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Theory of change for integrating social determinants of health into education, training and service delivery

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Local Health System Sustainability Project (LHSS)
Task Order 1, USAID Integrated Health Systems IDIQ

Local Health System Sustainability Project

The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support 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, $209 million project will build local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

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ACRONYMS

LHSS	Local Health System Sustainability Project
SDoH	Social Determinants of Health
ToC	Theory of Change
USAID	United States Agency for International Development
WHO	World Health Organization

1. INTRODUCTION

The social determinants of health (SDoH), that is, the set of circumstances in which people are born, grow, live, work and age, drive health inequalities and impact the health, wellbeing, and economic productivity of populations.[1] The distribution of money, power and resources influenced by a broad range of policy choices, globally, nationally and locally, shape these circumstances. [2] Socially stratifying forces, such as place of residence, race, ethnicity, culture, language, occupation, gender, religion, education, and socioeconomic status drive inequities across populations for incidence of disease, health outcomes, and access to health care. [3]

While action is required on multiple levels to address the structural determinants of health inequities, the health workforce plays a key role in mitigating the effects of the SDoH. Evidence suggests that not only do SDoH affect access to care, but the quality-of-care patients receive. [3] To deliver relevant quality care effectively and equitably, the workforce including health professionals, planners, and health managers, must understand the complex factors and SDoH that impact patients and communities and possess competencies aimed at reducing their effect. [4, 5]

Core Activity 10 of the Local Health System Sustainability (LHSS) project — seeks to identify, analyze, and document examples of successful efforts in integrating social determinants of health (SDoH) into health workforce education, training, and service delivery for improved quality of care and equity in health outcomes with a focus on Low-and Middle-Income Countries (LMIC). The scoping review that is a part of Activity 10 revealed thousands of articles, documents and reports highlighting the importance and impact of the SDoH and calling for addressing them at policy and community levels in both LMICs and from High Income Countries (HIC). At the same time, available literature reflects the lack of integrated approaches to addressing SDoH and the dearth of implementation research and systematic assessment of the impact of SDoH interventions on clinical practice and patient outcomes. The current body of knowledge on health workforce education and SDoH comes from HIC and tends to focus on describing specific courses and learning outcomes but is limited in terms of information about downstream impacts related to the effect on clinical practice, quality of care and equity outcomes.

Yet there are examples from LMICs where an understanding of SDoH has informed both institutional and instructional strategies and the curricular content of health workforce education institutions. [6,7] While more research is needed to understand the influence of individual institutional and instructional factors related to integrating SDoH in their programs, evaluation of the impact of such institutions that employ strategies often associated with social accountability, suggest that integrated SDoH-informed strategies can improve the relevance and quality of care and reduce health inequities. These strategies incorporate SDoH into the education and training of health workers throughout the curriculum. They also provide learners with opportunities to work in and with communities struggling with the negative effects of the unaddressed SDoH. In addition, the institutions themselves and their learners and graduates work closely with partners across health cadres and sectors to identify and address the SDoH in vulnerable communities.

Given the complexity of the causes and effects of the SDoH and the multitude of stakeholders and interventions needed, creating a Theory of Change (ToC) can help those seeking to develop interventions to address and mitigate the effect of the SDoH on health. It helps stakeholders explore causal pathways to change and identify necessary inputs, outputs, outcomes and conditions needed to achieve specific goals. It helps identify underlying assumptions and needed interventions and identify who needs to be involved in identifying problems and crafting solutions. A ToC should be a living document that guides evaluations but may also need to be adjusted to reflect new evidence or understanding.

Addressing the SDoH is highly context-driven and each institution, community, region or country will need to adapt their ToC, strategies and stakeholder engagement to their local context. Hence the draft ToC presented here focuses on interventions related to building the capacity of the health workforce to

address or mitigate the effect of the SDoH. The ToC elements and assumptions are based on currently available resources and experiences and should only be seen as a starting point for the stakeholder discussions that need to take place in each setting.

