SOCIAL DETERMINANTS OF HEALTH-RELATED COMPETENCIES FOR THE HEALTH WORKFORCE

TECHNICAL BRIEF

June 2022

Recommended citation: Pálsdóttir, Björg, Lyn Middleton, and Kate Greene. The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ. June 2022. *Social Determinants of Health-related Competencies for the Health Workforce*. Rockville, MD: Abt Associate

Introduction

The social determinants of health (SDoH)—the set of circumstances in which people are born, grow, live, work, and age—impact the health and well-being of individuals and populations. SDoH contribute to 45–60 percent of the difference in health status among different populations.[1] To deliver responsive quality care effectively and equitably, clinical care providers must have a solid understanding of how these complex sets of factors, and the forces that drive them, affect patients and communities, as well as providers themselves. Understanding is not enough; clinicians need to possess competencies aimed at eliminating or reducing the negative effects of these factors.

While there is overwhelming evidence of the need to mitigate the negative effects of SDoH-related factors to improve equity and health outcomes and optimize scarce resources, there are no global agreements on core SDoH-related competencies for pre-service health workforce education, in-service training, or continued professional development. However, there is general agreement that all clinicians, not just providers who focus on psychosocial issues, need to have SDoH-related competencies.

Photo Credit-Patan Academy of Sciences. Medical students at Patan Academy of Health Sciences in Nepal, learning about SDoH by interacting with community members

To help bridge the gap between agreement on the overall importance of these competencies and lack of consensus on specific competencies and approaches, the Local Health System Strengthening Project (LHSS) developed this brief on their relevance and importance, including examples of how providers with SDoH-related competencies can impact key health service areas. The brief includes a set of suggested competencies developed in collaboration with a diverse group of stakeholders from around the world who identified them as essential for the health workforce. Participants included international experts on SDoH, faculty with experience in teaching SDoH-related competencies, global student leaders, relevant professionals in non-health sectors, and advocates for marginalized groups from 20 countries, most from low- and middle-income countries (LMICs).

The competencies in this brief fall under six domains: equity lens, communication, people-centered care, evidence-informed practice, collaboration, and self-awareness and personal growth. See Table 1 below for the full list of 25 competencies and key stakeholder comments. LHSS anticipates the brief will help stakeholders understand the importance of these kinds of competencies and their impact on provider behavior and responsive, equitable care when adapted to and applied in a particular context.

LHSS is also developing a process guide for local stakeholders to collaboratively identify key SDoH challenges in their contexts and ways to incorporate SDoH-related competencies into education, training, programs, and practice at facility levels.

Methodology

The LHSS Project conducted a series of country case studies to identify, analyze, and document successful efforts to integrate competencies and practices related to SDoH into health workforce education, training, quality assurance, and service delivery in LMICs. LHSS also completed a literature review, surveys, resource mapping, and theory of change on this topic. The information presented in this brief draws from all of these LHSS materials. While the literature review did not identify agreements on a set of core competencies, LHSS identified eight provisional competencies related to SDoH. LHSS then surveyed educators, learners, and practitioners from different professions in 12 LMICs about whether they thought the competencies identified were relevant to addressing mitigating the adverse effects of SDoH and whether they were currently taught at their institutions.

LHSS subsequently conducted a rapid review of relevant frameworks (included in a section below) and curricula to identify and incorporate relevant competencies into a list of competencies related to SDoH. This list formed the starting point for a two-round E-Delphi survey of international experts on SDoH, faculty from LMICs with experience in developing SDoH-related competencies, global student leaders, relevant professionals in non-health sectors, and advocates for marginalized groups. In Round 1, these 25 stakeholders from 20 countries rated whether they agreed, somewhat agreed, somewhat disagreed, or disagreed that each of the 27 competencies was an important SDoH-related competency. They could also make comments and suggest missing competencies. In Round 2, participants were asked to (1) indicate their preference for the original or revised statement based on feedback from Round 1 and (2) rate the importance of their preferred statement as an SDoH-related competency. They also had an opportunity to comment on their choices. The focus of Round 2 was to obtain collective agreement on priority competencies.

How are SDoH linked to health?

Individuals and groups of lower social and economic status tend to be born, grow, live, work, and age in environments that are detrimental to their health and are, therefore, at greater risk of exposure to disease and ill health. As a result, their lives tend to be shorter and less healthy than individuals and groups more positively affected by SDoH-related factors. The risk factors range from basics, such as substandard housing, pollution, food and job insecurity, low level of education, and lack of sanitation to less tangible elements, such as violence, discrimination, social isolation, and the chronic stress of living in challenging conditions and circumstances.

The inter-relationship between health, biological, psychosocial, and economic factors is complex, dynamic, and interactive. Evidence is emerging that adverse and protective social factors, including individuals' physical environment, affect gene expression. Living conditions are, in turn, influenced by social and economic policies, power, resource allocation, and structural factors.[2] For example, evidence shows that children who live in difficult socioeconomic circumstances early in life have an increased incidence of respiratory and cardiovascular disease even if their social and economic status changes later in life.[3] However, factors such as social support and self-confidence, can reduce the effect of adverse circumstances.

What can providers do about SDoH?

