

Chapter 2

Putting the ‘Social’ Back in: Social Determinants of Health as a Methodological Lens

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Abstract The messages of the SDH Commission report are not necessarily novel but they have an additional significance in the current climate of health, which witnesses the failure of the Alma Ata declaration of achieving ‘Health for All’ with increasing evidence on persistent inequities in different parts of the world. The significance of the report also lies in the fact that it provides an apt forum for a *dialogue* among disciplines (roughly between social science disciplines including humanities and conventional health sciences) and different stakeholders including academics, practitioners and civil society advocacy groups. It signals the ‘coming together’ of a diverse set of actors/perspectives/methodologies that are, more importantly, liberating the study of health from a narrow lens of biomedicine in the common pursuit of striving towards health equity. The spirit of dialogue is hence critical as several concerns relating to conceptualization (the unpacking of the ‘social’) and operationalization (identifying actions on the social determinants and developing indicators for monitoring inequalities) emanate from such a conversational space among the different actors and disciplines involved. In the spirit of such a conversation, this chapter talks about what the ‘social’ in social determinants of health entails and its implications in terms of research and actions. It argues that social determinants of health needs to be seen as a methodological lens than rediscovering a new set of factors or causes leading to inequity.

Keywords Commission on social determinants of health • Methodology
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Locating the WHO Commission Report

Social justice is a matter of life and death. [...] The Commission calls on the WHO and all governments to lead global action on the social determinants of health with the aim of achieving health equity. It is essential that governments, civil society, WHO, and other global organizations now come together in taking action to improve the lives of the world's citizens. Achieving health equity within a generation is achievable, it is the right thing to do, and now is the right time to do it [1].

These excerpts from the report of the World Health Organization's (WHO) Commission on the Social Determinants of health (hereafter referred to as CSDH) powerfully sum up its mandate, thrust and key messages. The report offers three messages: the first is a forceful reminder that 'social' determinants matter in addressing health inequity. The second conveys that practices of inequities are unnatural, avoidable and preventable through appropriate actions on SDH and the third is a plea for collective actions on health inequity thus putting equity and social justice at the centre stage of discussions on health policies, programs and practices. The setting up of the commission and its subsequent report have generated a lot of discussions and debates about its mandate and content as much as the viability of its recommendations [2–6]. The messages of the CSDH report are not necessarily novel but they have an additional significance in the current climate of health which is witnessing the failure of the Alma Ata declaration of achieving 'Health for All' with increasing evidence on persistent inequities in different parts of the world. On the other hand, several national governments in different countries are seemingly putting forward the agenda of universal health coverage and revitalization of primary health care. The Commission report comes as a timely reminder to focus on the 'right thing at the right time' as academics and practitioners are increasingly wary of the changing discourse in the clamor for Universal Health Coverage that might entail package of health care services for specific diseases alone than ensuring Health for All [7–12]. The CSDH report reinstates a social perspective of health in the discussion of Health for All/universal health coverage.

The significance of the report also lies in the fact that it provides an apt forum for a *dialogue* among disciplines (roughly between social science disciplines including humanities and conventional health sciences) and different stakeholders including academics, practitioners and civil society advocacy groups. It signals the 'coming together' of a diverse set of actors/perspectives/methodologies that are, more importantly, liberating the study of health from a narrow lens of biomedicine in the common pursuit of striving towards health equity.¹ The report signals the reorientation of the established hierarchy of medical knowledge by pushing 'social knowledge' on health from the 'rear to the fore of health assessment' [13].

¹The social composition of the nine knowledge networks makes it a truly multidisciplinary exercise drawing on disciplines as well as professional backgrounds (academics, researchers, activists and practitioners). The very identification of the knowledge networks including early childhood, gender equity, health systems, social exclusion, urban settings, and employment conditions, demonstrate the inclusive understanding of health.

