

Social Determinants of Health



SDH in EMR

- There is evident inequity in SDH globally, but it is striking in the Eastern Mediterranean region.
- The SDH inequity is tangible not only between countries of Eastern Mediterranean region but also within each country.
- In 2019, life expectancy in Kuwait 81.4 years while it is 58.5 in Somalia.
- Moreover, death rate in Somalia with highest mortality rate is nearly 5.5 times higher than Qatar with lowest mortality rate in Eastern Mediterranean region.

SDH Social Determinants of Health Inequity In Iran

- The literacy rate improved over the last decades but, there is still inequality between provinces.
- Age and regional inequity exists, regarding NCD mortality.
- Food insecurity varies in different regions between 20% and 60%.
- Providing care for a growing aging population, with a large burden of NCDs and disabilities will be the major issue in the next decade.
- The decrease slope of mortality rate due to NCDs, have become smoother since impose of sanctions, while, cancer mortality have changed upwards.
- COVID-19, and sanctions negatively impacts lower socioeconomically vulnerable groups due to preexisting conditions which wider the existing inequity in SDH are adding a heavy burden of inequity in Iran.

Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary inequalities, and social determinants of health — and to eliminate disparities in health and health care.

Leveraging Healthy People to Advance Health Equity

Health Equity is the attainment of the highest level of health for all people.

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Objectives

Identify priorities by browsing **Leading Health Indicators and other objectives**

Compare **population-level progress** to national targets



Data

Use **Healthy People data** to track health disparities and inform program and policy development



Resources

Find inspiration by consulting **evidence-based resources** to use in your community

Review **Healthy People in Action stories** to learn how others are addressing health equity



Frameworks

Use the **Healthy People 2030 framework** as a model for program planning

Use the **social determinants of health framework** to build **partnerships across sectors** and communicate root causes of health disparities



Definitions

Use the definitions of **health equity** and **health disparities** to promote a shared understanding and identify areas for collaborative action to improve health for all

Figure 1

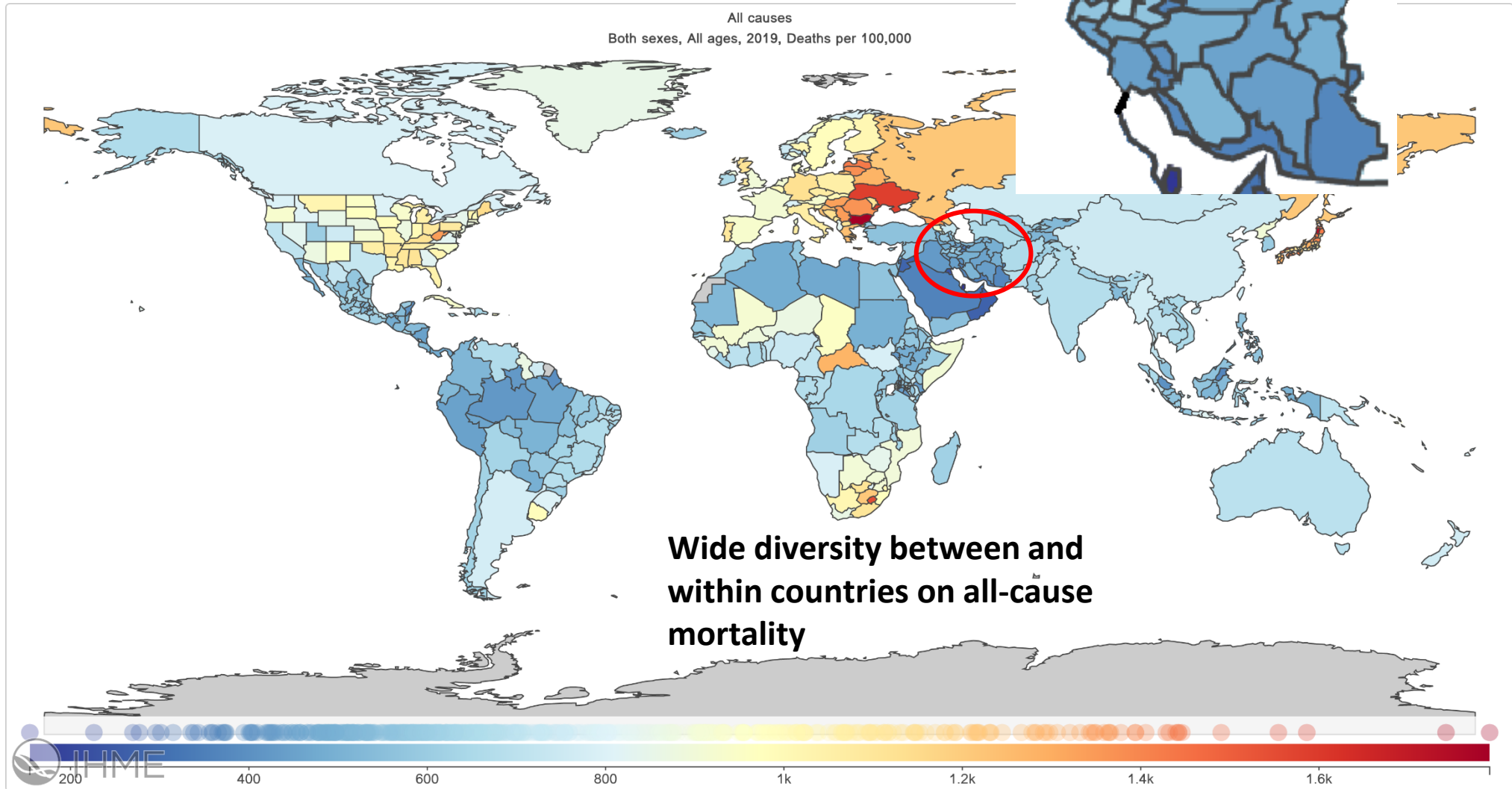
Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