With solid evidence emerging around the importance of SDoH in health outcomes, care providers need competencies that help them identify and address the SDoH-related factors that may be affecting their patients and communities.

Providers have the potential to influence factors related to SDoH at multiple levels in the clinical and organizational environment, in the communities they serve, and at policy levels. Individuals from marginalized groups are often especially vulnerable. For example, Browne et al. describe effective organizational strategies and approaches in primary health care services designed to meet the needs of Indigenous peoples in Canada.

Integration of SDoH Competencies into a Curriculum in the Philippines

Ateneo de Zamboanga School of Medicine and University of the Philippines, Manila, School of Health Sciences in Leyte integrate SDoH thinking into both instructional and institutional strategies. Their pedagogical methods include service-learning, theoretical and practical application of SDoH competencies, and community engagement and mobilization. Learners spend up to half of their clinical learning time in poor rural communities where they conduct community assessments, gain practical understanding of SDoH, and work with communities to address the negative effects of SDoH in these communities.

Impact so far

An impact study found that graduates from the two schools were more than three times more likely to practice in smaller and poorer communities than graduates from conventional medical schools. After adjusting for socioeconomic status, recent mothers in communities served by medical graduates from the two schools were more likely than mothers in communities served by conventional medical graduates to report receiving all the USAID-recommended prenatal, newborn, and postnatal examinations; measurements; and injections. Mothers from communities served by graduates of the two schools were significantly more likely to report better care during delivery, postnatal care, and the first postnatal check-up. Findings suggest that graduates who have significant exposure to and practical experience working in underserved communities may be better than graduates from conventional programs at reducing inequalities by providing more equitable access to essential maternal health services.

According to the authors, the four dimensions that underpin the understanding of how to increase health equity for marginalized population groups are trauma- and violence-informed care, culturally competent care, contextually tailored care, and inequity-responsive care[4].

If care providers only focus on risk factors and modifying the behavior of individuals—such as changing their diet—without understanding that individuals do not always control the factors that make them ill and may be taking cues from their social environment. In that case, their interventions are not likely to be successful.[2]

The literature suggests that SDoH-related competencies center around acquiring knowledge, holistic and people-centered approaches, and being able to communicate and collaborate effectively with others and advocate for their patients. Also frequently mentioned in high-income countries are screening tools and referring patients to services outside the health sector.

Deep-rooted bias based on race, gender, caste, ethnicity, sexual orientation, class, or other causes of marginalization and providers' professional status can affect power dynamics in clinical encounters and thereby the quality and equity of care.[5] Therefore, health care providers must also reflect on how their clinical settings, personal actions, and perspectives might entrench broader social prejudices and stereotypes against specific groups of health seekers.[2] [6] [7]

However, the literature and feedback from the Delphi survey suggest that care providers, up to 70 percent of whom are women, are also affected by SDoH-factors, including bias and social and professional power dynamics. Such contextual factors need to be considered when designing training or practice interventions.

Competencies Related to Stigma

Stigma is a driver of morbidity and mortality disadvantaging the stigmatized and causing stress. It undermines diagnosis, treatment, and positive health outcomes. Many individuals experience stigma in society, but also in health facilities, manifested in the form of denial of care, lower quality of care, physical and verbal abuse, or through misdiagnosis or inadequate treatment. Stigma affects patients in complex dynamic ways. For example, adherence to antiretroviral therapy is critical to HIV outcomes. Treatment adherence is not only affected by SDoH—such as income, education and transportation—but by stigma-related factors such as changes in social support and self-identification (e.g., as gender, sexual orientation and substance abuse, and increased poverty as a result of stigma).

What care providers can do

1. Build trust and support the empowerment of the patient to overcome stigma through cultural humility and effective communication.
2. Reflect on the extent to which their own clinical settings, social status, worldview, personal actions, and perspectives may affect assumptions and interaction with individuals and specific groups.
3. Engage in learning activities that strengthen SDoH-related competencies that foster empathy, humanize the stigmatized individual, and dismantle stereotypes.

Stigma reduction approaches in facilities

1. Improving knowledge about "stigmatized" health conditions and stigma, its manifestations and effect on health.
2. Skills-building to develop the competencies to engage with stigmatized groups.
3. Engaging members of stigmatized groups in the training interventions
4. Training providers to foster patients' agency to support client coping mechanisms to overcome stigma at the health facility level.
5. Changes in policies, clinical guidance material, and organizational structures and procedures.

How can SDoH-related competencies impact key practice areas?

Incorporating SDoH-related competencies and practices into clinical encounters and health interventions can positively impact outcomes across a wide range of practice areas. In high-income countries, care providers are increasingly using SDoH screening tools to improve social conditions for patients and their families. However, screening tools, while valuable, are not without controversy. There may be ethical concerns about using them if service availability, accessibility, and acceptability are in question or if clinicians/staff do not have the resources or competencies to address complex challenges, such as domestic violence.

