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# **How Physicians Take Action on the Social Determinants of Health in the Eastern Mediterranean Region?**

***A Qualitative Research Study***

**Family Medicine Forum  
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# Outline

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- Data analysis
- Results
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## Quick facts:

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- A map of the Middle East and surrounding regions. The map shows the following countries and territories:
- North Africa and the Levant:** Morocco, Tunisia, Algeria, Libya, Egypt, Syria, Jordan, Israel, Lebanon, Cyprus, Greece, Turkey, Turkmenistan, Afghanistan, Pakistan (highlighted in red and circled in orange).
  - Persian Gulf Region:** Saudi Arabia, Iraq, Kuwait, Bahrain, Qatar, U.A.E., Oman, Yemen.
  - Sub-Saharan Africa:** Mauritania, Mali, Niger, Chad, Sudan, Eritrea, Ethiopia, Somalia, Uganda, Kenya, Rwanda, Gabon, Cameroon, Nigeria, C.A.R., Liberia, Guinea, Sierra Leone, Ivory Coast, Ghana, Benin, Burkina Faso, Togo, Senegal, Mauritania, Western Sahara, Sao Tome and Principe, Principe.
  - Other:** Maldives.
- The Mediterranean Sea is labeled. The map uses color-coding: blue for North Africa and the Levant, green for the Persian Gulf region, and red for Pakistan. An orange oval highlights Iran and Pakistan.





# Social Determinants of Health (SDOH)

## WHO definition:

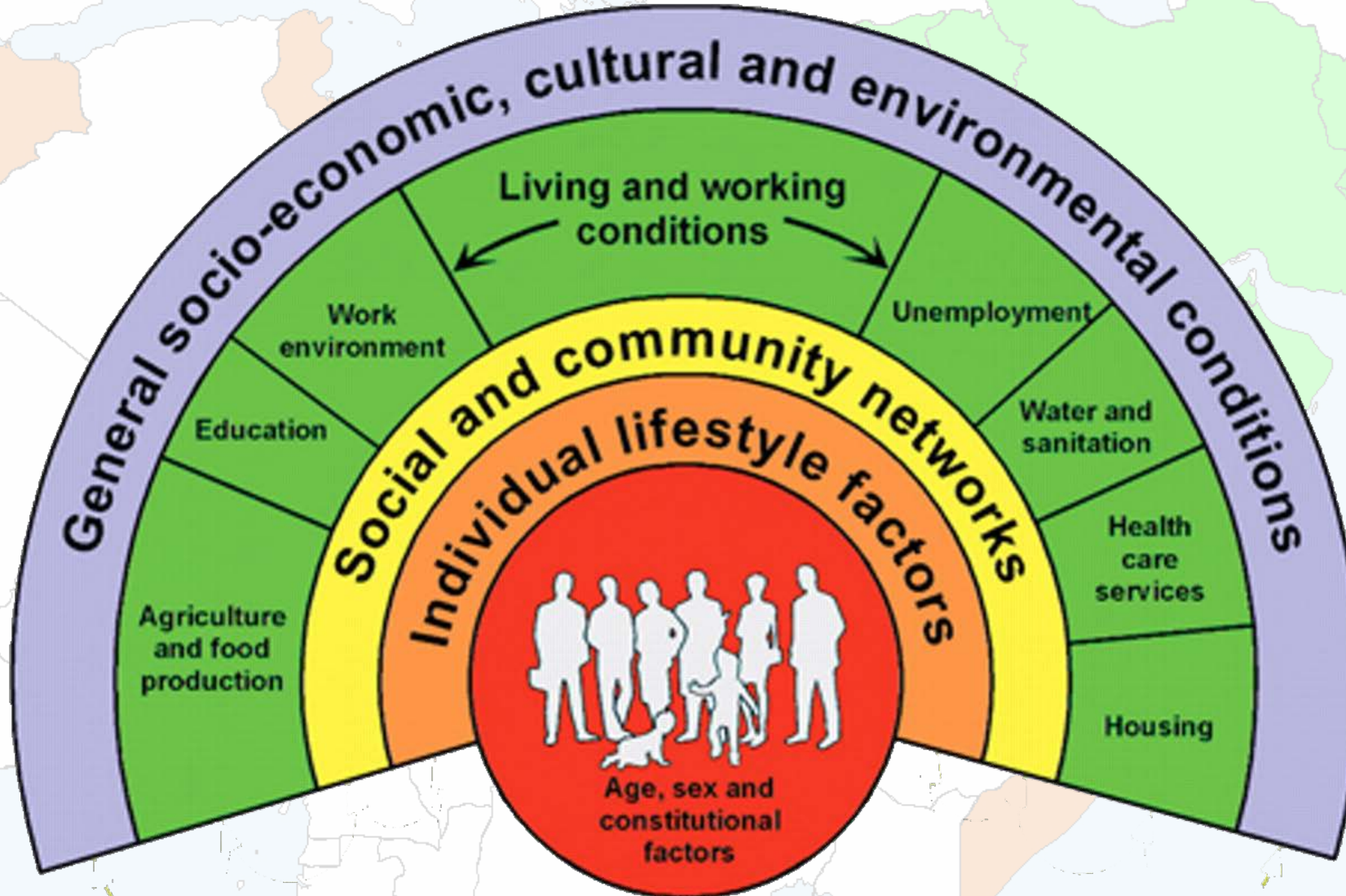
“The conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.”