The spirit of a dialogue is hence critical, as several concerns relating to conceptualization (the unpacking of the 'social') and operationalization (identifying actions on social determinants and developing indicators for monitoring inequalities) emanate from such a conversational space among the different actors and disciplines involved. In the spirit of such a conversation, this chapter talks about what the 'social' in social determinants of health entails and its implications in terms of research and actions. It argues that social determinants of health needs to be seen more as a methodological lens with which to approach health equity than as the rediscovering a new set of causes or factors leading to inequity.

Framing the 'Social' in Social Determinants of Health

An important point of contestation has been to understand the 'social' in social determinants of health, or more simply the question is often asked 'what are the social determinants of health?'. Are x, y, z social determinants? Framing the 'social' in social determinants of health is a methodological question rather than a mere listing of factors affecting health/ill health and bracketing these as social/political/ecological or cultural determinants. Social determinants of health is not a new phrase. For social scientists, this phrase is self-evident as their work necessarily locates health in society—its institutions, norms, social categories and processes. However, this phrase has an added meaning with the works of McKeown [14], Illich [15], the UK Black Report on Inequalities in Health (1980), Marmot [16–18] followed by others that show how social forces matter in explaining systematic differences in health outcomes leading to the popular debate on the role of biomedical/technological *vis-à-vis* social interventions (including education, housing and social welfare in addition to better medical care) in achieving equitable health outcomes [19]. SDH are thus necessarily discussed in relation to health equity. The Commission report furthers this understanding by making a conceptual distinction between SDH and SDH inequities largely to argue that it is not enough to talk about social factors that determine health but rather there is a need to identify the factors/causes that shape and reinforce health inequities thus getting at the 'causes of the causes'. It identifies these structural determinants as 'bad politics, unfair economic arrangements and unhealthy policies'. The conceptual framework (Fig. 2.1) clearly reflects this distinction, where the structural determinants of health inequities are explicitly stated as the socioeconomic and political context that includes governance, macroeconomic policies, social and public policies as well as the cultural and societal values that impact and are impacted by socioeconomic positions such as class, gender and ethnicity. Together, these influence material circumstances and individual/group behavior that may lead to inequitable health outcomes and differential experiences of ill-being/well-being.

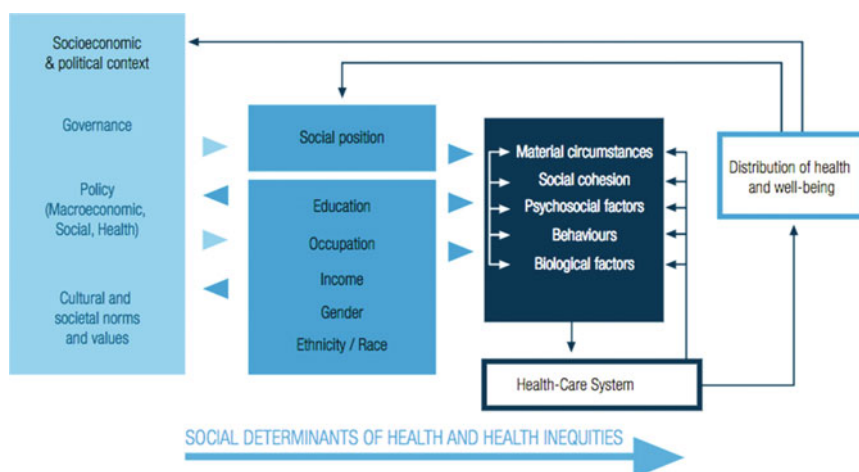


Fig. 2.1 A conceptual framework of social determinants of health (2008). *Source* (1, page 43)

The conceptual framework thus brings home an important realization that poverty by itself is not a cause of inequitable access to health services or maternal mortality, instead the larger public policies, culture of governance (that values health as a public good) and political will to combat poverty are the causes. These structural determinants resonate with the concept of structural violence, which Farmer [20] argues as the ‘social arrangements that put individuals and populations in harm’s way. The arrangements are *structural* because they are embedded in the political and economic organization of our social world; they are *violent* because they cause injury to people (typically, not those responsible for perpetuating such inequalities’) [21: 1686]. The bad politics and unhealthy policies, as Farmer (1999) would argue, are the social fault lines—the way society responds to social locations of inequality that lead to systematic differences in accessing and experiencing health. Such a social lens thus shifts the analysis and understanding of health inequities from the given social categories (caste, class, gender, poverty, education and their associated health outcomes) to structural factors and processes that act on these categories to produce inequitable health outcomes [20].