The impact of SDoH on non-communicable diseases is well-known[8], and the devastating effect of the COVID-19 pandemic on marginalized populations highlighted the impact of SDoH on morbidity and mortality from an infectious disease.[9]

Program developers and care providers focusing on HIV/AIDS prevention and care are increasingly incorporating SDoH-related interventions to address factors such as stigma, poverty, racism; and to prevent infections, influence behaviors, and improve treatment outcomes.[10]

The importance of SDoH factors in maternal and child health care is also well known. For example, a recent focus of initiatives in this area was on increasing the number of women giving birth in health facilities to reduce maternal mortality. However, such strategies alone have not had the desired results. Unnecessary medical interventions during childbirth, abusive and disrespectful treatment of women, particularly the youngest, poorest, and those from marginalized groups, during childbirth remain a chronic issue in many regions.[7] Its drivers include provider gender bias and stereotyping, socioeconomic inequalities, linguistic and cultural barriers, institutional structure, processes, and organizational culture. Thus, interventions addressing such diverse factors can improve the quality of care and reduce maternal mortality.[11]

Family planning is another practice area where SDoH have a significant impact. Women from lower socioeconomic groups are more likely than those from higher socioeconomic groups to experience unintended pregnancies and suffer harmful consequences. Care providers also need to adapt interventions for youth who, for economic, cultural, religious, legal, or logistical reasons are less likely to access the safe and affordable contraceptives they need.

Challenges with Screening Tools

While SDoH screening tools may help identify patients' needs and potential risks, it is essential that patients are engaged in the identification of priorities. Providers should determine patients' willingness or ability to use needed services.[2]

There may be ethical concerns about using SDoH screening tools if service availability, accessibility, and acceptability is in question or if providers do not have the resources or competencies to address difficult challenges, such as domestic violence.

Findings from the Delphi Process

Delphi is a useful method for consulting diverse experts and obtaining opinions and agreement on under-explored, but emerging issues, as in this case: SDoH-related competencies.

Results from Round 1: Overall, there was a high level of agreement for the competency statements:

- Agreement rating of 90 percent and above for six items.
- Agreement rating of 80–89 percent for 11 items.
- Agreement rating of 70–79 percent for eight items
- Agreement rating of 64 percent for one item.

Still, within this high level of agreement, 10 statements have a "somewhat disagree" rating from some participants: four percent for five items, eight percent for three items, and 12 percent for one item. Based on the high level of agreement, we removed two competencies because of their similarity to adjacent competencies, reducing the number of competencies to 25. While there was high-level agreement around the content of the SDoH, there were contradictory opinions about how competencies should be phrased and the use (or not) of measurable action verbs. This

difference is consistent with the different approaches to defining competencies, learning objectives, learning outcomes, and the link between them.

In Round 2, participants were asked to indicate their preference for the original or revised statement based on feedback from Round 1 and to rate the importance of their preferred statement as an SDoH-related competency on a scale from 1 to 10, with 10 as the most important. They also had an opportunity to comment on their choices. Obtaining a consensus among a diverse and multilingual group in only a two-round Delphi is difficult, if not impossible. However, this diverse group of experts largely agreed on the essence of a set of critical competencies, which lends credibility to the findings.

Delphi participants' advice and reflections were also highly valuable, including thoughtful comments around language. One participant mentioned the "need to move away from health behavior language" to focus more on "structural change and supportive environments," reflecting the broader forces affecting health and behavior.

The differences between the perspectives of participants coming from higher-income countries and those from LMICs were notable, particularly when it came to rating using screening tools for SDoH and referring patients to social services. The reasons for this were not explored in this effort. However, reasons for this difference could range from the lack of widespread use of screening tools in LMICs, limited social service options to refer patients to, to language around using tools rather than asking patients about their social needs and circumstance.

When commenting on competencies related to bias, one participant highlighted the importance of reflecting on hierarchy and power in health care systems and on the power and structural inequities that health workers experience that might shape their treatment of patients.

There were some interesting differences in comments on the competency: "applies the principles and methods of conducting a community assessment." Some felt that this might be an important competency for a "community clinic manager or program developer." However, others, particularly faculty at socially accountable health professional education institutions in LMICs, mentioned that this was an essential competency for clinicians as well. Participants from socially accountable health professions schools also mentioned the importance of seeing stakeholders—such as patients, communities, and policymakers—as part of the "team" to ensure "ownership and compliance."

Similarly, some participants felt that expecting providers to be familiar with and able to refer patients to social services, while useful in principle, might be asking too much of those providers. Another thoughtful comment mentioned the need to reflect on "how are people being remunerated and supported in doing what is strictly speaking beyond clinical work."