[http://www.who.int/social\\_determinants](http://www.who.int/social_determinants)





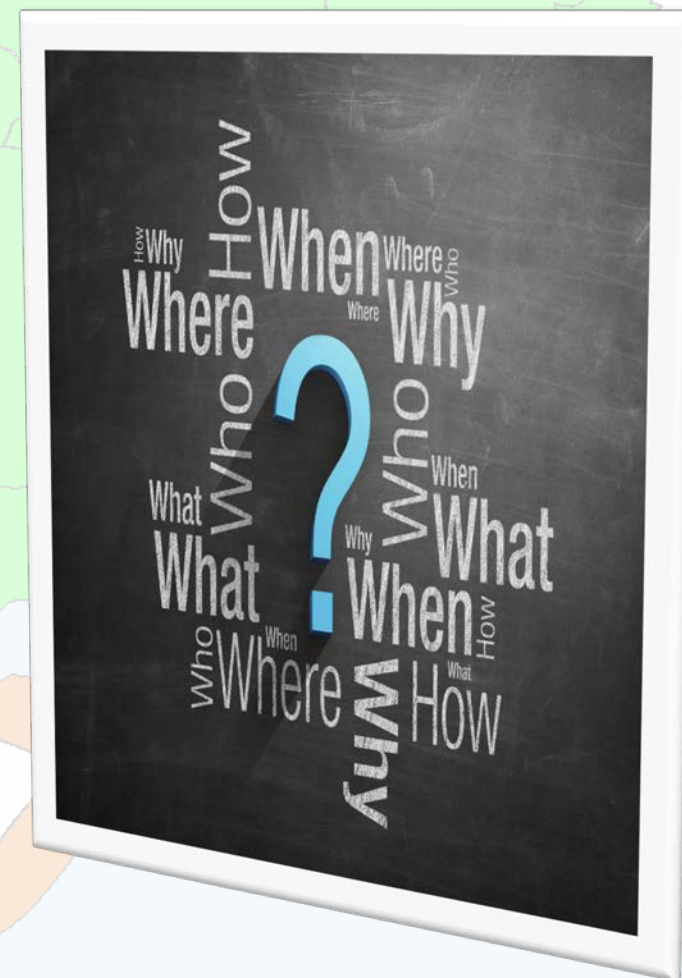
# Social Determinants of Health (SDOH)





# Research Question

**What are physicians in Eastern Mediterranean countries doing to address the social determinants of health of their patients; and how does this compare to the way that health workers practice in Western countries like Canada?**







# Research Objectives

To explore what doctors from the EMR have done to support their patients living in poor social conditions

To identify main social challenges facing patients in the EMR from the perspective of their doctors

To identify barriers to addressing social causes of poor health by doctors in EMR