With such a conceptual framework to locate the ‘social’, the Commission makes a significant departure from a factorial and/or associational model of approaching social determinants of health that has been widely used in the existing literature.

A factorial model of SDH tends to treat ‘social’ as one set of factors, the others being cultural, nutritional, environmental, psychological or political. Such an approach is problematic for three reasons. The first, as Parker and Harper [22] argue, it gives rise to a misleading conceptual distinction between science and culture, or science and beliefs. Such an approach ‘typically reduces the investigation of social and cultural aspects of disease to discrete, static, quantifiable “beliefs” held by (or sometimes about) the study population. The separation of these beliefs from the ideal medical science and its humanistic outcome has led researchers to investigate

the barriers to the uptake of the provision of health services' [22, pp. 1–2]. Social factors (or social knowledge of health) in such a model are considered as a supplement, or an ornament to biomedical knowledge of health and health care [13]. Typically such a model would argue that marriage patterns, local notions of health promotion among the indigenous communities or gendered norms are barriers to the uptake of (bio) medical health services assuming these factors to be static and isolated from the larger political economy in which these operate [23–25].

The second concern emanates from the tendency to assume social categories (caste, gender, ethnic groups, poor and tribal) and phenomena as given. For example, a common explanation I have heard during my research among the indigenous communities in Odisha that 'they are ignorant of scientific medical practices', 'not concerned about the health of their children so do not bring their children for immunization during the Immunization Days', and 'no matter what the state does, they continue to follow their health customs' etc. Such explanations tend to attribute lack of accessing services to typical attributes of the communities while plenty of research evidence shows that community demand/uptake of health services (biomedical or otherwise) is linked to a host of factors including modes of health communications, modes of delivery of health services (through outreach clinics, camps, health centres), social relations with the health workers, previous experiences with state supported medical services, history of overall engagement with the state, and alignment of specific health services with local health priorities etc [26–29]. Attributing the uptake of services to ignorance and typical characteristics of indigenous communities thus impacting on immunization coverage would qualify for what Farmer calls 'immodest claims of causality' [20]. This is immodest because it distracts attention away from social processes and factors that do affect access to health. Further, it tends to blame the communities (projecting them as victims of ignorance or perceptions) thus naturalizing health outcomes. This is misleading as it evades actions that could be taken up to address health inequalities.

The third related discomfort with a factorial model in the study of SDH is that social factors are looked upon as apolitical. For example, gender norms impacting on health access and outcomes are not *sui generis*. Such norms have political functions serving as a means of social control or disciplining of women's bodies, be it at the household level or state level. It would hence be imperative to understand the everyday practices through which such norms are created, nurtured and reinforced. A factorial model of looking at the 'social' as a distinct, isolated set of factors thus does not help us in addressing questions of inequity.

The CSDH's framing of the 'social' also departs from approaching SDH through the logic of mere associations. There is plenty of sociodemographic and epidemiological research that establishes associations between caste, class, education, age place of residence and ethnicity, with inequitable health access and outcomes. For example, a longitudinal study conducted among a cohort of young adults in the US shows that for individuals born between 1914 and 1939, one additional year of education lowers the probability of dying by 3.6% points. This applies to older adults

too where the relationship between educational attainment and health, measured as functional ability among older people in the US showed a positive and significant relationship (0.10 level of significance) [30]. Dahl's study among the Norwegians shows how occupational status is an important predictor of ill health [31]. In India, several studies have utilized the National Family Health Survey (NFHS) data to show associations between socioeconomic variables and health indicators. Dey and Mishra [32] based on an analysis of NFHS-III data show that there is a positive association between age, gender, low income and lack of education with utilization of public health care services private health facilities in India. Other studies, in a similar vein, demonstrate a strong association between mother's education (or parental education) and utilization of maternal and child health services and health outcomes in different parts of India [33–35].

