblies is another pillar of the socialization of health that was formed in the country, the province, the city, and the neighborhood. With the combination of all sections of society, they tried to increase people's participation in decision-making in the field of health. Then the minister ordered the cessation of the social deputy's activity three years after its establishment and the established structures were transferred to other deputies, or they became directly the subset of the minister and the president of the university at the university level. Some previous established structures, including the assemblies and the office of social components affecting health, became passive, and according to the interviewees, no clear official structure is found for the socialization of health at the national level. Given that multiple structures are found among the country's universities, and this policy did not have the necessary intelligence support.

No necessary coordination and coherence are found between the departments and sub-sets of this deputy, and many of the structures formed in the previous policy to achieve the goals of socialization of health are now passive.

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There is no pre-determined mechanism for coordination between the departments that previously were operated under the supervision of this deputy. It seems that the Ministry of Health does not have enough coherence in its new policy, and the necessary studies and research have not been carried out before determining the policy on how to advance the goals of socialization of health. There is no new policy for policy-making to implement and evaluate the socialization of health plans and policies. No clear and definite path is found in the way of socialization of health due to the lack of a clear structure after six months of the announcement of the plan, inactivation of some elements of socialization of health, different orientations of medical universities in this regard that all of them have a significant effect on the Ministry of Health to promote community health.

Conclusion

Despite the overlap and parallelism between the individual duties of the units in the previous structure of health socialization in Iran, the existence of a center, as the proctor and also the focus of socialization of health policy-making in this deputy, leads to facilitate inter-sectoral cooperation and more accurate monitoring the implementation of interdisciplinary plans. Such a framework will lead to an integrated approach to health socialization and create a common path for the activities of structures related to this field, as well as more executive guarantees for implementing policies in community health improvement, which surely depends on the establishment of structures and processes of legislation and support at the macro level, developing effective communication between the Ministry of Health and legislative bodies such as the Islamic Consultative Assembly and establishment of the necessary infrastructure and information platforms to determine the policy options based on awareness and monitoring and evaluating their implementation.

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Confilict of interest

The authors declare that they have no confilict of interests.

Author Contribution

R.KH, L.T contributed to the design and implementation of the research, to the analysis of the results and to the writing of the manuscript ,H.J , S.A contributed to the ,to the analysis of the results and to the writing of the manuscript .

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