2. THEORY OF CHANGE NARRATIVE

2.1 PROBLEM STATEMENT

While there isn't agreement on the exact level of influence of the SDoH, a review by Donkin and al suggests that they contribute to between 45 and 60 percent of the difference in health status among different populations within and among countries. [6]

A major barrier to achieving equity in health outcomes is the limited knowledge on how best to address the causes and consequences of SDoH and factors beyond the health sector. To deliver quality care effectively and consistently, health workers, managers, and planners need to understand the SDoH and the multi-sectoral approaches and resources needed to address the structural determinants of health inequities. Acquiring core competencies for addressing SDoH will enable and empower workers and leaders at all levels of the health system to collaborate with stakeholders and integrate action on SDoH into health programs and the provision of care. This could range from advocating for policies that impact health across other sectors (e.g., education, transport, sanitation, housing, or the environment), or educating service providers in particular on the social and economic factors that may for example affect patients' vulnerability and exposure to risk and to their behavior, response to treatment plans, medication adherence or ability to follow sanitary requirements.

2.2 GOAL OF INTEGRATING SDOH INTO EDUCATION, TRAINING AND SERVICE DELIVERY

At the center of the ToC presented here (See Figure 1) are the people that interventions seek to affect i.e. communities and patients and particularly those most vulnerable to the negative effects of the SDoH. The specific goal or desired impact of SDoH interventions should be defined by the stakeholders involved in achieving it. In this ToC the goal was made broad:

The population will benefit from improved access to quality health care, and social services and social protection that they need.

Key Assumptions

1. Adequate leadership, commitment and resources, systems and services are in place so that individuals and communities have appropriate health coverage, protection and can afford and access needed care.
2. Health and social care workers have the competencies to incorporate considerations related to the SDoH into educating patients, promoting healthy behaviors and preventive measures, treatment plans and/or collaborative efforts to get the services they need.

2.3 HEALTH WORKFORCE

The World Health Organization (WHO) defines the health workforce as "all people engaged in actions whose primary intent is to enhance health." They include everyone from community health workers, to planners, health facility and a range of clinicians and health and social care providers. Their roles and

responsibilities vary and any interventions will have to reflect differing roles and responsibilities. However, the importance of creating and managing effective and efficient health and social care teams that work together and with people and organizations outside the health sectors to improve the health of individuals and populations is well recognized. As a result, interprofessional and inter-sectoral learning and practice are often seen as key to addressing the SDoH.

Key Interventions

1. All members of the health workforce, from planners and educators to clinicians and community health workers, are educated about key elements of the SDoH, including their impact on health, behavior and treatment adherence, how systems and services or lack therefore affect health, and their competencies should be obtained and assessed including through practical experiences and service learning in underserved and vulnerable communities.
2. Health workers and clinicians demonstrate competencies related to listening, communicating, working and collaborating with patients, communities and partners from across different professions and cadres so that problems can be addressed and solutions co-created.
3. Health workers/clinicians' SDoH competencies are assessed and upgraded through lifelong learning, in-service and continuous professional development approaches and quality assurance systems.

Key Outcomes

1. Health and social care teams screen patients for SDoH, incorporate SDoH into treatment plans and collaborate to provide patients with the care and services they need.
2. Health and social care teams advocate for and contribute to developing effective community-based health education, screening, prevention and primary care systems in collaboration with other stakeholders including the specific communities being served.
3. Building on the assets of communities and all other partners and through cross-sector collaboration the effect of the SDoH is mitigated and patients are empowered and engaged.

Key Assumptions

1. The leadership of the organizations, institutions and facilities that employ health workers are committed to and allocate resources to addressing the SDoH.
2. Health workers and clinicians need to have the time and access to resources and tools that help them screen for SDoH-related challenges and address the SDoH of their patients and the communities they serve.
3. The facilities, programs and supervisors that health workers/clinicians work for, understand the SDoH, offer an enabling environment and are supportive of health workers/clinicians efforts to address the SDoH.
4. Health workers/clinicians are located close enough and are affordable enough for vulnerable communities to access care when they need it.

