

# The Sociopolitical Health Hegemony Theory (SPHHT) of Health and Diseases: Towards a Healthier World

Evariste Erwin Sebahutu

Ballsbridge University, Common Wealth of Dominica.

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\*Corresponding author:  
Email: Erwin.ndaruhutse@gmail.com

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## Abstract

The Sociopolitical Health Hegemony Theory (SPHHT) offers a critical reinterpretation of the determinants of health and disease, emphasizing the central role of sociopolitical power structures in shaping population health outcomes. Departing from traditional models that predominantly attribute health disparities to biological, environmental, or isolated social factors, SPHHT argues that health is a politically governed domain where systemic inequalities are both produced and perpetuated through strategic policy decisions and governance practices. Beyond neglect or systemic failure, SPHHT highlights the deliberate compromise of healthcare systems through over-commercialization, where profit motives override public health needs, and policies that, whether by action or omission directly harm populations. SPHHT also exposes the emergence of Hippocratic bioterrorism, wherein healthcare systems and biomedical knowledge are weaponized by governments or dominant institutions to inflict harm under the pretense of care. This theory critiques the prevailing focus on Gross Domestic Product (GDP) as the primary measure of national progress, advocating instead for a model that prioritizes Gross Domestic Happiness (GDH) and genuine citizen well-being. Through the lens of SPHHT, investments in healthcare infrastructure, technological advancements, and mortality management systems are revealed not merely as responses to population needs but as politically motivated strategies that often anticipate and accommodate preventable disease and death rather than eliminate them. By exposing the hegemonic dynamics underlying health governance, SPHHT calls for a paradigm shift toward equitable health systems that center individual and household well-being as the true foundations of a healthier world and true foundations of national development.

## Introduction

In *Homo Deus: A Brief History of Tomorrow*, Yuval Noah Harari argues that humanity has made extraordinary progress, overcoming famine, plague, and war not only through technology but also through our unique ability to unite around shared myths: political, religious, or cultural that enable collective action. With rapid technological advances, he suggests we are now entering a new frontier: the pursuit of immortality, where extending human

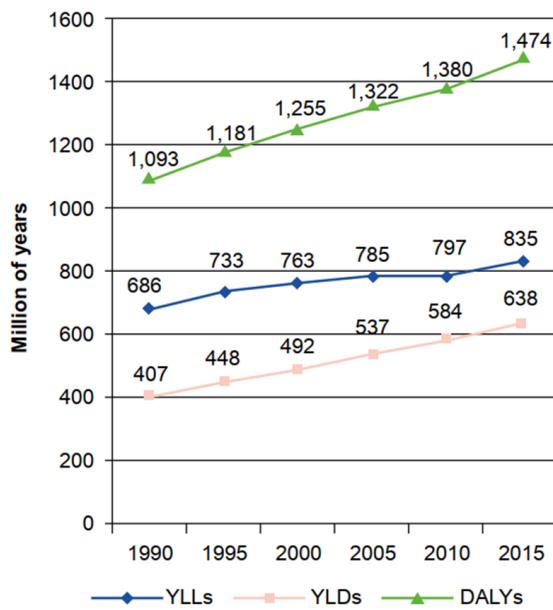
life becomes the next great chapter in our story of progress. He maintains that immortality remains far from reach, yet for the first time in history, humanity faces a new reality: more people die from overeating than starvation, from old age rather than infectious disease, and by suicide rather than violence. He highlights how the twentieth century nearly doubled life expectancy, from forty to seventy years, thanks to modern biomedicine. While these challenges are not fully eradicated, humanity has largely brought once-