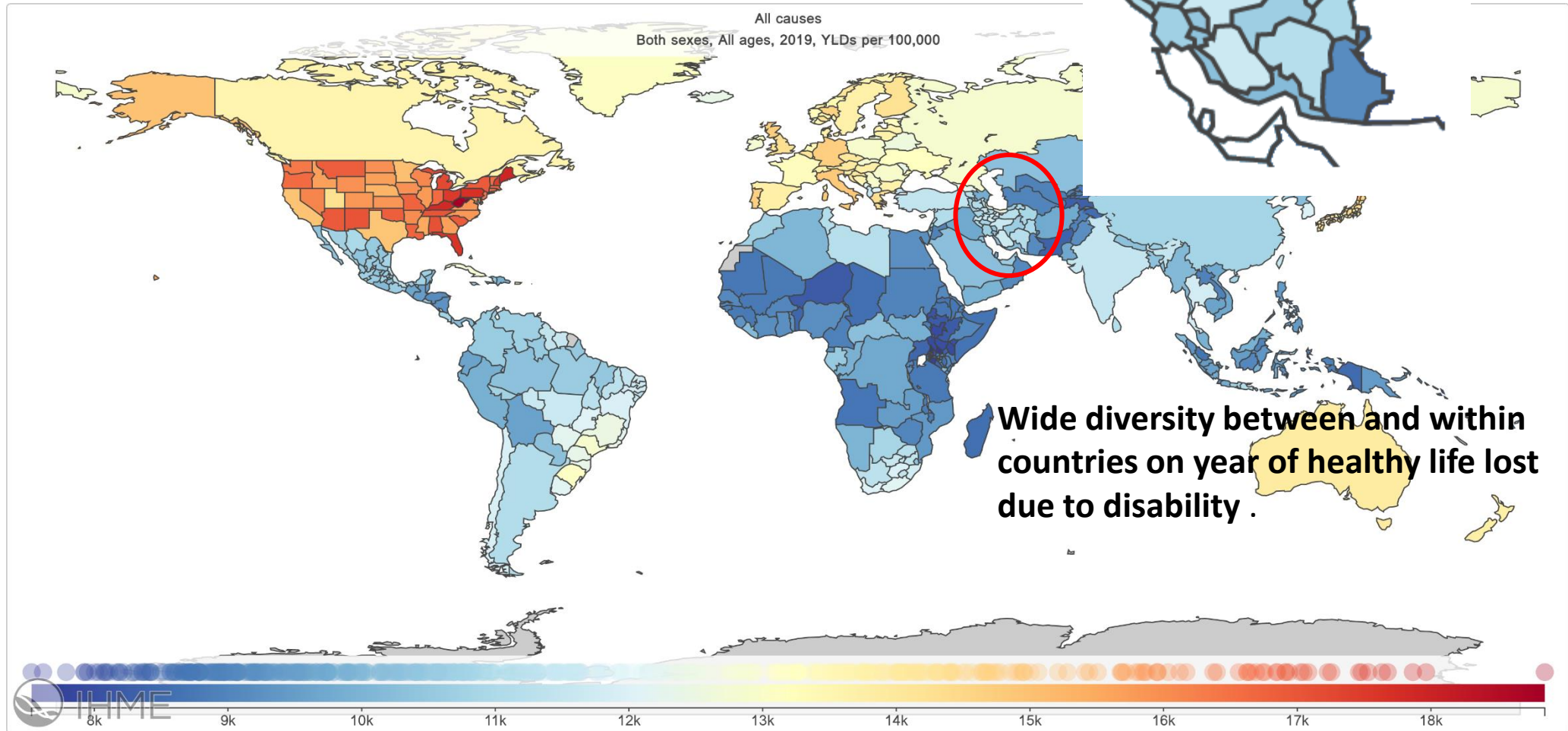
Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

All-Cause Mortality Rate Between And Within Countries



All-cause Morbidity(YLD) Between and Within Countries



Maternal Mortality Rate

- Over the past 40 years, the **child mortality rate** at the national level **decreased by 7 folds**, although the reduction in **adult mortality rate** was **about 2 folds** at the same time .
- Regarding the **establishment of Primary Health care worker service**, Iran could achieve the fourth goal of the Millennium Development Goals (MDGs) on child mortality and Sustainable Development Goals (SDG) in most provinces, However there are still inequalities remained.
- **At the provincial level**, the difference in child mortality rate was nearly 35 per 100000 (Mazandaran with 6.7 versus South Khorasan with 41.7).
- This difference in adult mortality rate was 4 per 100000 (Alborz with 4.0 versus Sistan and Baluchistan with 8.0) in **females** and 7.1 in **males** (Alborz with 7.0 versus Sistan and Baluchistan with 14.1) which resemble **gender inequity** .
- The **geographical inequity** is obvious between central and border provinces particularly eastern border provinces, not only in child mortality as an indicator for health system performance quality, but also in adult mortality .

Life expectancy

- There is a gap between provinces in life expectancy at birth.
- The highest life expectancy is (Tehran) 82.8 in both the women and the men.
- The lowest life expectancy is (Golestan and Sistan and Baluchistan) 77 in women and 72 in men.
- The provinces with the lowest life expectancy, have a **better situation** than Iraq, Afghanistan, and Pakistan.
- **Iran** has a **lower mean life expectancy** than Turkey, Kuwait, Qatar, and Jordan as Middle East and North Africa (MENA) region countries.

Hale(Health Adjusted Life Expectancy)

- Healthy Life Expectancy (HALE) is **lower** than life expectancy about **a decade** in Iran.
- The HALE is higher in men comparing to women in Tehran which are **in contrast** with life expectancy.
- This means that, in the capital of Iran, women have a longer life although, it **is not healthy** compared to men .
- This age gap in life expectancy and HALE may owing to the socio-economic **inequity between genders** as they age.
- Male ownership within the household, and subordinate position of women in society, and the gap of payment between genders, resulting in the lower capacity of women welfare.

Income and poverty

The number of poor households varies between more than 200 per 1000 households in some eastern districts to on rare occasions in some central districts in both rural and urban regions.