2.3.1 HEALTH WORKFORCE EDUCATION INSTITUTIONS

To ensure the health workforce has the SDoH competencies they need, they must undergo training and education. A range of private and public academic and non-academic institutions and organizations are

involved in educating and training the health workforce from pre-service or foundational education, through in-service training and continuous professional development (CPD.) The type of institutions/organizations they are, how and by whom they are regulated and overseen, and the resources and capacities they have to provide education or training varies widely between and within countries and among health cadres. For example, how education is funded can also affect the quality of education. In some countries, some public institutions have limited support and oversight from government levels so they must rely on student fees to operate. This reliance on fees sometimes leads to student admission being far beyond what the infrastructure, faculty and programs are able to handle. Rapid growth in for-profit health training institutions has emerged in some countries and there are concerns over the lack of oversight and quality assurance of these programs. [10] In other countries, institutions have limited or no control on student/trainee admissions policies or curricula. Therefore, interventions aimed at improving how health workforce education institutions/organizations address and incorporate the SDoH and health equity into the instructional and institutional strategies and policies must reflect the resource-availability, operational, regulatory and policy context where the intervention is to take place.

Key Instructional Interventions

1. Curricula integrate the development of SDoH-related competencies including the key causes of health inequities and health disparities in the region the institution serves into the training of all cadres of the health workforce.
2. Learners gain practical experiences of SDoH by engaging in experiential and service-learning and community engagement in underserved and/or vulnerable communities.
3. Learners practice working in teams by participating in interprofessional and/or cross-sector learning.

Key Outcomes

1. The production of health workforce graduates is aligned with current and projected health system workforce needs.
2. Health workforce graduates possess competencies to advocate and screen for as well as address the SDoH either directly or by referring or collaborating with relevant service providers.
3. Health workforce graduates possess the competencies to work in underserved and vulnerable communities where resources might be scarce.
4. Health workforce graduates have competencies to build on the assets of communities and external partners, work in interprofessional and cross-sectoral teams and are able to develop effective partnerships with and in communities and across sectors.

Key Institutional Interventions

1. Investment in multi-stakeholder curricula review, adequate infrastructure and the human and material resources needed to provide relevant quality training in classroom as well as community and primary care settings.
2. Educational organizations and institutions responsible for health workforce governance, such as ministries of health and health professional councils, design and implement policies and strategies aligned with priority needs and key SDoH. These policies aim at addressing inequities in the regions they serve such as policies on student admission and support, faculty recruitment, training and

promotion policies and research. This includes policies and practice related to gender equality and social inclusion.

3. Communities have input into the design, implementation, and evaluation of health workforce education.
4. Institutions engage key stakeholders including vulnerable communities in decision-making processes, program design and evaluation and form strong partnerships with relevant public, private and the civil-society actors.
5. The impact of instructional and institutional interventions, processes and partnerships are assessed and strategies, policies and programs are adjusted to reflect new knowledge and evidence.

Key Assumptions

1. Institutional leadership committed to addressing health inequities and the SDoH.
2. Ministries and professional councils support, and education and training institutions have the power to shape, policies such as student selection and change in curricular content to address the SDoH.
3. Education and training institutions have the human, financial resources, capacities and infrastructure to provide faculty and learners with the competencies and experiences required to address SDoH.

2.4 HEALTH SERVICES

According to the WHO, the building blocks of the health systems are service delivery, health workforce, information, medicines, financing, and governance. While each of the building blocks should be examined when designing SDoH related interventions, this ToC only highlights key elements and interventions that relate to preparing and supporting the health workforce to address and/or mitigate the effect of the SDoH and particularly the quality, relevance and equity of the services they deliver.

Key interventions

1. Investment and design of facilities, processes, protocol and systems at service delivery sites that include resources and a focus on the SDoH, collection and sharing of data that inform and provide evidence to design or adjust interventions, programs and policies at local and national levels.
2. Health workers/clinicians have access to tools, data and processes that support SDoH screening and referral to other services and programs.
3. In-service training, CPD, mentoring and supervision is supportive of addressing the SDoH.
4. Service facilities partner with communities and other stakeholders in the design, implementation and evaluation of services and programs.

Key Outcomes

1. Facilities and providers deliver patient-centered, integrated services and SDoH-related problems are identified and addressed in and with patients and communities and in collaboration with partners across different sectors and services.

2. The health workforce is equipped and supported to screen and advocate for and act on the SDoH of individuals including adapting clinical decision-making to reflect the social risks and circumstances patients are living with and/or identify solutions that directly improve patients' social situation.
3. The competencies of the health workforce are continually improved and aligned with emerging evidence and best practice.
4. Health care providers and leaders have up to date information that can help identify gaps and priorities for action.
5. Health care resources are maximized by building on the assets, expertise and actions of partners outside the health sector and collaborations to reduce exposure, vulnerabilities and the impact of the SDoH on the health of the patients and communities that clinicians/providers and facilities serve.