Such evidence is certainly important but it is limiting. While these studies reinforce the point that social factors including gender, caste, class, education, place of residence etc. matter in health, such associations do not explain why and how lower caste groups have inequitable access to health or why they have a higher rate of morbidity than higher castes living in the same area. Or how does mothers' education contribute to better health access and outcomes? Does greater awareness about existing health services or information about causes of a specific disease condition evidently result in better access to services? How do gender norms matter in the utilization of services and health status of women? What are the mechanisms and processes through which such norms are created, practiced and reinforced? Thus, in the language of the CSDH report, evidence on mere associations does not ask fundamental questions about the structures and processes that contribute to and reinforce such inequalities. Additionally, Saikia and Kulkarni [36] in a recent paper argue how the database on the health of the population in India is inadequate to address inequalities in health [36]. This is despite the fact that India draws on more than six different sources for the collection of data on the health status of its population. They argue that many of these surveys are inadequate to reflect on differences in health by socioeconomic groups at district levels and below, and nor do they identify causes of mortality by socioeconomic groups. The framing of the social in the CSDH report is thus beyond identifying 'social factors' (as one set of factors) or associations of social variables with health outcomes. It highlights a social perspective of health whereby the social does not merely add to the predominant form of biomedical knowledge, but shows how health and medicine are socially situated and where the social necessarily includes the political, economic and other factors.

Implications for Research

Social determinants of health as a methodological lens with which to study health equity favours the framing of research questions that demand a deeper investigation of the what, how and why. For example, such a lens, at a broad level, demands

interrogation of health inequity by asking: How does one *explain systematic* differences in access, vulnerability and outcomes in health and health care (beyond stating association)? What are the *factors, mechanisms and processes* through which these differences are produced and reinforced (beyond treating health inequity as an individualized, given and natural phenomena)? And what and which levels of *actions* are required to intervene to strive towards health equity (beyond technomanagerial solutions)?² Such a line of inquiry, Östlin et al. [37] argue, characterizes a paradigm shift in undertaking health research, demanding the application of a range of methods, perspectives and disciplinary insights largely used in the social sciences and non-biomedical sciences [37]. They explicate this paradigm shift further by identifying four key research priorities. These include the study of (1) global factors and processes that affect health equity; (2) structures and processes that differentially affect people's chances to be healthy within a given society; (3) health system factors that affect health equity; and (4) policies and interventions to reduce health inequity [37].

Such a paradigm shift has several implications in terms of undertaking research through a SDH and health equity lens. We highlight three such implications. The first requires an analysis of factors and processes of inequities at the *intersections* of multiple social locations including caste, class, race, geography etc. Intersectionality as an analytical perspective has been widely used in feminist research to demonstrate how gendered forms of oppression are an outcome of the interactions of different social locations that operate within a connected system of structures and power [38, 39]. Research using an intersectionality framework has shown how inequities never result from individual, isolated and distinct factors (only class, or gender) but are due to the ways that multiple factors intersect with one another. The usefulness of this framework to the study of SDH and health inequity is increasingly being recognized (though often not so explicitly stated as using an intersectionality framework). Samuelsen et al. [40] for example, show how poor, rural, less educated women in Tanzania are subject to systematic processes of exclusion in their efforts to seek care for their sick children. These technologies of exclusion operate in a system of inequitable power relations between health care providers and the women that get reflected in inadequate referral systems, the inefficient organization of health services and the culture of communication [40] explaining how health systems delay the treatment of poor children leading to preventable deaths. Back home, Sébastia [41] shows how patients with severe mental disorders navigate through complex processes of seeking care that are marked by gender, class, place of residence, familial and neighborhood support (and the lack of it) and the responses of the medical institutions. The narratives of these patients defy simple and singular attribution of either gender or class in determining experiences of mental health. Such research, along with many others

²IDRC, Canada has begun a Closing the Gap initiative based in the Sree Chitra Tirunal Institute of Medical Science and Technology (SCTIMST), Thiruvananthapuram in order to strengthen the capacity for undertaking health equity research in India. See for details <https://www.idrc.ca/en/project/closing-gaps-health-equity-research-initiative-india>.

studies in the Indian context and elsewhere, help to explain how multiple locations of disadvantage or multiple axes of discrimination work in ways that lead to inequitable health outcomes [42–46].