TABLE 1: LEVEL OF AGREEMENT ON PRIORITY SDOH-RELATED COMPETENCIES

	COMPETENCY	RANKING MEAN 1–10	COMPETENCY DOMAIN
1.	Evaluates multiple factors, including social, religious, environmental, economic, political, and cultural factors, influence individuals' health and health behaviors.	9.75	Equity Lens
2.	Communicates effectively in simple, clear language, actively listens, and ensures the patient, family, or colleague feels understood and valued.	9.33	Communication
3.	Recognizes how social and cultural norms and worldviews—about the place of residence, race/ethnicity, occupation, gender, religion, culture, education, social capital, socioeconomic status, age, disability, sexual orientation, and others—affect structural discrimination and the assumptions and behaviors of individuals and groups in the health system.	9.08	Equity Lens
4.	Associates the structural and individual barriers affecting marginalized, unserved, and underserved individuals and groups to their access to care, service use, and health behaviors.	9.00	Equity Lens
5.	Expresses openness to other peoples' preferences and opinions through interpersonal skills of warmth, humility, respectful inquiry, empathy, and participatory engagement.	8.92	Communication
6.	Gives examples of how social and health-related policies and/or the lack of policies differentially affect people and their health outcomes.	8.83	Equity Lens
7.	Distinguishes the concepts of people-centered care and holistic approaches to individual and community health and well-being.	8.75	People-Centered care
8.	Demonstrates the principles and approaches of critical and systems thinking.	8.75	Evidenced-Informed Practice
9.	Identifies relevant social and community services that patients and families could benefit from in relation to social determinants of health, such as social work services.	8.75	Collaboration
10.	Advocates for equitable access to health and social services for patients and marginalized groups, community participation in health services decision-making, and equity-oriented policies.	8.67	Communication
11.	Incorporates the perspectives of individuals, caregivers, families, and communities as participants in and beneficiaries of health systems into planning program interventions and delivering culturally sensitive, respectful, and compassionate care.	8.58	People-Centered Care

COMPETENCY	RANKING MEAN 1–10	COMPETENCY DOMAIN
12. Demonstrates respect, empathy, and is critically self-reflective and applies communication skills to equalize power relations and self-care skills to maintain own psycho-social health.	8.58	Self-awareness and Personal Growth
13. Recognizes own limits to understanding others' worldviews and cultures.	8.58	Self-awareness and Personal Growth
14. Collaborates with relevant stakeholders to identify challenges and build on individuals' and communities' existing resources and assets to co-create solutions.	8.50	Collaboration
15. Devises and applies context-specific strategies that remove or minimize the effect of specific barriers for marginalized, unserved, and underserved individuals and groups and facilitates adherence to treatment plans and solutions.	8.42	Equity Lens
16. Applies the principles and methods of conducting a stakeholder-engaged community assessment.	8.33	Evidence-Informed Practice
17. Actively seeks out the expertise, experience, and knowledge of others while acting with professional agency in forming own clinical opinions and decisions.	8.25	Collaboration
18. Collaborates and communicates effectively with different interprofessional team members and decision and policy makers.	8.18	Collaboration
19. Distinguishes personal bias toward people from different backgrounds, race, gender, or population groups and applies this knowledge when interacting with others.	8.08	Self-awareness and Personal Growth
20. Explains the role of different health and social care providers as well as non-traditional care providers, including traditional healers and others who influence people's health-related behaviors.	8.00	Communication
21. Uses critical policy analysis to advocate for improved social care referral pathways, equity in accessing and using health and social services.	8.00	Evidence-Informed Practice
22. Applies participative problem-solving approaches—such as using and sharing multiple sources of data, knowledge, and professional resources—to jointly identify problems and solutions and monitor outcomes for SDoH-related challenges.	8.00	Collaboration
23. Creates an enabling environment for self-empowerment for patients and communities and mobilizes them to become aware of their rights and take charge of their own health.	7.92	People-Centered Care

COMPETENCY	RANKING MEAN 1–10	COMPETENCY DOMAIN
24. Uses a screening tool or relevant framework to identify SDoH affecting patients and families as part of the routine bio-psycho-social assessment and treatment plan.	7.83	Evidence-Informed Practice
25. Refers individuals to local affordable and appropriate health and social services and resources and follows up with the individual on the referral experience and outcome.	7.75	Collaboration

Future Steps

Notwithstanding the overwhelming evidence supporting the need to mitigate the negative effects of SDoH to improve health outcomes and optimize scarce resources, the term SDoH lacks conceptual clarity with implications for integrating SDoH-related competencies into health workforce education programs, policies, service delivery, education, and accreditation standards. Future directions could include reviews with a larger group of participants to help clarify terms and develop a consensus on the core competencies clinical and other health providers need to improve the quality and equity of services and optimize scarce health resources.

The lack of global agreement around competencies, however, should not deter leaders, educators, and practitioners from ensuring that clinicians in their context receive the training they need. They should engage with key stakeholders from across sectors, including communities to identify SDoH-related challenges, clarify what is meant by each term, delineate realistic goals, and define clear objectives for interventions. These could be competency-based education programs for pre-service and in-service training, as well as facility- and community-level interventions.

Glossary for Social Determinants of Health

Agency: The power and autonomy people have to think and act for themselves. It can take individual and collective forms.[12]

Attitude: A person's feelings, values, and beliefs that influence their behavior and the performance of tasks.[13]

Collaboration Domain: Working collaboratively with other health professionals, patients, families, communities, and social services to maximize available support and co-create solutions for increasing access to resources for bio-psycho-social well-being.