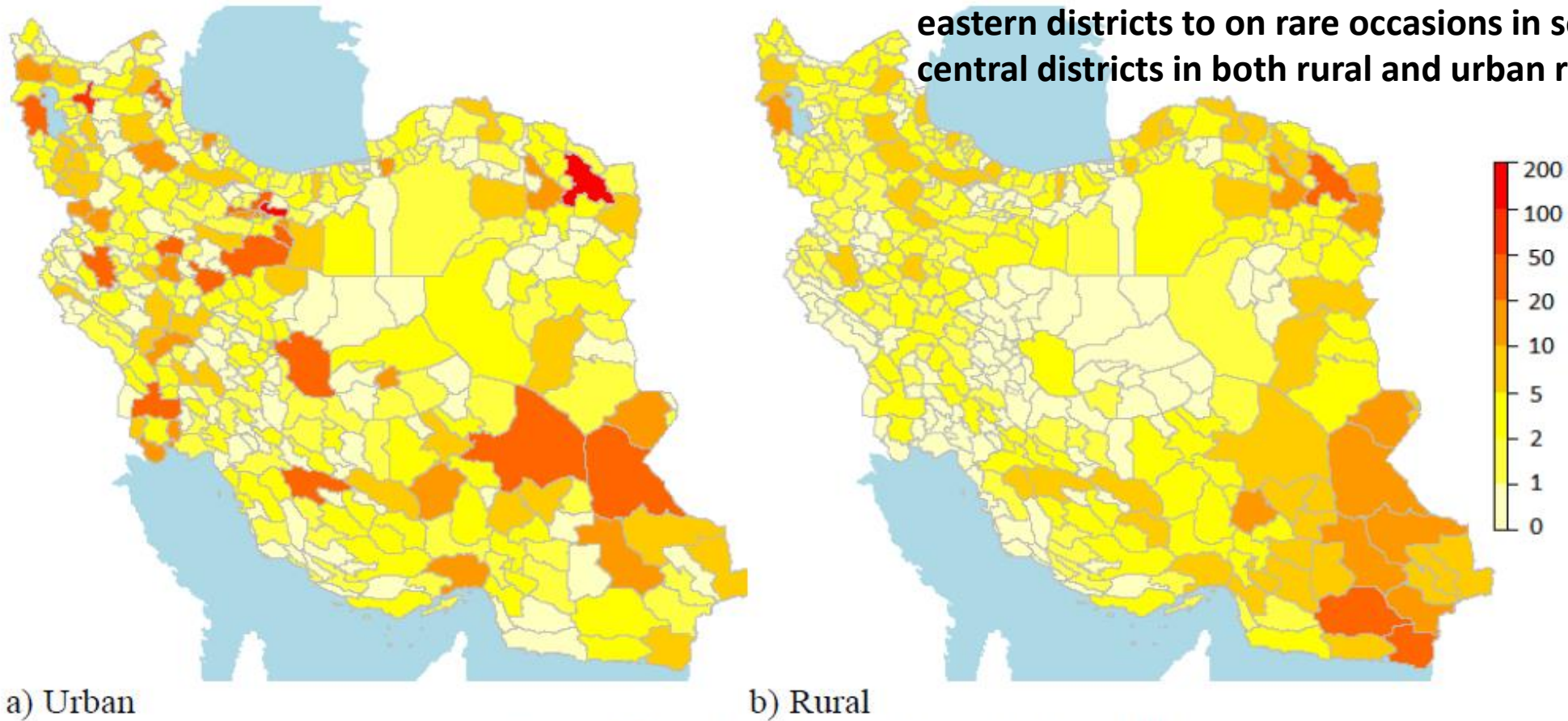


Figure 3 Number of Poor Households (x1000)

Unemployment and Education

- According to the latest labor force survey report of Iran in 2018, over 12 years period, **the female unemployment rate has increased about 1.8%** while this is **only 0.4% in the case of male unemployment**.
- Moreover, the **female** labor force participation rate (16.1%) is **low** in comparison with **male** (64.8%), and **the average of the MENA (20%)** countries, and neighboring countries such as Afghanistan (49%) ,and Pakistan (24%).
- This demonstrates gender discrimination , as well as, geographical unfairness in employment rate as an SDH element.
- Unemployment, Informal jobs, working in dangerous and unregulated settings, poverty, child labor, and lack of social and economic protection will negatively affects health.
- The literacy rate improved over the last decades in Iran, but there **is still over 19 percent** inequality in literacy rate between Tehran with the highest rate and Sistan and Baluchistan with the lowest rate.

Food Insecurity

- A study during the COVID-19 pandemic in Tehran demonstrates that **61 %** of the capital households **confronted marginal, moderate** and **nearly 35%** had **severe food insecurity**.
- There are other reports that indicate food insecurity prevalence in different regions of Iran varies between **20% and 60%** .
- This is even worse in female-headed households (**75%**) and low income communities (**86%**) .
- These reports show a wide range of gender, regional and socio-economical inequity which shows that immediate governmental action is needed, given that food insecurity is rooted in **unemployment, poverty , economic status of households, and food price**.

Environmental Inequity

- Environmental inequity **is rooted in income inequity** which results in lower coping capacity, lower access to healthy infrastructures like safe water, and prevention services.
- Environmental hazards include pollution, natural resource degradation, climate change, natural disasters, and conflicts.
- This is the vicious cycle of environmental inequity that flows within and between countries .
- In Iran, urbanization is growing rapidly especially in cosmopolitan cities particularly **in central and north of Iran** due to enhanced economic conditions and availability of various facilities .
- The ineffective urban structure causes environmental concerns such as water, soil, and air pollution, forest degradation in the north of Iran, and per capita reduction of green space.

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Definitions

Use the definitions of **health equity** and **health disparities** to promote a shared understanding and identify areas for collaborative action to improve health for all

Gathering **high quality data** is an important step to evaluate the inequities at national and subnational level .