Key Assumptions

1. There is commitment at the highest level of the health system or facility to address the SDoH.
2. There is adequate investment in a well-trained and well-supported health workforce and infrastructure not only at the secondary and tertiary, but at primary care and community levels.
3. Health system stakeholders have the resources, capacity, and ability to work across sectors to implement interventions.

2.5 PATIENTS AND COMMUNITIES

Patients and communities need to be respected partners in understanding and addressing health and SDoH related problems. They need to be educated and empowered to ask questions and voice their concerns so that care providers, facility managers and health and other authorities fully understand their context and challenges so that solutions can be co-created. Patients and community members should be involved in creating and enforcing mechanisms to hold care providers, facilities, and authorities accountable and involved in developing theories of change for interventions and programs. Research shows that when individuals and communities are meaningfully involved in well-designed and well-supported governance interventions such as social accountability processes, such efforts can increase trust in facilities and health authorities, reduce corruption and improve the quality and equity of care. [11].

Key Interventions

1. Managers and service providers listen to patients and communities and seek to build mutual trust.
2. Patients receive patient-centered and integrated services, and they and their communities are educated about the effects of the SDoH and are engaged in identifying health and health-related challenges as well as in identifying appropriate and effectives solutions to address them.
3. Communities have input into the design, implementation, and evaluation of health service delivery.
4. Communities have input into the design, implementation, and evaluation of health workforce education.
5. Communities are organized and engaged to assess and mobilize resources, to address SDoH and to hold service providers, facilities and the health system accountable.

Key Outcomes

1. Patients are empowered and engaged in addressing their own health challenges and are more likely to engage in healthy behaviors and trust the guidance of health professionals.
2. Communities hold health facility managers, health professionals, and health systems leaders accountable for quality, equitable care.
3. Community and patients' assets and existing capacities optimize resources available for health and social care services.

Key Assumptions

1. Trust, circumstances, and conditions are such that patients and communities feel enabled and empowered to speak their mind, co-create solutions, share their capacities and resources and hold the health workforce and service providers accountable.
2. Resources, structures and mechanisms are in place to provide platforms for collaboration and accountability.

2.6 POLICIES, SYSTEMS AND GOVERNANCE

A multitude of processes and decision-making, policies, regulations, systems, data collection and management, and accountability mechanisms at local, regional, national, and global levels affect the building blocks of the health system including workforce and services and ultimately health outcomes. Key ministries, agencies and bodies as well as processes such as accreditation and quality assurance affect the education, training and service delivery of health workers. There are multiple global policy guidance documents and quality standards available for different the education and professional qualification for different cadres and clinical facilities aimed at improving the education of the health workforce and the quality of care. The WHO's National Health Workforce Accounts calls for countries to report on whether they address the SDoH and whether institutions that educate health workers are accredited. It also includes reporting on whether education institutions are socially accountable, which assumes they address the SDoH. However, countries approach quality assurance and accreditation of health workforce education institutions differently and apply different mechanisms for the application or enforcement of standards. Many lack the resources to adequately enforce standards and different organizations and agencies are involved in quality assurance. In some countries, there is for example limited oversight of private educational and service delivery facilities. Regulation of different cadres and scope of practice also differs across contexts. To date accreditation and quality standards frequently do not incorporate competencies or services relevant to the SDoH. Addressing challenges at this level of intervention therefore requires careful consideration including an analysis of political and power dynamics and multistakeholder engagement processes and discussions.

These elements and potential stakeholders should be included in discussions and decision-making when developing ToC for SDoH interventions. In this ToC we will only focus on those that most affect education, training and service delivery of the health workforce as it relates to the SDoH.

Bodies Responsible for Information And Human Resources For Health Management Systems

Key Interventions

1. Health information systems collect data on the impact of SDoH and interventions to address them, identify community-based assets related to SDoH, measure population vulnerabilities and monitor health equity indicators.
2. Human Resources Management systems include SDoH competencies in performance management and promotional policies.

Key Outcomes

1. Policymakers, planners, managers and service providers have up-to-date and actionable information to guide planning and implementation for 1) preparedness and response to urgent crises such as outbreaks and pandemics, 2) for longer-term planning for non-health sector interventions, and 3) for strengthening the health system at community, primary, secondary and tertiary care levels.
2. HRH planners and policymakers monitor key health workforce competencies, including addressing the SDOH, and routinely identify and address gaps as population needs change.