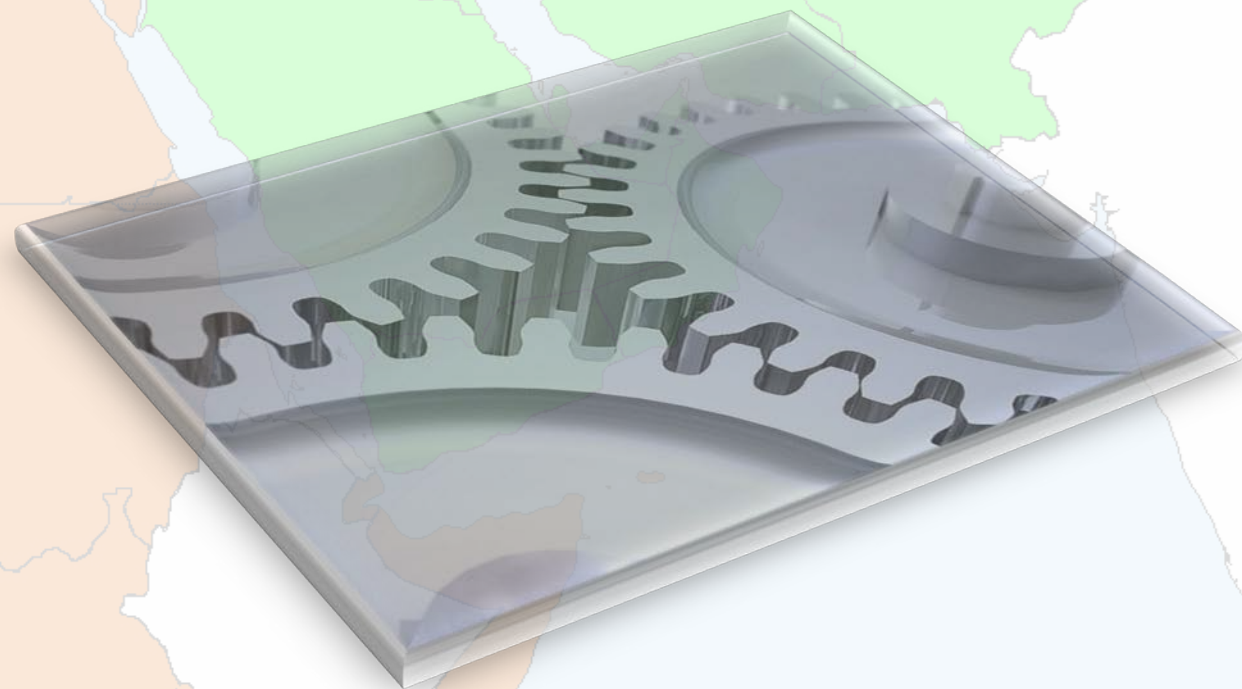
To highlight the difference between EMR & Canada in addressing SDOH



# Study Design

## **Qualitative Description:**

To obtain a direct description of what the doctors do to tackle the underlying causes of poor health of their patients in the clinical practice in EMR.







# Methods

- Semi-structured in-depth interview
- Interview guide
- Sampling strategy:
  - Purposive maximum variation sampling
  - Snowball technique
  - Targeting wide range of countries, ages, genders, time since graduation, etc.
- Sample size:
  - Recruitment continued until data saturation was reached (18 interviews)





# Study setting

- Department of Family Medicine at McGill University in Montreal
- 15 out of 18 were conducted in person (face-face)
- Three interviews were conducted by phone with participants living outside the city of Montreal





# Inclusion Criteria

- Doctors who have been trained and had provided direct medical care in one of the EMR countries.
- All participants have to be currently living in Canada







# Data Analysis

- The 18 in-depth interviews were conducted and recorded in English
- The audio-recordings were transcribed
- Qualitative Content Analysis  
Allows the emergence of codes and categories from the research data rather than using codes from a previous theory.