STEPS

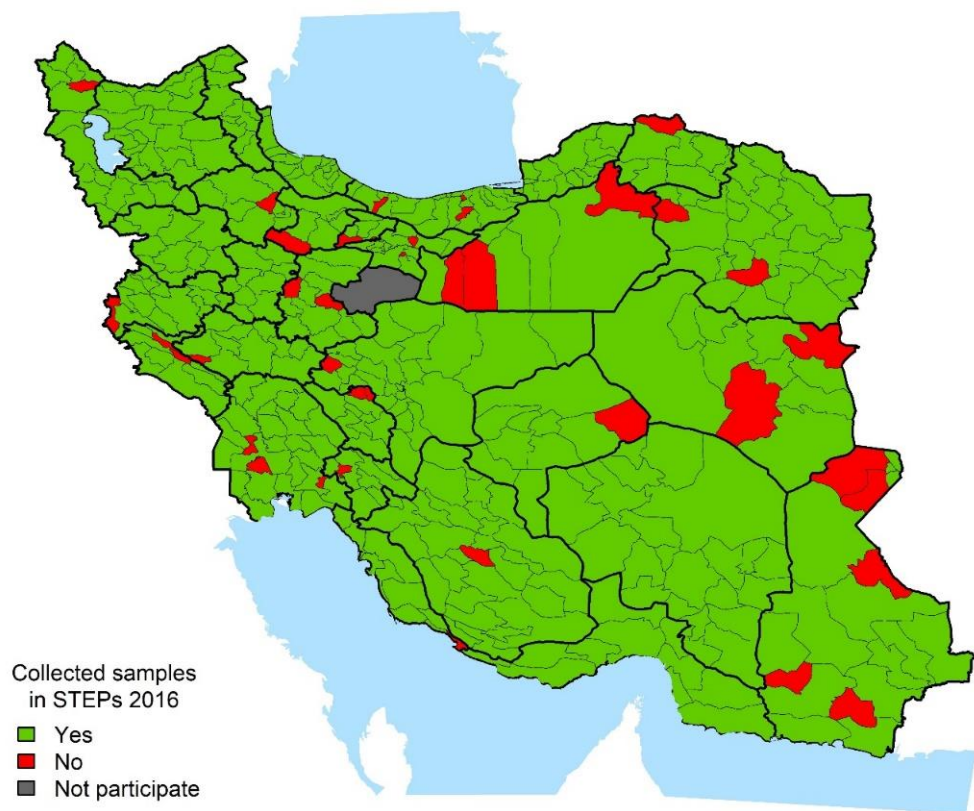
- The **WHO STEPwise approach to surveillance (STEPS)** is the WHO-recommended framework for NCD surveillance and one of the best ways to reach representative **national data**.
- STEPs survey has **three levels** of data gathering: questionnaires, physical measurements, and biochemical (laboratory) measurements.
- Iran has run **8 rounds** of the STEPs surveys in years: 2005, 2006, 2007, 2008, 2009, 2011, 2016, and 2021. Only three rounds did not have laboratory data (2006, 2008, and 2009).
- The **last 2 rounds** of STEPs were conducted at NCDRC/EMRI and **fully digitalized** with highest standard of large-scale national surveys.

Iran STEPs 2021 Survey

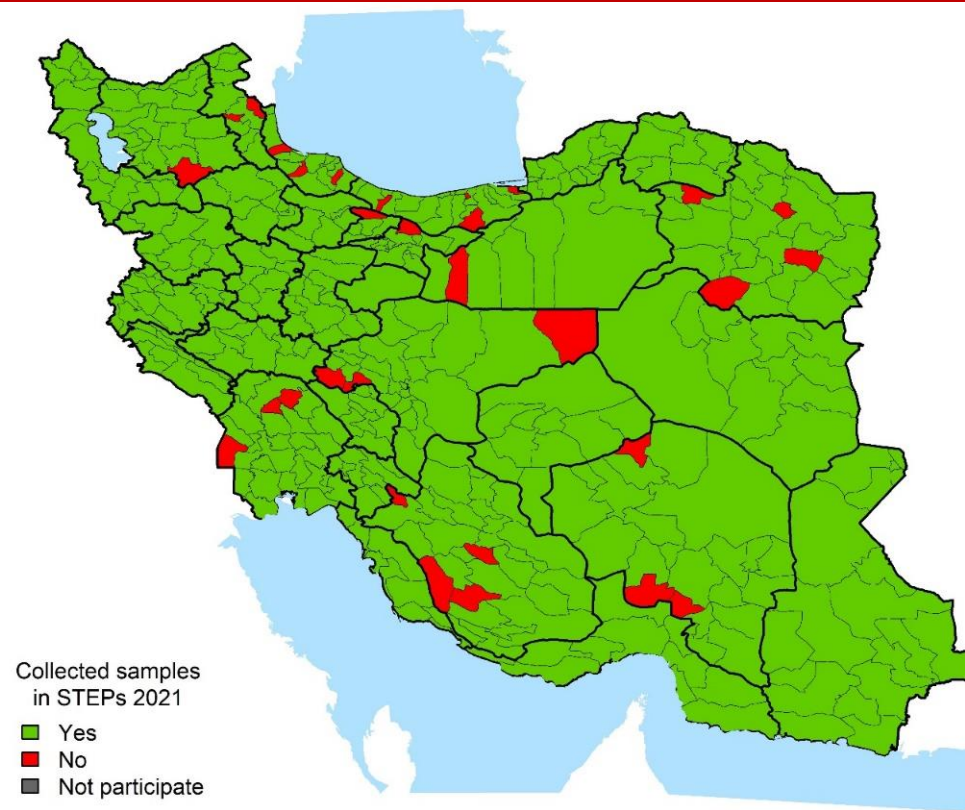
- The latest round was run during the **COVID-19 pandemic** in Iran.
- While COVID-19 pandemic was present at the time of survey, **no cases of infection** happened due to STEPs survey and this was because of the implemented **protective measures** and **restrictive guidelines**.
- **Novelties** of Iran STEPs 2021 Survey:
 - **COVID-19 IgG antibody test** and history
 - **Chronic kidney disease (CKD)** evaluation
 - **Traffic light and food labelling** evaluation
 - **Fully digitalized** with highest standard of large-scale national surveys
 - **Recording** the interview process for quality assessment and control
 - **Comprehensive drug consumption** among patients with **major NCDs**
 - **History of major cancers screening**
 - Many **other** novelties in questions and assessments like oral health and premature cardiovascular disease, etc.