Accreditation and Quality Assurance Bodies

Key Interventions

1. Context-relevant SDoH competencies are incorporated into education and CPD standards for all health workforce cadres.
2. Standards and mechanisms to ensure quality of health services and clinical training sites incorporate SDoH considerations, including issues related to gender equality and social inclusion.
3. Ensuring that regulations and regulatory frameworks incorporate SDoH considerations, including issues related to gender equality and social inclusion.

Key Outcomes

1. Accreditation and professional quality assurance mechanisms and standards (such as health worker licensure) ensure that the health workforce possesses and applies SDoH competencies.
2. Accreditation and quality assurance mechanisms and standards address issues related to gender and social inclusion.
3. Health facilities and clinical sites provide programs, services or referrals that reduce patients and communities' vulnerabilities and improve quality and equity of care by addressing the SDoH.
4. Regulations and regulatory frameworks foster cross-sectoral approaches and patient-centered methods to ensure patients receive quality care and services they need.

Key Assumptions

1. The country has the commitment, resources and capacities to develop and/or enforce accreditation and quality assurance standards for all education institutions and health worker cadres.
2. The country has the commitment, resources and capacities to develop and/or enforce accreditation and quality assurance standards for all health facilities and clinical training sites.

3. Regulations are aligned with addressing the SDoH and enforcement mechanisms are in place and have the resources to enforce regulations and adjust them should that be needed.

2.6.1 POLICYMAKERS, RELEVANT MINISTRIES AND AGENCIES

Key interventions

1. National, regional and local planning incorporates stakeholders from relevant sectors and affected communities to plan, design and evaluate programs.
2. Governments at all levels engage in incorporating Health in All Policies approaches.
3. Health and workforce plans include explicit goals and interventions related to addressing the SDoH.

Key Outcomes

1. Health care resources are maximized by building on the assets, expertise and actions of partners outside the health sector and collaborating to reduce vulnerabilities, thereby reducing the impact of the SDoH on the health of patients and communities.

Key Assumptions for Policies, Systems and Governance

1. There is commitment at the highest level of the local, regional and/or health system and government to address the SDoH.
2. There is commitment at health system leadership levels to address the SDoH.
3. There is adequate investment in a well-trained and well-supported health workforce and infrastructure not only at secondary and tertiary, but at primary care and community levels.
4. Health system stakeholders have the resources, capacity and ability to work across sector to implement interventions.

2.7 FORCES THAT AFFECT ALL INTERVENTIONS AND STAKEHOLDERS

The WHO's Commission on Social Determinants of Health (CSDH) Conceptual Framework for Action on the Social Determinants of Health informed the development of the ToC and key elements are mentioned as *Forces* in the ToC [9]. It stresses the importance of understanding how the socioeconomic and political context shapes health of individuals, populations, and the health system itself. Understanding the specific context of a country, region, or population group, is needed to develop effective policies and interventions to reduce the negative effect of SDoH. The CSDH defines context as "…all social and political mechanisms that generate, configure and maintain social hierarchies."[9]

According to the CSDH there are six important contextual factors that must be considered: (1) governance, that includes elements such as civil society participation, social accountability and discrimination patterns; (2) macroeconomic policy; (3) social policies such as those related to the labor market, land and housing; (4) public policies in relevant sectors including education and social protection policies; (5) cultural and societal values; and (6) epidemiological conditions in the country or region, such as scope and effect of major epidemics such as HIV/AIDS.

These contextual factors in turn affect Intermediary Determinants of SDoH. They include exposure to risk and vulnerability brought on by various factors such as material circumstances, health enhancing or damaging behaviors, biological factors, gender, and psycho-social factors such as living in stressful circumstances. All these factors shape the contextual and operational environment of stakeholders and SDoH interventions.