Along with intersections, a SDH lens locates research on practices of health inequity at the *interfaces* of different levels and actors—the global/national/subnational and local, the WHO with the national health bureaucracy or the interface of frontline health workers and local communities. Health equity research it requires studying up (Global level initiatives or National Health Mission) as much as studying below (the Village Health and Nutrition Days). Roalkvam et al. [47] expand the usefulness of this concept in a multidisciplinary research on explaining differential immunization coverage in India and Malawi. They seek to demonstrate how ‘interfaces’ is a useful concept in understanding how global ideas, practices and technologies on health circulate. Interfaces are sites of interactions between different levels and actors which continuously witness processes of translation and the reinterpretation of ideas and practices. Thus ideas/technologies do not flow in a simple, mechanistic way. These sites are on the one hand characterized by relatively established rules and procedures (a Village Health and Nutrition day for example is a not an ad-hoc event but has certain prescribed guidelines that are expected to be followed) and on the other by ‘the juxtaposition of distinctive and potentially conflicting sets of values, beliefs, rationalities and intentions’ (e.g., notions around institutional delivery or immunization) [44, p. 42] that make translations, reinterpretations and negotiations of policy processes integral to such interfaces. Such a concept enables not merely an examination of the flow and circulation of ideas and technologies across global-local levels but also lends a comparative lens to the understanding of the structural mechanisms at work across different sites. Mishra et al.’s [27] research on Village Health and Nutrition days in the state of Odisha in India and Outreach Vaccination Clinics in districts of Thyolo, Malawi as interfacing sites between the health system and community shows how a focus on such interfaces and observing the interactions that take place between the frontline health workers and mothers offers a granular understanding of the practices and processes that help explain either the increasing rate of immunization coverage or the rate of dropouts from the immunization schedule. As Farmer argues, what happens in Rural Haiti in terms of poor people dying of tuberculosis or HIV/AIDs cannot be comprehended through observing local factors [20]. Thus the tuberculosis deaths in rural Haiti or the local immunization practices in the remote tribal districts in south Odisha or Malawi are manifestations of transnational events/processes. Thus the immunization coverage among the tribal communities in Odisha is as much related to what happens at the sites of the Immunization Day as to the larger global focus on immunization (as part of MDG4 and beyond), the national Government’s policies on strengthening of primary health care through the National Rural Health Mission (NRHM) and how these policies unfold through mandatory Immunization Days in each village, incentivizing the health workers and installing stricter monitoring mechanisms. Thus what one witnesses in local sites is a manifestation of global policies as well as a central program like the NRHM unfolding in a specific state and further down the line through a series of translations, interpretations and

negotiations [27, 28, 48]. Interfaces like intersections are useful conceptual tools to help understand and map inequitable health practices and the processes that create and sustain them.

A SDH lens distinctly implies that health equity is a political project. It involves the systematic and explicit study of power. The study of power needs methodological sophistication in terms of framing research questions, tools used, sites explored and dissemination of research implications. In an explicit study of power to understand the processes involved in immunization policymaking, McNeill, Andersen and Sandberg examine the different sources of power and authority of a range of actors (including WHO, UNICEF, Bill and Melinda Gates Foundation, International Academic Institutions etc.) [49]. They show how understanding sources of power and how these are played out in concrete situations helps in situating the significance of emerging global alliances, the select verticality of policies and their implementation in national settings, and the continuous changing configurations among different global actors. In an interesting study in Odisha, India, Papp et al discuss how power dynamics in the social accountability process are shaped by providing opportunities and spaces for women to confront those more powerful [50]. Providing these spaces then allows for women to generate the demand for better services and mobilize communities to change the power imbalance. Similarly Sheikh et al.'s [51] examination of the power of different actors unpacks the hidden dynamics shaping the implementation of HIV/AIDS policy guidelines. Recognizing the criticality of addressing power through rigorous research, Erasmus and Gilson [52] draw attention to how power can be methodologically concretized in the study of policy processes in the context of low and middle income countries. While the concept of power is central in social sciences, empirical analyses of power in the emerging field of health policy and system research, and more specifically in addressing health inequity, are few. More research is needed that systematically investigates the role of power in addressing and redressing health inequity.