Iran STEPs 2016 and 2021: Sampling frame

STEPs 2016: collected samples in **388** districts out of 429



STEPs 2021: collected samples in **399** districts out of 429



Ref: Protocol Design for Large-Scale Cross-Sectional Studies of Surveillance of Risk Factors of Non-Communicable Diseases in Iran: STEPs 2016; Archives of Iranian Medicine; Djalalinia Sh, ..., Larijani B, et al.

Ref: Protocol Design for Surveillance of Risk Factors of Non-Communicable Diseases during the COVID-19 pandemic: An experience from Iran STEPs 2021 Survey; Under review; Djalalinia Sh, ..., Larijani B, et al.



Visualized projects by VIZIT (2)



حمایت از ما

زبان

ویزیت

خدمات

راهنما

لیست پروژه ها

صفحه اصلی

مصورسازی اطلاعات لیست پروژه ها

نکته!

برای استفاده از بعضی قسمت ها نیاز به دسترسی ویژه و یا ساخت کاربری (رایگان) خواهید داشت.

Mean and prevalence of NCDs risk factors by 102 types, sex, age groups, and area of residency at national and provincial levels in 2016 , 2021

استپس دسترسی آزاد
Steps

مرکز تحقیقات بیماریهای غیر واگیر

مشاهده توضیحات

۱۰۲	۳۳	۲۰۱۶
تعداد شاخص ها	گروه های سنی جنسی	بازه زمانی پروژه

مسئول پروژه: دکتر فرشاد فرزادفر

ایمیل مسئول پروژه: Farzadfar3@yahoo.com

مشاهده پروژه

نسباد دسترسی آزاد
NASBOD

مرکز تحقیقات بیماریهای غیر واگیر

مشاهده توضیحات

۲۰۶	۷۲	۱۹۹۰-۲۰۱۵
تعداد شاخص ها	گروه های سنی جنسی	بازه زمانی پروژه

مسئول پروژه: دکتر فرشاد فرزادفر

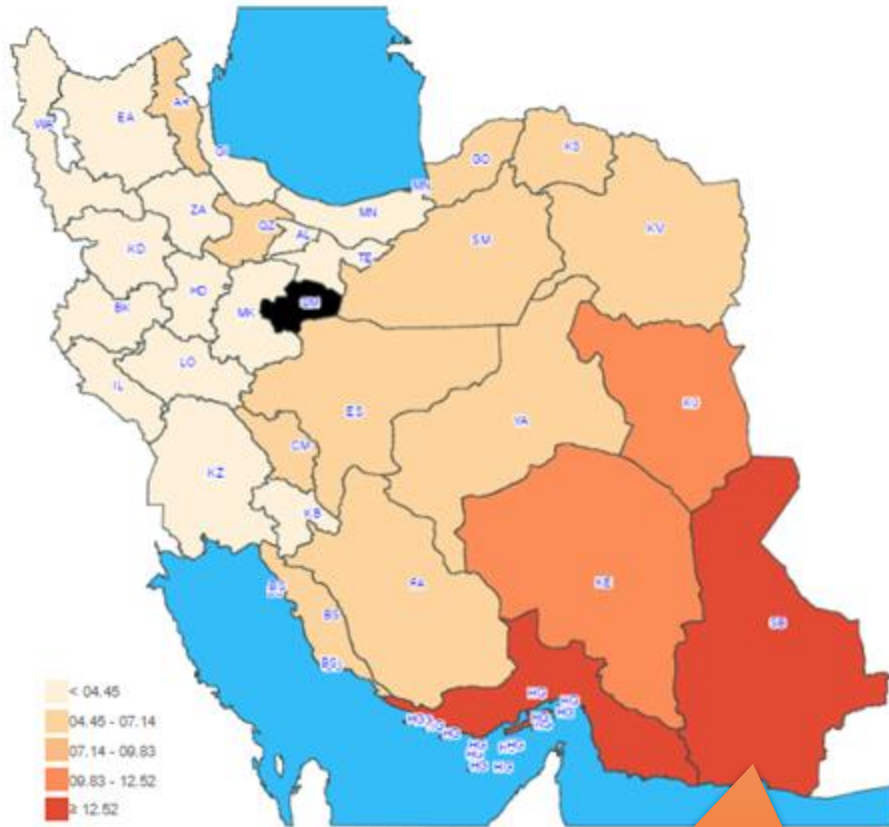
ایمیل مسئول پروژه: Farzadfar3@yahoo.com

مشاهده پروژه



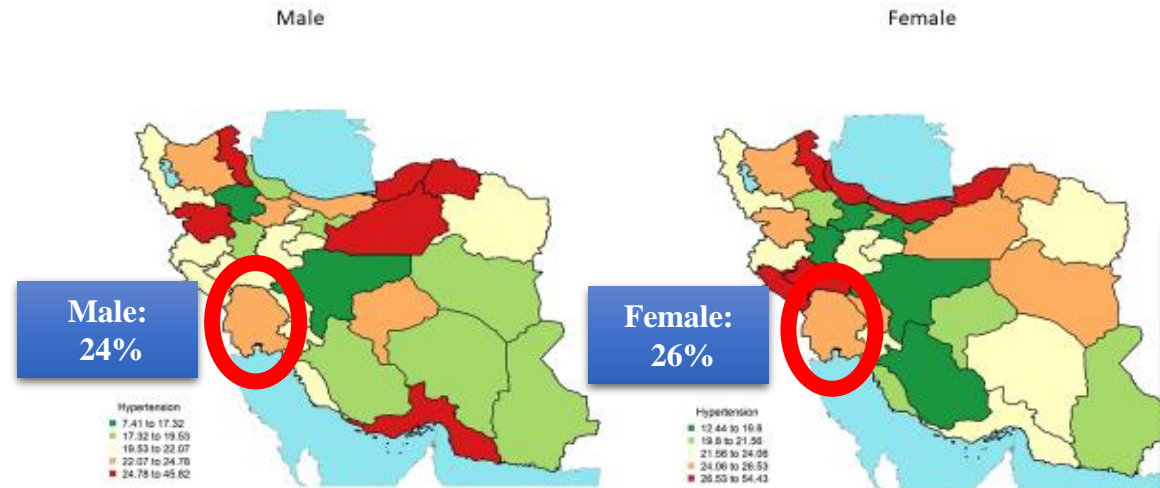
An example of STEPs finding on wide diversity via VIZIT