Communication Domain: The provider's capacity to understand the experience, preferences, and needs of others within their specific roles, context, and social and life circumstances. Using effective interpersonal communication skills to communicate that understanding back to others.[14]

Competencies: A set of measurable, observable, and clearly defined knowledge, skills, and attitudes that are critical to job performance and serve as a basis for assessing, developing, and evaluating people.[15]

Competency Domain: A broad, distinguishable area of content; domains, in aggregate, constitute a general descriptive framework.[16]

Contextually Tailored Care: Expanding the concept of patient-centered care to include services that are explicitly tailored to the populations served and local contexts. This may include organizational tailoring to address the local population demographics and social trends (e.g., programs or services addressing HIV, seniors, women's or men's issues, support for new immigrants, etc.).[17]

Cultural Humility: A process of self-reflection to understand personal and systemic biases and to develop and maintain respectful processes and relationships based on mutual trust.[7] It is a basic knowledge of the diversity, worldviews, spiritual, and cultural values of different peoples, and the historical and contemporary issues that influence them.[18]

Culturally Competent Care: Taking into account not only the cultural meaning of health and illness, but equally important, people's experiences of racism, discrimination, and marginalization and the way those experiences shape health, life opportunities, access to health care, and quality of life.[19]

Culture: The values, attitudes, norms, ideas, internalized habits, and perceptions of a group or groups of people. For example, social roles, structures and relationships, codes of behaviors, and explanations for behavior that are to a significant extent shared among a group people. Culture is learned and internalized, and influences people's actions and interpretations of circumstances at the same time as people, in turn, influences the content of culture by their compliance with it or by challenging it.[20]

Discrimination: The process by which a member (or members) of a socially defined group is treated differently (especially unfairly) because of their membership in that group. This unfair treatment arises from socially derived beliefs each group holds about the other, and patterns of dominance and oppression, viewed as expressions of a struggle for power and privilege.[21]

Equity: The absence of avoidable or remediable differences among populations or groups defined socially, economically, demographically, or geographically.[22]

Equity Lens Domain: The provider's appreciation of the various individual, social, and structural factors, conditions and behaviors that differentially affect individual and group vulnerabilities, and access to and use of resources and health outcomes.

Evidence-Informed Practice: The integration of the best available evidence with the knowledge and considered judgements from stakeholders and experts to benefit the needs of a population. This includes using the best available evidence about the SDoH and potential health impacts, from multiple sources, including research studies, people, and communities, to inform bio-psycho-social interventions. Adapted from WHO's Global Competency and Outcomes Framework for Universal Health Coverage [23]

Health Inequality: Differences, variations, and disparities in the health achievements of individuals and groups of people.[24]

Health Inequity: Differences in health that is systematic, avoidable, and unjust.[25]

Inequity-Responsive Care: Explicitly addressing the social determinants of health as legitimate and routine aspects of health care, often as the main priority.[26]

Knowledge: The practical or theoretical understanding of a subject.

People-Centeredness Domain: An approach to care that deliberately adopts individuals', caregivers', families', and communities' perspectives as participants in and beneficiaries of trusted health systems that are organized in accordance with the comprehensive needs of people, rather than individual diseases, and respects social preferences. People-centered care also requires that patients have the education and support they need to make decisions and participate in their own care and that caregivers are able to attain maximal function within a supportive working environment. People-centered care is broader than patient- and person-centered care, encompassing not only clinical encounters, but also including attention to the health of people in their communities and their crucial role in shaping health policy and health services.[1]

Self-awareness and personal growth: The provider's ability to regularly reflect on, understand, and act on personal and systemic biases. Connected to communication self-reflection helps the provider understand intrapersonal and interpersonal barriers and enablers for effective patient-centered communication.

Skill: A specific cognitive or motor ability that is typically developed through training and practice, and is not context specific.[27]

Social Determinants of Health: According to the World Health Organization, these are the conditions or circumstances in which people are born, grow, live, work, and age. These conditions are shaped by political, social, and economic forces.[28]

The 3-D Commission proposes that SDoH include all forces outside the body that affect health, including local, national, and global political and policy decisions and laws, religion and culture, the environment, commercial influences, and forces that structure the availability of goods and services, and individual and collective emotions.[29]

Social Needs: A measurement of what the individual patient feels to be important in their life.[30]

Social Risk Factors: A specific detrimental social conditions that may negatively affect health.[31]

Stakeholder: A person, or group of persons, who have an interest or concern in a particular process or issue due to direct or indirect involvement. Examples include government ministries, politicians, nongovernment organizations, religious organizations, research institutes, labor unions, professional associations, and businesses.[32]

Stigma: When elements of labeling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them.[33]

Structural Determinants of Health: Processes that create inequities in money, power, and resources. They include political, cultural, economic, and social structures; natural environment, land and climate change; and history and legacy, ongoing colonialism and systemic racism. Also known as structural drivers, they shape the conditions of daily life (social determinants of health), including education, work, aging, income, social protections, housing, environment, and health systems.[34]

Trauma- and Violence-Informed Care: Recognizing that most people affected by systemic inequities and structural violence have experienced, and often continue to experience, varying forms of violence with traumatic impact. Such care consists of respectful, empowerment practices informed by understanding the pervasiveness and effects of trauma and violence, rather than "trauma treatment," such as psychotherapy.[35]

Unconscious Bias/Implicit Bias: Mental processes that operate outside our consciousness, intentional awareness, or control. Unconscious biases include (1) a tendency to favor and/or feel more affinity with people who are share a background, interests, or identify; (2) assessing people performance based on some elements of their identity or appearance; (3) a tendency to attribute a person's behavior, success, or outcomes as a result of favoritism or luck versus their natural capabilities or performance; and (4) a tendency to favor, seek, interpret, or more easily accept information that is in alignment with a person's existing opinion or beliefs.[36]

Frameworks and Tools Reviewed

3-D Commission. 2021. *Data, social determinants, and better decision-making for health: The report of the 3-D Commission*. Boston: 3-D Commission.