Implications for Actions

The CSDH Report had a firm message saying that intervening in health inequity is real and actionable, yet this message is marred with ambiguity and contestations. A pertinent tension often expressed by public health practitioners is if research evidence on health equity is so complex that translating it into actions is not feasible, and hence research must be geared towards actionable features. An equally evocative concern shared largely by the academic community is that a focus on 'actions' runs the danger of an inadequate understanding of the 'social' thereby leading to more engineering than systemic solutions. This calls for an ongoing dialogue among several disciplines and stakeholders that demands, in principle, an acknowledgement of such tensions as much as resolving them. Actionable research evidence does not demand compromise on rigor or intellectual blindness but careful

translation and dissemination of research findings. Research and practice (focus on actions) are spurious distinctions that will cause harm to the aim of health equity [48]. There is encouraging evidence to show that critical perspectives on SDH are actionable (or are certainly meant to be) and research studies using such perspective do not merely end with messy, thick descriptive data to wonder ‘so what?’. If a SDH lens seeks to unpack the understanding of the structural causes of health inequities, it also implies that actions cannot simply be technomanagerial ones. Actions need to have an expanded understanding of unsettling the status quo (where needed), redistribution of power, and knowledge and resources. Such actions qualify for ‘system challenging praxis’ as much as ‘system correcting praxis’ [21]. Thus for example, actions need to range from addressing structural features of the health system (the ways in which health systems are governed) to system correcting ones (intersectoral actions, efficient delivery of services etc.) in order to address health. Bhatia and Rifkin [53] argue in this context that a renewed focus on the Alma Ata Declaration in the CSDH demands a *reframing* rather than a mere revitalizing of the principles of primary health care. Research evidence prioritizing a health equity lens shows how actions have included efforts to unsettle gendered norms to prioritize maternal health in a remote community in North Karnataka,³ ensure equitable health service provision to life threatening illnesses [21], promote equity sensitive primary health care [54], identify and reduce barriers to occupational health [5] and have led to an efficient response by the state to an AIDS epidemic [13]. This volume, in this regard, is an apt and timely exercise to initiate such a dialogue in a meaningful way that showcases several possibilities of combining research with praxis.

Locating the Chapter

This chapter is not necessarily intended to offer anything new. For many social scientists like me, the CSDH report comes as a respite as social science research has been speaking for a long time about why social matters in health are important. The objective of the chapter is not to offer a new set of data, but to reprioritize, revitalize and renew the understanding of SDH in the light of the CSDH report. This is necessary as the collective shouldering of responsibility for actions on health inequity needs a shared understanding of the ‘social’ conceptually, methodologically and from the point of view of praxis. This chapter has sought to do that by affirming that SDH is indeed a methodological lens with which to approach health inequity, demanding the asking of bold questions and requiring bold solutions to be adopted. Such a framing of the ‘social’ demands critical and reflective thinking while venturing to crack the complex reality of the conditions which result in health inequities.

³The film ‘Enough of this silence’ (2005), based on research in Koppal district, projects such actions.