uncontrollable natural forces under control. Today, when things go wrong, our instinct is to assume human error and demand accountability (Harari, 2017). Harari observes that when famines or epidemics overwhelm our defenses, it is “almost always caused by human politics rather than by natural catastrophes” and that if an epidemic gets out of control is mainly due to human incompetence and I can add the possibility of some occult group’s political and economic gains in addition to what he calls “ruthless ideology.” While he praises *Homo sapiens*’ success in reducing deaths from infectious disease and malnutrition, he stresses that modern biomedicine, though it saves us from premature death, has not extended the natural human lifespan. Looking ahead, he identifies humanity’s next pursuits as immortality, happiness, and divinity, but emphasizes that progress will hinge on politics. Happiness, he notes, is often seen as a collective project requiring governments to prioritize social and economic policies that increase well-being. Drawing on Jeremy Bentham’s principle of “the greatest happiness of the greatest number,” he criticizes governments for measuring progress by GDP rather than by Gross Domestic Happiness (GDH). He argues that many political systems prioritize national strength and the power of elites over the health of their populations. This explains why, despite rapid development, well-being levels in the U.S. and Japan remained stagnant from the 1950s to the 1990s. For Harari, happiness arises when reality matches expectations, echoing John Stuart Mill’s view that happiness is pleasure and freedom from pain.

Yet, I argue that a distinction must be made between living longer and living a longer, healthier life. Harari points out that while South Koreans escaped poverty, their suicide rate has tripled since 1985, and despite antibiotics, vaccines, and advanced medical systems, half of humankind is expected to be obese by 2030. Non-communicable diseases such as cancer, heart disease, and mental disorders now dominate the global burden of disease. This reflects not only unhealthy lifestyles but systemic failures, since with our capabilities, much more should have been achieved. As a result, we live longer but often unhealthier lives. A more suitable measure of this shortfall is years lived with disability (YLD), which captures the healthy years lost to disease or injury, an

indicator increasingly shaped by non-communicable and mental disorders. An interpretivist-constructivist approach used to examine the impact of politics and political systems on the global rise of mental disorders, especially in poor and developing countries, led to the formulation of the biopsychological model of mental health and diseases as a guide for both preventive and curative strategies (Sebahutu, 2023a). Within this framework, a class of politically driven mental and related somatic disorders, such as hypertension, was proposed under the name Social Distress Coping Disorders (SDCDs). Empirical studies from different regions reinforce this perspective. In South Korea, Park et al. (2019) analyzing data from 2002 to 2015, projected that by 2030, 80% of all deaths will be due to non-communicable diseases (NCDs), with cardiovascular diseases among the top three. I refer to such conditions as diseases of choice, not because they are freely chosen, but because both individuals and political leaders are coerced or compelled into choices shaped by political and economic structures. These can thus be considered politics-driven diseases, many falling within the SDCDs category (Sebahutu, 2023a). In Poland, using data from 1990 to 2015, Kissimova-Skarbek (2016) found that the top ten causes of disability were all NCDs, including lower back and neck pain, depressive disorders, diabetes, migraines, and anxiety disorders. Almost all of these showed rising contributions to years lived with disability (YLDs) over the study period, with YLDs from diabetes mellitus increasing by more than 77%. Regarding years of life lost (YLLs), she concluded that they were largely avoidable. Similarly, in Qatar, Bener et al. (2013) reported that 72.7% of the total disease burden in 2013 came from non-fatal health outcomes (YLDs), urging a stronger focus on cardiovascular diseases, road traffic accidents, and mental health. In Sierra Leone, Zembe et al. (2022) tracked disease burdens from 1990 to 2017 and found that while communicable, maternal, neonatal, and nutritional (CMNN) diseases were still high due to endemic conditions, they were declining, whereas NCDs were steadily increasing, thereby driving YLD growth. In high-income settings, similar patterns appear. In Australia, Islam et al. (2023) used data from 1990 to 2019 and found that although overall disability-adjusted life years (DALYs) decreased by

24.6% (95% UI 21.5–28.1), the leading causes of YLDs in 2019 were NCDs, particularly low back pain and depressive disorders. Between 1990 and 2019, YLDs rose significantly: anxiety disorders by 1.3% (95% UI: -5.4 to 9.1), drug-use disorders by 35.8% (95% UI: 19.9–55.6), and diabetes by 64.5% (95% UI: 47.6–85.2). In the Americas, Martinez et al. (2021) examined adults aged 65 and older between 1990 and 2019. Life expectancy at 65 increased from 17.1 years (95% UI: 17.0–17.1) in 1990 to 19.2 years (95% UI: 18.9–19.4) in 2019. However, healthy life expectancy rose only modestly, from 12.2 years (95% UI: 10.9–12.4) to 13.6 years (95% UI: 12.2–14.9). They concluded that older adults now spend a significant proportion of their lives with disability and illness, with most of the burden attributable to preventable NCDs. At the global level, Kissimova-Skarbek (2016) analyzing data from 1990 to 2015, found that both YLLs and YLDs increased worldwide, with cardiovascular diseases at the forefront. Strikingly, 54% of all global deaths and 43% of NCD-related deaths were premature and avoidable. She attributed the rise to aging populations and unhealthy lifestyles.