Figure 1: Theory of Change for Integrating SDoH into education, training and service delivery

Ultimate Goal: All patients feel empowered and engaged and receive the quality health care, social services and social protection that they need													
Outcomes	**Health Workforce** Health & social care teams advocate & screen for SDoH, incorporate into treatment plans & collaborate to provide needed care & services						**Health Services** Patient-centered, integrated services and SDoH-related problems are identified and addressed in and with communities & in collaboration with partners across sectors and services			**Patient & Communities** engage in healthy behaviors, trust and follow the directions of health professionals		**Policies, Systems, Governance** Governance is strengthened, systems aligned and resources are used more efficiently, maximizing the impact of health and social care services and health of patients and communities		
Stake-holders	**Health Workforce Education Institutions**						**Health Service Facilities**			**Patients**	**Communities**	**Information & HRH Mngt. Bodies**	**Accreditation & Quality Assurance Bodies**	**Policymakers, Relevant Ministries & Agencies**
	Institutional			Instructional			Organization	Tools	Staff					
Interventions	Policies incl. decision-making, student admission, faculty recruitment, training & promotion, target inequities and SDoH	1.Stakeholders incl. vulnerable communities are involved in decision-making, program design evaluation 2. Institutions support cross-disciplinary collaboration & form strong partnerships with public, private and civil-society actors	The impact of instructional and institutional interventions, processes and partnerships are assessed, & strategies, policies & programs are adjusted to reflect new knowledge and evidence	Curricula integrate the development of SDoH-related competencies including the key causes of health inequities in the region the institution serves into the training of all cadres of the health workforce.	Learners practice working in teams by participating in interprofessional and/or cross-sector learning by working with communities to solve SDoH-related problems	Learners gain practical experiences of SDoH by engaging in service-learning and community engagement in vulnerable communities	1. Investment & design of facilities, protocols & systems done in collaboration with partners focusing on SDoH 2.Collection & sharing of data to inform interventions programs & policies	Health workers/clinicians have access to tools, data and processes that support SDoH screening and referral to other services and programs	In-service training, CPD, mentoring & supervision supports addressing the SDoH	Trust is built, & patients are educated about the effect of SDoH and are engaged in identifying challenges as well appropriate and effectives solutions to address them	1. Have input into the design, implementation, and evaluation of health service delivery 2.Have input into the design, implementation, and evaluation of health workforce education 3.Are organized & mobilize resources & hold system & services providers accountable	1.Health information systems collect data on SDoH, community-based assets, track population vulnerabilities & monitor health equity indicators 2.HRM Systems include SDoH competencies in performance management and promotional policies	1.SDoH competencies incorporated into education & CPD standards for all health workers and institutional standards 2.Standards & processes to ensure health services & clinical training sites incorporate SDoH. 3.Regulations incorporate SDoH considerations.	1.National, regional and local planning & evaluation incorporates stakeholders from relevant sectors and affected communities 2.Health in All Policies approaches applied including explicit priority setting on how to address the SDoH
Forces	**STRUCTURAL DETERMINANTS-SOCIAL DETERMINANTS OF HEALTH INEQUITIES** **Socioeconomic and Political Context (governance, economic, social and public policies, culture and societal values)** **Social Hierarchies (Class & access to resources, power, prestige & discrimination)**									**INTERMEDIARY DETERMINANTS OF SDoH** **Exposure to Risk – Vulnerabilities ie. compromising conditions**				
Key Assumptions	1.Institutional leadership committed to addressing health inequities and the SDoH 2. Education and training institutions have the power to decide on policies such as student selection and change in curricular content to address the SDoH 2.Education and training institutions have the human, financial resources, capacities and infrastructure to provide faculty and learners with the competencies and experiences required to address SDoH.						1.There is commitment at facility leadership level to address the SDoH. 2.There is adequate investment in a well-trained and well-supported health workforce and infrastructure to provide needed services. 3.Facilities have the commitment, resources, capacity and ability to work across sector to design and implement interventions			1.Trust, circumstances and conditions are such that patients and communities feel enabled and empowered to speak their mind, co-create solutions, share capacities and resources and hold the health workforce and service providers accountable. 2.Resources, structures and mechanisms are in place to provide platforms for collaboration and accountability		1.There is commitment at the highest level of government to health in all policies and cross-ministerial and cross-sector collaboration 2. There is commitment at health system leadership levels to address the SDoH. 3.There is adequate investment in a well-trained and well-supported health workforce and infrastructure not only at secondary and tertiary, but at primary care and community levels. 4.Health system stakeholders have the resources, capacity and ability to work across sector to implement interventions		

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