References

1. World Health Organisation Commission on Social Determinants of Health. 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. 2008 [cited 2016 Nov 18]; Available from: <http://apps.who.int/iris/handle/10665/43943>.
2. Bhattacharya S, Messenger S, Overy C, eds. Social determinants of health: assessing theory, policy and practice. Orient Blackswan; 2010.
3. Hunt P. Missed opportunities: human rights and the commission on social determinants of health. *Glob Health Promot.* 2009;16(1 suppl):36–41.
4. Navarro V. What we mean by social determinants of health. *Int J Health Serv.* 2009;39(3):423–41.
5. Schofield T. Health inequity and its social determinants: a sociological commentary. *Health Sociol Rev.* 2007;16(2):105–14.
6. Irwin A, Valentine N, Brown C, Loewenson R, Solar O, Brown H, et al. The commission on social determinants of health: tackling the social roots of health inequities. *PLoS Med.* 2006;3(6):e106.
7. Gwatkin DR, Ergo A. Universal health coverage: friend or foe of health equity? *Lancet.* 2011;377(9784):2160–1.
8. Latko B, Temporão JG, Frenk J, Evans TG, Chen LC, Pablos-Mendez A, et al. The growing movement for universal health coverage. *Lancet.* 2011;377(9784):2161–3.
9. Mishra A, Rao SS. Unpacking the discourse on universal health coverage in India. *Soc Med.* 2016;9(2):86–92.
10. Marmot M. Universal health coverage and social determinants of health. *Lancet.* 2013;382(9900):1227–8.
11. Sengupta A, Prasad V. Developing a truly universal Indian health system: the problem of replacing “health for all” with “universal access to health care”. *Soc Med.* 2011;6(2):69–72.
12. Narayan R, Narayan T. Universal health coverage for India. *BMJ.* 2012;344:e2247.
13. Bastos C. The social determinants of health and the hierarchies of knowledge. *Soc Determinants Health Assess Policy Theor Pract.* 2010;263–271.
14. McKeown T. The modern rise of population. London: Edward Arnold; 1976.
15. Illich I. Medical nemesis. New York: Pantheon. 1976;30:41.
16. Marmot MG, Rose G, Shipley M, Hamilton PJ. Employment grade and coronary heart disease in British civil servants. *J Epidemiol Community Health.* 1978;32(4):244–9.
17. Marmot MG, Shipley MJ, Rose G. Inequalities in death—specific explanations of a general pattern? *Lancet.* 1984;323(8384):1003–6.
18. Marmot MG, Stansfeld S, Patel C, North F, Head J, White I, et al. Health inequalities among British civil servants: the Whitehall II study. *Lancet.* 1991;337(8754):1387–93.
19. Court SD. Inequalities in health. Report of a research working group. *Arch Dis Child.* 1981;56(3):161.
20. Farmer P. Infections and inequalities: the modern plagues. University of California Press; 2001.
21. Farmer PE, Nizeye B, Stulac S, Keshavjee S. Structural violence and clinical medicine. *PLoS Med.* 2006;3(10):e449.
22. Parker M, Harper I. The anthropology of public health. *J Biosoc Sci.* 2006;38(01):1–5.
23. Narayan T. A violation of citizens' rights: the health sector and tuberculosis. *Issues Med Ethics.* 1999;7:3.
24. Das V, Das RK. Urban health and pharmaceutical consumption in Delhi, India. *J Biosoc Sci.* 2006;38(1):69.
25. George A. Persistence of high maternal mortality in Koppal district, Karnataka, India: observed service delivery constraints. *Reprod Health Matters.* 2007;15(30):91–102.
26. Greenough P. Introduction. *Soc Sci Med.* 1995;41(5):605–7.