**Figure 1.** Global burden of non-communicable diseases expressed in YLLs, YLDs, and DALYs, years 1990–2015.

\* Reproduced from Kissimova-Skarbek (2016) under Creative Commons License

In its 2017 study, the Global Health Metrics (2018) and its collaborators found that between 1990 and 2017, the all-age YLD rate increased by 7.2% (6.0–

8.4), while the total global YLDs rose from 562 million (421–723) to 853 million (642–1100). Across both sexes, the leading contributors were NCDs, particularly low back pain, headache disorders, and depressive disorders. The authors argue that as biomedical advances extend life expectancy, populations increasingly face complex and costly diseases, non-communicable conditions that dominate the global burden of ill health. Another telling indicator of the world's unhealthy living patterns is the rapid expansion of pharmaceutical consumption. González Peña et al. (2021) reported that the global pharmaceuticals market exceeded USD 1 trillion, growing at 5.8% annually since 2017, with revenues reaching USD 1,143 billion and projected to hit USD 1,462 billion by 2021. Chronic diseases were identified as the major driver of this growth. The top five most consumed drugs globally targeted cardiovascular and metabolic diseases, particularly diabetes. Between 2000 and 2015, cholesterol-lowering drug use nearly quadrupled, antidepressant consumption doubled, and the use of antihypertensive and antidiabetic drugs almost doubled across OECD countries. These trends illustrate that while people now live longer, they spend a significant portion of those years in poor health, as reflected in the sustained rise of YLDs.

Why, then, are we failing at such a fundamental point? Political systems often appear more invested in the abstract development of the nation than in the lived realities of individuals and households, which form the true foundation of national progress. Instead of fostering healthier, more fulfilling lives, governments frequently channel resources into building hospitals, acquiring advanced medical technologies, and even expanding mortuary facilities, as though rising disease and death are inevitabilities to be managed rather than prevented. In Rwanda, there is a widely accepted yet problematic saying: “*Igihugu giteza imbere abaturage*” (“A country develops its citizens”). This raises a crucial question: which truly drives development, the state or its citizens? I contend that genuine progress arises from the development of individuals and households, not the reverse. When governments prioritize national prestige over personal well-being, the result is a hollow vision of development. In many developing nations, national budgets disproportionately favor large-scale projects

aimed at generating tax revenue and boosting GDP-projects that may result in skyscrapers occupying a tiny fraction of land while the majority of citizens remain in poverty. Meanwhile, political leaders benefit from enhanced welfare in the form of higher salaries, bonuses, and, in some cases, corruption. Yes, some funds are allocated to schools, but education cannot flourish in communities ravaged by poverty, ill health, and economic instability. Unless the well-being of individuals and households is made the true centerpiece of development, national progress will remain superficial, inequitable, and unsustainable.

## Objectives

A central outcome of this research is the development of the Sociopolitical Health Hegemony Theory (SPHHT) of Health and Diseases, which provides a conceptual framework to analyze and explain the complex connections between political factors, systemic inequities, and targeted actions by governments or corporations that undermine public health. By bridging political science, public health, and epidemiology, this theory aims to deliver actionable insights for policymakers, healthcare professionals, and global health advocates. The goal is to foster the creation of targeted interventions and evidence-based policies that not only promote health equity but also protect populations from deliberate harm and ensure accountability in governance and commerce.