Geographical pattern of underweight in the country

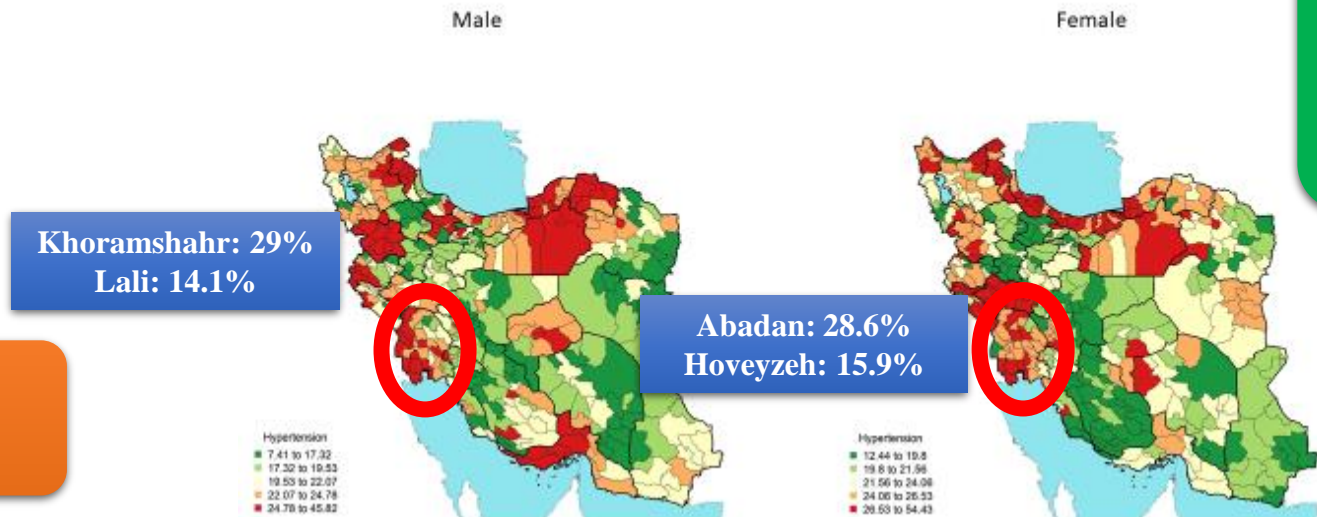


Prevalence of underweight is **15.2%** among residence of Sistan & Baluchistan

Prevalence of **hypertension** at provincial level, 2016



Prevalence of **hypertension** at district level, 2016



Wide diversity between and within provinces



Fact sheet at various levels

Health status at a glance



IRAN

Based on STEPSwise approach to surveillance (STEPS) 2016 results

Metabolic Risk Factors					
Title	Definition	Male		Female	
		Prevalence ¹ (%)	Burden ² (Population)	Prevalence (%)	Burden (Population)
Hypertension (aged ≥ 18 years old)	Systolic blood pressure ≥ 140 mmHg or diastolic blood pressure ≥ 90 mmHg or self-report of drug taking	25.2	7,289,983	27.5	7,845,267
Hypertension awareness (aged ≥ 18 years old)	Awareness of individuals diagnosed with hypertension based on self-report	47.4	3,452,131	64.8	5,082,750
Hypertension coverage (aged ≥ 18 years old)	Individuals with hypertension who are currently taking related medication based on self-report	32.1	2,343,639	46.2	3,623,436
Effective care for hypertension (aged ≥ 18 years old)	Systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg for those treated individuals with hypertension	39.4	923,616	36.5	1,322,383
Diabetes (aged ≥ 25 years old)	Fasting plasma glucose ≥ 126 mg/dl or self-report (HbA1c and/or insulin taking)	10.0	2,466,421	11.5	2,800,350
Diabetes awareness (aged ≥ 25 years old)	Awareness of individuals diagnosed with diabetes based on self-report	70.3	1,734,634	77.7	2,177,079
Diabetes coverage (aged ≥ 25 years old)	Individuals with diabetes who are currently taking related medication based on self-report	53.1	1,310,028	59.6	1,668,379
Effective care for diabetes (aged ≥ 25 years old)	HbA1c < 7% for those treated individuals with diabetes	35.9	470,737	36.0	600,817

¹ Prevalence are estimated for all ages
² The term burden refers to the number of target population

³ Oral Hypoglycemic Agents



at National level



سیمای سلامت

استان تهران

بر اساس پیمایش ملی عوامل خطر بیماری‌های غیرواگیر در سال ۱۳۹۵ (STEPS)