Breakthrough ACTION. 2022. *Intentionally incorporating the social determinants of health into social and behavior change programming for family planning: A technical report*. Baltimore: Johns Hopkins Center for Communication Programs.

DeVoe, Jennifer E., Andrew W. Bazemore, Erika K. Cottrell, Sonja Likumahuwa-Ackman, Jené Grandmont, Natalie Spach, and Rachel Gold. 2016. "Perspectives in Primary Care: A Conceptual Framework and Path for Integrating Social Determinants of Health into Primary Care Practice." *Chinese General Practice*. Chinese General Practice. https://doi.org/10.1370/afm.1903.

Frank, J. R., L. Snell, and J. Sherbino, editors. 2015. *CanMEDS 2015 Physician Competency Framework*. Ottawa: Royal College of Physicians and Surgeons of Canada.

Global Alliance for Leadership in Nursing Education and Science. 2019. *Global Alliance for Leadership in Nursing Education and Science Global pillars for nursing education*. Washington, DC: American Association of Colleges of Nursing. https://ganes.info/

Guingona M, Halili S, Cristobal F, Woolley T, Reeve C, Ross SJ, Neusy AJ. 2021 *A Curriculum for Achieving Universal Health Care: A Case Study of Ateneo de Zamboanga University School of Medicine*. Front Public Health. 2021 Apr 29;9:612035.

National Academies of Sciences, Engineering, and Medicine. 2016. *A Framework for Educating Health Professionals to Address the Social Determinants of Health*. Washington, DC: National Academies Press. https://doi.org/10.17226/21923.

Patel, S. C., and S. Rajasekaran. 2021. Wayne State *University School of Medicine Social Accountability Competencies*. (Unpublished).

Rosa, W. E., C. J. Hannaway, C. McArdle, M. F. McManus, S. T. Alharahsheh, and M. Marmot. 2021. *Nurses for Health Equity: Guidelines for Tackling the Social Determinants of Health*. WISH. https://www.researchgate.net/publication/352282240_Nurses_for_Health_Equity_Guidelines_for_Tackling_the_Social_Determinants_of_Health.

Swaziland Nursing Council. October 2014. *Swaziland Entry-to-Practice Nursing Competencies: General Nursing, Midwifery, Community Health Nursing, Community Mental Health Nursing*. Mbabane, Swaziland: Swaziland Nursing Council.

World Health Organization (WHO). 2019. *Strengthening quality midwifery education for Universal Health Coverage 2030: framework for action*. Geneva: WHO. License: CC BY-NC-SA 3.0 IGO.

The Council on Linkages. October 2021. *Core Competencies for Public Health Professionals Revisions Adopted*. Washington, DC: American Psychological Association.

United States Agency for International Development (USAID), Human Resources for Health in 2030 (HRH2030). 2018. *Defining and advancing a gender-competent family planning service provider: a competency framework and technical brief*. Washington, DC: USAID. Avail. https://www.hrh2030program.org/wp-content/uploads/2019/06/Defining-and-Advancing-a-Gender-Competent-Family-Planning-Service-Provider_A-Competency-Framework-and-Technical-Brief.pdf.

Woolley, T., Halili, S.D., Siega-Sur, J.-L., Cristobal, F.L., Reeve, C., Ross, S.J., Neusy, A.-J. (2017). *Socially accountable medical education strengthens community health services*. Medical Education. https://doi.org/10.1111/medu.13489

World Federation of Medical Education. 2020. *Basic Medical Education WFME Global Standards for Quality Improvement Explanatory Note to Guide the Use of the Standards: The 2020 Revision*. Copenhagen: World Federation of Medical Education.

World Federation for Medical Education. 2015. *Basic Medical Education: WFME Global Standards for Quality Improvement*. Copenhagen: World Federation for Medical Education, 36.

World Health Organization (WHO). 2022. *Global Competency and Outcomes Framework for Universal Health Coverage*. Geneva: WHO. Licence: CC BY-NC-SA 3.0 IGO.

World Health Organization (WHO). 2021. *Refugee and migrant health: global competency standards for health workers*. Geneva: WHO. License: CC BY-NC-SA 3.0 IGO.

Acknowledgements

The authors would like to express special thanks to all the Delphi review participants who gave generously of their time and global expertise to help shape and reach a shared understanding of the 25 priority SDoH-related competencies captured in this brief.