## Methods

This study adopted an interpretivist-constructivist qualitative design aimed at developing new theoretical insights into the politics of health and diseases. It relied entirely on secondary sources, including peer-reviewed publications on the global burden of disease, political determinants of health, and mental health, as well as international policy reports and country case studies such as South Korea, Poland, Sierra Leone, Qatar, Australia, and Rwanda. These cases were chosen for their ability to illustrate contrasting political, economic, and social contexts influencing health outcomes. The analysis was guided by conceptual frameworks I have

previously pioneered, namely the Biopsychopolitical (BPP) Model of Mental Health and Diseases, Social Distress Coping Disorders (SDCDs), Multiple Mental Disorders (MMD), Psychoicide, Psychoethnicide, Hippocratic Terrorism, and Hippocratic Bioterrorism. The analytical process followed three steps: first, thematic synthesis, focusing on identifying recurring patterns in the literature and contextual observations, particularly those related to the political prioritization of state interests, the neglect of household wellbeing, and structural drivers of diseases; second, comparative analysis across different contexts to highlight how political systems shape health trajectories; and third, theoretical integration that expanded the existing frameworks into the Sociopolitical Health Hegemony Theory (SPHHT). Rather than generating new empirical data, this methodology systematically synthesized secondary evidence through the lens of original models, with the aim of reconceptualizing the burden of modern somatic and mental disorders as fundamentally political in origin, thus offering a novel explanatory lens for both prevention and policy intervention.

## Literature review

### *Review of existing theories of health and disease causation*

From the demonic theory and miasma theory of diseases to the modern understanding of biomedicine and human psychological origins of diseases, tremendous achievements have been made. In order to influence medical practice, and especially preventive approaches to diseases (Satyarup et al., 2020). Through a long and still ongoing journey, many theoretical frameworks for health, diseases and care have been formulated. However, it can be confidently predicted, by looking at the current trends in the global morbidity of diseases, especially the rise and ever-increasing burden of non-communicable diseases (NCDs), that the current knowledge and understanding of the quadripartite health, disease, care and prevention is far from being fully digested. Broadbent (2009) argues that conceptualizing a framework for thinking and understanding disease causation has proved “astonishingly difficult.” As long as humanity doesn’t fully account for this very complex issue, it will always be positioned itself a

significant step far away from eradicating existing and very importantly shield itself from other possible future emergence of new diseases. Primitive theories, i.e., theories before the 18th century, of health and diseases include the demonic theory according to which diseases results from the infestation of the body by demons and evil spirits hence the recourse to sorcery to cure the diseased person (Satyarup et al., 2020). According to this theory, the cure lies in practices such as sacrifices and exorcism. The punitive theory regards the God or gods' outrage as the source of ill health hence practices to appease the deity for the disease to go away (Satyarup et al., 2020). The metaphysical theory of health and diseases was built upon the belief that there exist occult forces beyond our physical universe hence the doctrine of signatures, where there exist similarities between the disease and its cure, such as using toads to treat warts (Dan-Bush, 2022). The miasmatic theory regards miasma, poisonous emission from putrefying carcasses, rotting vegetation or molds and invisible dust particles inside dwellings, as the cause of diseases hence breathing bad air mainly in areas around swamps, marshes, as a result of ill health (Kannadan, 2018; Satyarup et al., 2020). Kannadan (2018) argues that even malaria derives its name from this theory since in Italian mala means bad and aria means air. According to the same author, the father of the theory is the Greek physician Hippocrates. The theory of four humors, in which the human body is made of four humors: blood, phlegm, yellow bile and black bile that have to maintain a balance and hence their imbalance result in diseases. While based on the Hippocratic bodily humors, the theory was elaborated by Galen (Freezer, 1921; Lips-Castro, 2015; Satyarup et al., 2020). According to (Lips-Castro, 2015), Galen proposed that "health is a condition of harmony and balance between humors, i.e., a state of eucrasia, and the opposite generated disease." All these primitive theories share the fact that they are based on beliefs rather than established facts. The contagion theory was pioneered by Fracastoro. Besides the malodorous miasmatic origin of diseases, Fracastoro in his *De contagione et contagiosis morbis* proposed that *seminaria primaria* were the fundamental seeds of contagion (Lips-Castro, 2015). The Sydenham's theory of diseases causation was built on the premises

that the disease was the result of the effort made by the body to throw off or to expel the *materies morbi*, which are the dead materials within it and which had made the trouble (Freezer, 1921). The Homeopathy theory was pioneered by Hahnemann, who suggested that diseases are effects of some spiritual influence and that they must be treated by removing the symptoms in a holistic manner. This empiricist reasoning led him to suggesting the introduction into the diseased body of a small amount of drugs that produce disease-like effects in the healthy body (Freezer, 1921).