# Results

## Main social challenges faced by patients in EMR

Poverty

Lack of Education

Illiteracy

Job Precarity

Food Insecurity

Stress

Addictions

Unstable Families

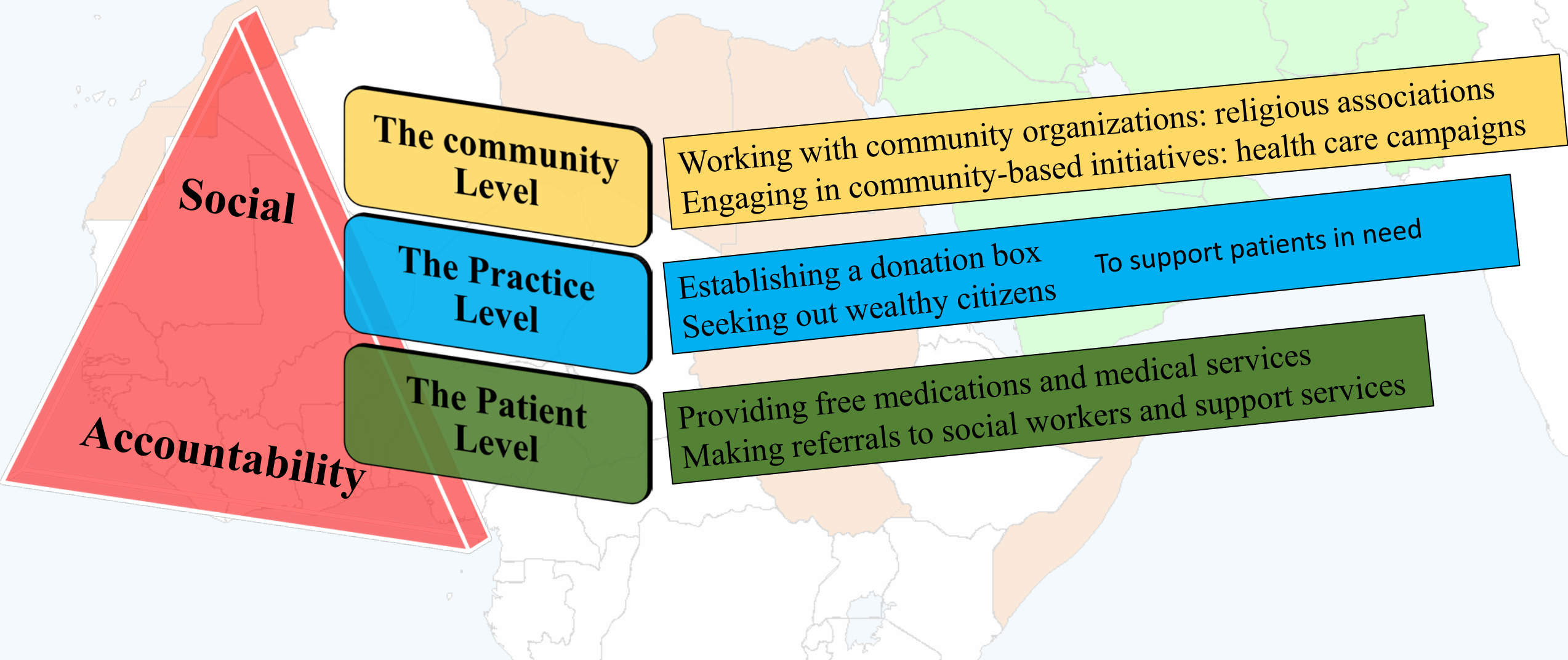
Domestic Violence

Child Abuse



# Results

## Action on SDOH in clinical practice







# Results

## Barriers to Addressing SDOH

### **Cultural constraints and social norms**

**Avoid getting involved in other people's business**

**Avoid being singled out as going against the norm**

### **Limited access to primary care and social support organizations**

**Doctors have too little time**

**Too many patients to see**

**Not enough family doctors**

**Lack of availability and effectiveness of referral resources**

### **Government policies and structural factors**

**Few social security nets**

**Limited national wealth**



# Results

## Difference between EMR & Canada in addressing SDOH

Canada is better in dealing with the social challenges than EMR

- Greater financial resources available
- More developed system of primary care
- Doctors are more likely to be trained to ask about social determinants of health
- Greater availability of social support organizations and social workers
- Doctors are provided with lists of referral resources to know where to refer

**WHY?**



# Recommendations for EMR

## Educating doctors about SDOH

- **Integrate education about SDOH into medical school curriculum**
- **Train health workers to ask about SDOH**
- **Familiarize health care providers with resources available**

## Educating patients about SDOH

- **Organize sessions to raise patients' awareness about the importance of discussing their social challenges during the clinical encounter**

## Financial support

- **Find suitable financial resources to support doctors action on SDOH**







# Recommendations for EMR

## Strengthening the doctor-patient relationship

- **Doctors should avoid being judgemental towards their patients**
- **Doctors must place themselves in the patient's position**
- **The social challenges should be addressed, directly or indirectly, and must be adapted to the local culture**

## Governmental actions

- **Copying the social aid system in Canada**
- **Establishing effective collaboration between government and NGOs**





# Conclusion & Implications for Canada

**Better understanding  
the social challenges  
and contexts faced by  
patients in their  
countries of origin**

- **Provide South-North learning**
- **Help Canadian health workers identify and act upon social challenges of the diverse patient populations**
- **Promote greater cultural competence**
- **Reduce marginalization and inequity in the Canadian context.**



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# Questions ?

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