عنوان	تعریف	عوامل خطر متابولیک					
		رشته کسب و کار (۱-۳)	شعبه (۱-۳)	سواد (۱-۳)	رشته کسب و کار (۱-۳)	شعبه (۱-۳)	
شیوع فشار خون بالا	فشار خون سیستولیک و دیاستولیک هرگز به‌سوی ۱۳۰ mmHg یا ۸۰ mmHg فشار خون خود، سیستولیک و دیاستولیک هرگز گزارش نشده است	۳	۱۱۴-۹۱۴	۱۹۵	۶	۱۱۱۲۳۸	۱۸
افراد آگاه از فشار خون بالا	آگاهی فرد مبتلا به فشار خون بالا از بیماری خود بر اساس خوداظهاری	۱۷	A-۸۶A۵	۴۷۱	۱۳	۵۳۳۲۸	۳-۴
پوشش فشار خون بالا	مردان مبتلا به فشار خون بالا که تحت درمانی مرتبط با فشار خون هستند بر اساس خوداظهاری	۱۵	P-۸۳۸	۵۵۶	۶	۹۱۸۳-۱	۲۱
دریافت خدمات موثر مرتبط با فشار خون بالا	فشار خون خود، سیستولیک کمتر از ۱۳۰ mmHg یا دیاستولیک کمتر از ۸۰ mmHg، این دو بر روی دفتر معاینه	۱۵	۲۳۹۱۱	۳۸۴	۳	۱۷۹-۰-۳	۳-۴
شیوع دیابت	فشار خون بالا، مصرف انسولین، قند خون ناشتا ≥ ۱۲۶ mg/dl	۱۸	۵-۲۲۴۳	۹	۲۱	۶۶۶۲۲	۱۰
افراد آگاه از دیابت	آگاهی فرد مبتلا به دیابت از بیماری خود بر اساس خوداظهاری	۲۰	۳۸۶-۹	۵۲	۱۵	۹۱۸۸-۹	۲۴-۲
پوشش دیابت	مردان مبتلا به دیابت که تحت درمانی مرتبط با دیابت هستند بر اساس خوداظهاری	۲۰	۳۰-۵-۵	۳۶۶	۱۲	۳۱۲۶۸	۲۱-۲
دریافت خدمات موثر مرتبط با دیابت	مردان مبتلا به دیابت که تحت درمانی مرتبط با دیابت هستند بر اساس خوداظهاری	۲۵	۷۵۴-۷	۱۹۸	۲	۱۱۲۸۸۸	۲۴-۲



at Provincial level



سیمای سلامت

استان تهران

دانشگاه علوم پزشکی تهران

بر اساس پیمایش ملی عوامل خطر بیماری‌های غیرواگیر در سال ۱۳۹۵ (STEPS)

عنوان	تعریف	عوامل خطر متابولیک					
		رشته کسب و کار (۱-۳)	شعبه (۱-۳)	سواد (۱-۳)	رشته کسب و کار (۱-۳)	شعبه (۱-۳)	
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افراد آگاه از فشار خون بالا	آگاهی فرد مبتلا به فشار خون بالا از بیماری خود بر اساس خوداظهاری	۲	۳۶	۱۲۳۳۵	۳۷۶	۲-۱۲۸۸	۳-۴
پوشش فشار خون بالا	مردان مبتلا به فشار خون بالا که تحت درمانی مرتبط با فشار خون هستند بر اساس خوداظهاری	۱	۱۶	۱-۲-۲۹	۲۰۸	۱۸۳۸۳۸	۳۳۸
دریافت خدمات موثر مرتبط با فشار خون بالا	فشار خون خود، سیستولیک کمتر از ۱۳۰ mmHg یا دیاستولیک کمتر از ۸۰ mmHg، این دو بر روی دفتر معاینه	۳	۱۰	۳۹-۱۹	۵-۷	۵۱۷-۱	۳۱۱
شیوع دیابت	فشار خون بالا، مصرف انسولین، قند خون ناشتا ≥ ۱۲۶ mg/dl	۳	۵۶	۱۵-۵۱۲	۱-۱۱	۱۳۵۲۵۷	۹۱
افراد آگاه از دیابت	آگاهی فرد مبتلا به دیابت از بیماری خود بر اساس خوداظهاری	۱	۳۱	۹۵۴-۵	۹۸۲	۱-۳۱۱۸	۵۱۷
پوشش دیابت	مردان مبتلا به دیابت که تحت درمانی مرتبط با دیابت هستند بر اساس خوداظهاری	۱	۱۱	۱۱۶۵	۳۷۶	۸۵۲۴۷	۳۸۶
دریافت خدمات موثر مرتبط با دیابت	مردان مبتلا به دیابت که تحت درمانی مرتبط با دیابت هستند بر اساس خوداظهاری	۱	۱۱	۲۶۲۰	۲۷۲	۲۲۹۲۲	۱۷۲



at University level



سیمای سلامت

استان شاهرستان

شهرستان شمیرانات

بر اساس پیمایش ملی عوامل خطر بیماری‌های غیرواگیر در سال ۱۳۹۵ (STEPS)

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افراد آگاه از فشار خون بالا	آگاهی فرد مبتلا به فشار خون بالا از بیماری خود بر اساس خوداظهاری	۵	۲۰-۱	۱۹۶۶	۳۰-۲۷	۳	۲۳۰	۲۶۶۷	۴۴-۹
پوشش فشار خون بالا	مردان مبتلا به فشار خون بالا که تحت درمانی مرتبط با فشار خون هستند بر اساس خوداظهاری	۵	۹۰	۱۵۱۲	۲۰-۳۲	۵	۱۷۵	۲۲۲۲	۲۸-۶۶
دریافت خدمات موثر مرتبط با فشار خون بالا	فشار خون خود، سیستولیک کمتر از ۱۳۰ mmHg یا دیاستولیک کمتر از ۸۰ mmHg، این دو بر روی دفتر معاینه	۵	۳۸	۶۶۸	۵۸-۹۵	۱۲	۲۴۱	۹۰-۷	۲۹-۳۲
شیوع دیابت	فشار خون بالا، مصرف انسولین، قند خون ناشتا ≥ ۱۲۶ mg/dl	۷	۳۶۱	۲۰-۸۴	۹-۱۱	۱۱	۲۶۱	۱۹۰-۹	۹-۲۵
افراد آگاه از دیابت	آگاهی فرد مبتلا به دیابت از بیماری خود بر اساس خوداظهاری	۱۵	۵۵۴	۱۲۵۱	۳۵-۲	۱۴	۲۹۲	۱۹۹۴	۵۱-۵۶
پوشش دیابت	مردان مبتلا به دیابت که تحت درمانی مرتبط با دیابت هستند بر اساس خوداظهاری	۱۳	۱۹۴	۱۰-۱	۳۲-۶	۱۴	۲۵۶	۱۱۲۸	۳۶-۳۳
دریافت خدمات موثر مرتبط با دیابت	مردان مبتلا به دیابت که تحت درمانی مرتبط با دیابت هستند بر اساس خوداظهاری	۱۵	۸۴	۳۶۷	۴۱-۸	۱۲	۳۳۵	۳۱۵	۱۶-۶۶

^۱ تمامی داده‌های شیوع ابتلا به دیابت، فشار خون بالا، دیابت، چاقی، مصرف سیگار و نوشیدنی الکلی بر اساس خوداظهاری است.
^۲ جهت مطالعه تعداد افراد تحت درمانی مرتبط با فشار خون بالا، دیابت، چاقی، مصرف سیگار و نوشیدنی الکلی بر اساس خوداظهاری، به گزارش‌های فصلی مراجعه کنید.
^۳ در همه موارد، عدد کوچک‌تر نشانگر وضعیت بهتر است.



at District level

Leveraging Healthy People to Advance Health Equity

Health Equity is the attainment of the highest level of health for all people.

Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and social determinants of health — and to eliminate disparities in health and health care.



Objectives

Identify priorities by browsing **Leading Health Indicators and other objectives**

Compare **population-level progress** to national targets



Data

Use **Healthy People data** to track health disparities and inform program and policy development



Resources

Find inspiration by consulting **evidence-based resources** to use in your community

Review **Healthy People in Action stories** to learn how others are addressing health equity



Frameworks

Use the **Healthy People 2030 framework** as a model for program planning

Use the **social determinants of health framework** to build **partnerships across sectors** and communicate root causes of health disparities



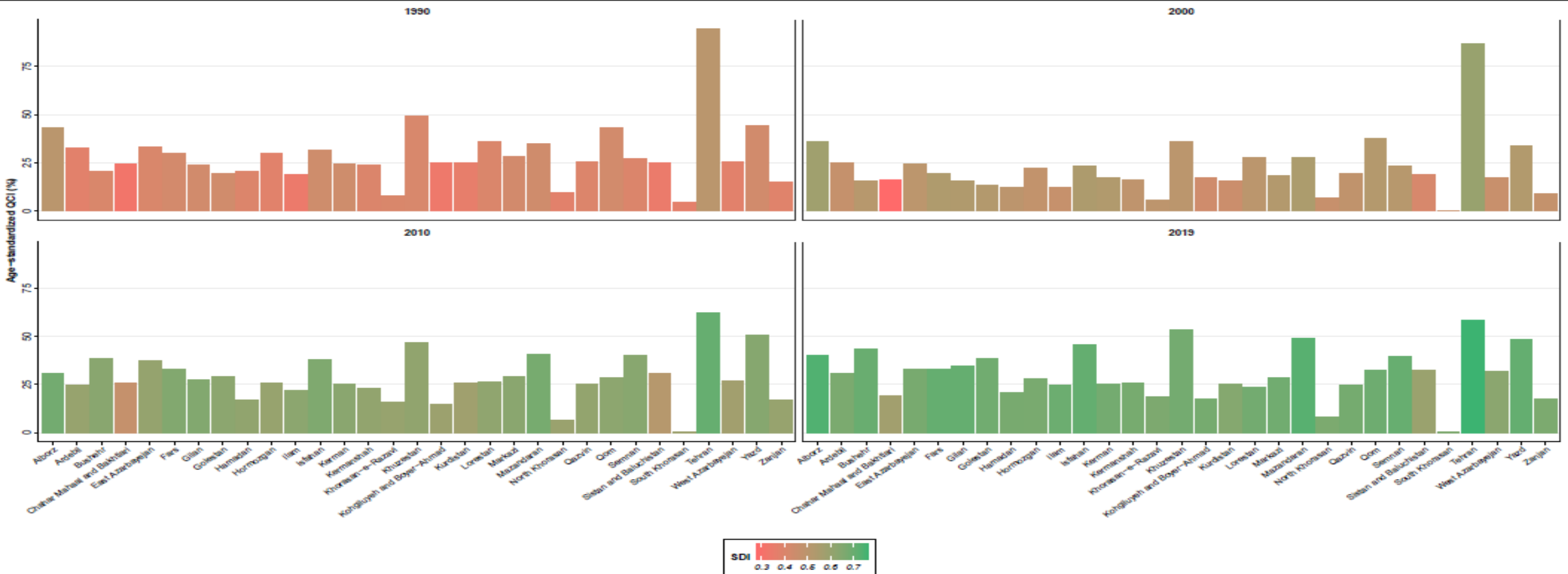
Definitions

Use the definitions of **health equity** and **health disparities** to promote a shared understanding and identify areas for collaborative action to improve health for all

Quality of Care Index

Although the SDI improved in all provinces, the **quality of care** is unchanged in most provinces.

- QCI trend of DM type 2 at national and subnational level 1990,2000,2010,2019 by SDI



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Health Equity in Healthy People 2030

“Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.”

<https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030>

Plan of Action

- It's important to provide **information and tools** to help communities, states, and organizations use Healthy People.
- Set **national goals and measurable objectives** to guide evidence-based policies, programs, and other actions to improve health and well-being.
- Provide **accurate, timely, and accessible data** that can drive targeted actions to address regions and populations that have poor health or are at high risk for poor health.
- Foster impact through **public and private efforts** to improve health and well-being for people of all ages and the communities in which they live.
- Provide **tools for the public, programs, policymakers**, and others to evaluate progress toward improving health and well-being.
- Share and **support the implementation of evidence-based programs** and policies that are replicable, scalable, and sustainable.
- Report **biennially on progress** throughout the decade from 2020 to 2030.
- Stimulate research and innovation toward meeting Healthy People 2030 goals and highlight critical research, data, and evaluation needs.
- Facilitate the **development and availability of affordable means of health promotion**, disease prevention, and treatment.

Conclusion

- Iran, similar to large numbers of countries, face inequity at regional level in different SDH related issues.
- One of the main goals of health authorities is to reduce SDH inequity in order to achieve the goal of “health for all”.
- It is almost important to work on district-level issues as well as national issues to achieve fairer health equity .
- To take action guided by national principles to avoid preventable SDH inequity, evidence and a monitoring framework on various aspects of SDH inequities at the subnational level is needed.
- This enable government and stockholders to rebuild the health system in a way that profits the whole population by available resources.