These individuals are: Abu-Bakr Othman (Sudan), Akaninyene Patrick Obot (Nigeria), Amira Rayene Abdelhadi (Algeria), Andreia Bruno-Tomé (Portugal), Anne Andermann (Canada), Bernhard Gaede (South Africa), Caline Mattar (USA), Eva Moya (USA), Gandes Retno Rahayu (Indonesia), Jennyfer Ambe (Nigeria), Kumanan Rasanathan (Switzerland), Mariam Arikosi (Uganda), Mohamed Osman Gafar Abdalla (Sudan), Monsie Guingona (Philippines), Mthembeni Tebelele (South Africa), Mzukisi Kolosa (South Africa), Nkosinathi Nkwanyana (Eswatini), Noelle Campbell (Jamaica), Oraib Alsmadi (Jordan), Rachel Marcus (USA), Salwa Najjab (West Bank and Gaza), Senkyire Ephraim Kumi (Ghana), Shambhu Kumar Upadhyay (Nepal), Sherly Meilianti (Indonesia).

---

[1] Donkin A., P. Goldblatt, J. Allen, et al. 2018. "Global action on the social determinants of health." *BMJ Global Health* 2018;3:e000603.

[2] Braveman, P., and L. Gottlieb. 2014. "The social determinants of health: it's time to consider the causes of the causes." *Public Health Rep.* 2014 Jan-Feb;129 Suppl 2(Suppl 2):19-31. doi: 10.1177/00333549141291S206. PMID: 24385661; PMCID: PMC3863696.

[3] Miller, G., and E. Chen. 2007. "Unfavorable socioeconomic conditions in early life presage expression of proinflammatory phenotype in adolescence." *Psychosom Med.* 2007 Jun;69(5):402-9. doi: 10.1097/PSY.0b013e318068fcf9. Epub 2007 Jun 7. PMID: 17556642.

[4] Browne, Annette J., Colleen Varcoe, Josée Lavoie, Victoria Smye, Sabrina T. Wong, Murry Krause, David Tu, Olive Godwin, Koushambhi Khan, and Alycia Fridkin. 2016. "Enhancing Health Care Equity with Indigenous Populations: Evidence-Based Strategies from an Ethnographic Study." BMC Health Services Research 16 (1): 1–17. https://doi.org/10.1186/s12913-016-1707-9.

[5] Gita, Sen, Bhavya Reddy, Aditi Iyer, and Shirin Heidari. 2018. "Addressing disrespect and abuse during childbirth in facilities." *Reproductive Health Matters*, 26:53, 1-5, DOI:10.1080/09688080.2018.1509970To.

[6] Bachrach, Christine A. 2014. "Culture and Demography: From Reluctant Bedfellows to Committed Partners." *Demography 51* (1): 3–25. https://doi.org/10.1007/s13524-013-0257-6.

[7] Marcelin, Jasmine R., Dawd S. Siraj, Robert Victor, Shaila Kotadia, and Yvonne A. Maldonado. 2019. "The Impact of Unconscious Bias in Healthcare: How to Recognize and Mitigate It." *The Journal of Infectious Diseases* 220 (Supplement_2): S62–73. https://doi.org/10.1093/infdis/jiz214.

[8] Adgoy, E. T. 2019. "Social determinants of non-communicable disease." *MOJ Public Health*. 2019;8(4):149-152. DOI: 10.15406/mojph.2019.08.00300.

[9] Maani, Nason, and Sandro Galea. 2020. "COVID-19 and Underinvestment in the Health of the US Population." *Milbank Quarterly* 98 (2): 239–49. https://www.milbank.org/quarterly/articles/covid-19-and-underinvestment-in-the-health-of-the-us-population/.

[10] Hogan, J. W., N. Galai, and W. W. Davis. "Modeling the Impact of Social Determinants of Health on HIV." *AIDS Behav.* 2021 Nov;25 (Suppl 2):215-224. doi: 10.1007/s10461-021-03399-2. Epub 2021 Sep 3. PMID: 34478016; PMCID: PMC8414021.

[11] Shakibazadeh, E., M. Namadian, M. A. Bohren, J. P. Vogel, A. Rashidian, V. Nogueira Pileggi, S. Madeira, et al. 2018. "Respectful Care during Childbirth in Health Facilities Globally: A Qualitative Evidence Synthesis." *BJOG: An International Journal of Obstetrics & Gynaecology* 125 (8): 932–42. https://doi.org/10.1111/1471-0528.15015.

[12] World Health Organization (WHO). 2022. *Global Competency and Outcomes Framework for Universal Health Coverage*. Geneva: World Health Organization. License: CC BY-NC-SA 3.0 IGO.

[13] World Health Organization (WHO). 2022. *Global Competency and Outcomes Framework for Universal Health Coverage*. Geneva: World Health Organization. License: CC BY-NC-SA 3.0 IGO.

[14] World Health Organization (WHO). 2022. *Global Competency and Outcomes Framework for Universal Health Coverage*. Geneva: World Health Organization. License: CC BY-NC-SA 3.0 IGO.

[15] United States Agency for International Development (USAID). 2018. Human Resources for Health in 2030 (HRH2030). Defining and advancing a gender-competent family planning service provider: a competency framework and technical brief. Washington, DC: USAID. HRH2030; 2018. https://www.hrh2030program.org/wp-content/uploads/2019/06/Defining-and-Advancing-a-Gender-Competent-Family-Planning-Service-Provider_A-Competency-Framework-and-Technical-Brief.pdf.