27. Mishra A, Flikke R, Nordfeldt C, Nyirenda L. Immunization is good for your children': local immunization practices in India and Malawi. *Prot Worlds' Child Immun Policies Pract.* 2013;149–186.
28. Mishra A. "Trust and teamwork matter": community health workers' experiences in integrated service delivery in India. *Glob Public Health.* 2014;9(8):960–74.
29. Nichter M. Vaccinations in the Third World: a consideration of community demand. *Soc Sci Med.* 1995;41(5):617–32.
30. Ross CE, Wu C-L. The links between education and health. *Am Sociol Rev.* 1995;60(5):719–45.
31. Dahl E. Social inequalities in ill-health: the significance of occupational status, education and income—results from a Norwegian survey. *Sociol Health Illn.* 1994;16(5):644–67.
32. Dey DK, Mishra V. Determinants of choice of health care services utilization: empirical evidence from India. *Indian J Community Health.* 2014 Dec 15;26(4):356–63.
33. Mehta S, Parmar GB, Gamit CL, Mansuri BM, Patel PB, Patel SS. Does maternal education affect maternal and child health care utilization? A community based study in a urban slum area of western India. 2014. [cited 2016 Nov 18]; Available from: <http://imsear.li.mahidol.ac.th/handle/123456789/176207>.
34. Govindasamy P, Ramesh BM. Maternal education and the utilization of maternal and child health services in India. 1997. [cited 2016 Nov 18]; Available from: <http://scholarspace.manoa.hawaii.edu/handle/10125/3472>.
35. Choudhury PK. Explaining the role of parental education in the regional variations in infant mortality in India. *Asia Pac Policy Stud.* 2015;2(3):544–72.
36. Saikia, N, Kulkarni P. Data for research into health inequalities in India: Do we have enough? *Econ Polit Wkly.* 2016;(11):26 & 27.
37. Östlin P, Schrecker T, Sadana R, Bonnefoy J, Gilson L, Hertzman C, et al. Priorities for research on equity and health: towards an equity-focused health research agenda. *PLoS Med.* 2011;8(11):e1001115.
38. McGibbon E, McPherson C. Applying intersectionality & complexity theory to address the social determinants of women's health. 2011. [cited 2016 Nov 18]; Available from: <https://tspace.library.utoronto.ca/handle/1807/27217>.
39. Sen G, Iyer A, Mukherjee C. A methodology to analyse the intersections of social inequalities in health. *J Hum Dev Capab.* 2009;10(3):397–415.
40. Samuelsen H, Tersbøl BP, Mbuyita SS. Do health systems delay the treatment of poor children? A qualitative study of child deaths in rural Tanzania. *BMC Health Serv Res.* 2013;13(1):1.
41. Sébastia B. The last resort: Why patients with severe mental disorders go to therapeutic shrines in India. *Restoring Ment Health India Pluralistic Ther Concepts.* 2009;184–209.
42. Roodt D. Yesterday, Film (Language English and Julu). HBO Films: USA; 2004.
43. Sen G, Iyer A, George A. Systematic hierarchies and systemic failures: Gender and health inequities in Koppal District. *Econ Polit Wkly.* 2007;682–90.
44. Jeffery P, Jeffery R. Only when the boat has started sinking: a maternal death in rural north India. *Soc Sci Med.* 2010;71(10):1711–8.
45. Holmes SM. An ethnographic study of the social context of migrant health in the United States. *PLoS Med.* 2006;3(10):e448.
46. Chard SE. Routes to government TB treatment. *Med Anthropol Q.* 2009;23(3):257–76.
47. Roalkvam S, McNeill D, Blume S. Protecting the world's children: immunisation policies and practices [Internet]. OUP Oxford; 2013.
48. Mishra A. Anthropology and public health. *Indian Anthropol.* 2013;(special issue):42.
49. McNeill, D, Andersen, S, Sandberg, K. The global politics of health: actors and initiatives. In Roalkvam S, McNeill D, Blume S, editors. *Protecting the world's children: Immunization policies and practices.* Oxford University Press.
50. Papp SA, Gogoi A, Campbell C. Improving maternal health through social accountability: a case study from Orissa. India. *Glob Public Health.* 2013;8(4):449–64.

51. Sheikh K, Porter JD. Disempowered doctors? A relational view of public health policy implementation in urban India. *Health Policy Plan.* 2010;26:83–92.
52. Erasmus E, Gilson L. How to start thinking about investigating power in the organizational settings of policy implementation. *Health Policy Plan.* 2008;23(5):361–8.
53. Bhatia M, Rifkin S. A renewed focus on primary health care: revitalize or reframe? *Globalisation and Health.* 2010;6(13).
54. Wong ST, Browne AJ, Varcoe C, Lavoie J, Smye V, Godwin O, et al. Enhancing measurement of primary health care indicators using an equity lens: an ethnographic study. *Int J Equity Health.* 2011;10(1):1.

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