[16] World Health Organization (WHO). 2022. *Global Competency and Outcomes Framework for Universal Health Coverage*. Geneva: World Health Organization. License: CC BY-NC-SA 3.0 IGO.

[17] Browne, Annette J., Colleen Varcoe, Josée Lavoie, Victoria Smye, Sabrina T. Wong, Murry Krause, David Tu, Olive Godwin, Koushambhi Khan, and Alycia Fridkin. 2016. "Enhancing Health Care Equity with Indigenous Populations: Evidence-Based Strategies from an Ethnographic Study." *BMC Health Services Research* 16 (1): 1–17. https://doi.org/10.1186/s12913-016-1707-9.

[18] Hook, J. N. 2013. "Cultural Humility: Measuring openness to culturally diverse clients." *Journal of Counseling Psychology*.

[19] Browne, Annette J., Colleen Varcoe, Josée Lavoie, Victoria Smye, Sabrina T. Wong, Murry Krause, David Tu, Olive Godwin, Koushambhi Khan, and Alycia Fridkin. 2016. "Enhancing Health Care Equity with Indigenous Populations: Evidence-Based Strategies from an Ethnographic Study." *BMC Health Services Research* 16 (1): 1–17. https://doi.org/10.1186/s12913-016-1707-9.

[20] Child Rights International Network (CRIN). 2017. *Glossary of Human Rights Terms*. London: CRIN. https://www.crin.org/en/library/publications/glossary-human-rights-terms.

[21] Krieger, N. 2001. *A Glossary for Social Epidemiology. Journal of Epidemiology and Community Health.* 2001; 55(10): 693-700. Available at https://jech.bmj.com/content/55/10/693.long

[22] World Health Organization (WHO). 2015. *Glossary. Health in All Policies: Training Manual*. Geneva: WHO. http://who.int/social_determinants/publications/health-policies-manual.

[23] World Health Organization (WHO). 2022. *Global Competency and Outcomes Framework for Universal Health Coverage*. Geneva: WHO. License: CC BY-NC-SA 3.0 IGO.

[24] Centers for Disease Control and Prevention (CDC). 2014. *Definitions: Social Determinants of Health.* Atlanta: CDC. https://www.cdc.gov/nchhstp/socialdeterminants/definitions.html.

[25] World Health Organization (WHO). 2015. *Glossary. Health in All Policies: Training Manual*. Geneva: WHO. http://who.int/social_determinants/publications/health-policies-manual.

[26] Browne, Annette J., Colleen Varcoe, Josée Lavoie, Victoria Smye, Sabrina T. Wong, Murry Krause, David Tu, Olive Godwin, Koushambhi Khan, and Alycia Fridkin. 2016. "Enhancing Health Care Equity with Indigenous Populations: Evidence-Based Strategies from an Ethnographic Study." *BMC Health Services Research* 16 (1): 1–17. https://doi.org/10.1186/s12913-016-1707-9.

[27] Global Competency and Outcomes Framework for Universal Health Coverage. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO.

[28] Commission on Social Determinants of Health. 2008. Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization.

[29] 3-D Commission. 2021. Data, social determinants, and better decision-making for health: The report of the 3-D Commission. Boston: 3-D Commission.

[30] Alderwick, Hugh, and Laura M. Gottlieb. 2019. "Meanings and Misunderstandings: A Social Determinants of Health Lexicon for Health Care Systems." *The Milbank Quarterly* 97 (2): 407–19. https://doi.org/10.1111/1468-0009.12390.

[31] Alderwick, Hugh, and Laura M. Gottlieb. 2019. "Meanings and Misunderstandings: A Social Determinants of Health Lexicon for Health Care Systems." The Milbank Quarterly 97 (2): 407–19. https://doi.org/10.1111/1468-0009.12390.

[32] Glossary. Health in All Policies: Training Manual. World Health Organization 2015. http://who.int/social_determinants/publications/health-policies-manual.

[33] Link, B. G., and J. C. Phelan. 2001. "Conceptualizing stigma." *Annu Rev Sociol*. 27:363–385.

[34] National Collaborating Centre for Determinants of Health. 2022. *Glossary of essential health equity terms*. Antigonish, NS: National Collaborating Centre for Determinants of Health, St. Francis Xavier University.

[35] Browne, Annette J., Colleen Varcoe, Josée Lavoie, Victoria Smye, Sabrina T. Wong, Murry Krause, David Tu, Olive Godwin, Koushambhi Khan, and Alycia Fridkin. 2016. "Enhancing Health Care Equity with Indigenous Populations: Evidence-Based Strategies from an Ethnographic Study." n.p.: BMC Health Services Research 16 (1): 1–17. https://doi.org/10.1186/s12913-016-1707-9.

[36] Adapted from definition on https://equity.ubc.ca/resources/equity-inclusion-glossary-of-terms/ and Cuellar NG. 2017. "Unconscious bias: What is yours?" *Journal of Transcultural Nursing*; 28(4):333-333. doi:10.1177/10436596177135666.

The Local Health System Sustainability Project (LHSS) under the United States Agency for International Development (USAID) Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support access to universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year project will build local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

This brief was made possible by the support of the American people through USAID. The contents are the sole responsibility of the authors and do not necessarily reflect the views of USAID or the United States government.