Modern theories start with the 18th century's germ theory of disease, named after the Louis Pasteur's landmark research on microscopic organisms diseases causation. Hence, the focus from empirical causes such as bad air and the wrath of God was altered to scientifically plausible causes like the presence of specific microorganisms. This is the basis for the "monocausal model" of diseases' etiology, also known as the "doctrine of specific etiology" (Broadbent, 2009; Hewa, 2015; Najman, 1980; L. N. Ross, 2018; Satyarup et al., 2020). According to Broadbent (2009), The medical and scientific community has dwelt in thinking diseases in the monocausal model of diseases' etiology that in fact worked for infectious diseases but is deficient regarding modern chronic non-communicable diseases. The biomedical model, on the other side, considers the human body as "efficiently functioning machinery" hence any deviations results in the malfunctioning of its component organs. This model is also known as Western medicine where a disease is considered a deviation from the normal biological or somatic variables hence the balance is restored by medicines (Hewa, 2015; Satyarup et al., 2020). Since the doctor is considered a mechanic to repair the bodily machine, according to Hewa (2015), This lead to the model being termed the "mechanistic biomedical model." The epidemiological triad model, considered superior to the germ theory due to its taking into account the complementarity of the tripartite Host, Agent, and Environment for an agent to succeed in disease causation (Satyarup et al., 2020). The Dever's epidemiological model considers the disease to result from the interplay of four elements: Human biology (genetics, physiological processes, maturation and aging), Lifestyle (daily habits, customs, and

traditions), Environment (living and non-living factors that surround us) and Health system (accessibility and availability of health services) (Satyarup et al., 2020). The ecological theory of health and diseases was built on the 1979's Bronfenbrenner's ecological systems theory (Sadownik, 2023) and was adapted to public health by scholars such as (McLeroy et al., 1988) emphasizing that health outcomes result from interactions between individual, interpersonal, community, and societal factors. The multifactor causation model or the concept of multicausality was pioneered by Pettenkofer, where he contends that a disease results from many factors as opposed to the germ theory. In this regards, diseases are a result of "continuous chains of cause and effects, not of single or specific causes alone". The model recognizes diseases as interacting factors from the physical and social environment (Najman, 1980; Satyarup et al., 2020). The web of causation model was proposed by MacMahon, Pugh, and Ipsen in 1960. They argue that multiple factors that cause diseases cannot be explained using a linear causation relation since according to them "there are complex precursors to each causal component in the chain that have their respective complex interactions that overlap each other" hence a complicated web of interactions rather than a linear causal relation. This model integrates social factors with biomedical etiological factors (Satyarup et al., 2020). The wheel of disease causation model was pioneered by Mausner and Kramer in 1985 and rejects the agent as the sole cause of diseases but instead the complex interaction of physical, biological, and social environments but also including the genetic make-up in the blend. The core of the wheel is made of the genetic make-up while the outer circumference is divided between environmental factors comprising of social, biological, and physical factors (Satyarup et al., 2020). The Diathesis-Stress Theory of Health and Disease proposes that diseases develop from the interaction between underlying vulnerabilities (biological, psychological, or social) and external stressors (Ingram & Luxton, 2005; Monroe & Simons, 1991). The psychosomatic theory of disease on the other side hand is argued to have originated from the works of Sigmund Freud and Jean-Martin Charcot on the effect of the subconscious on health and disease. According to this theory, somatic signs

and symptoms have a psychological origin since psychosocial factors play an important role in the occurrence and development of diseases (De la Serna, 2019; Okumura et al., 2020; Wolf, 1971).

The medical model or biomedical model was fused with the psychosomatic theory by (Engel, 1977) to produce the currently widely accepted model known as the biopsychosocial model mainly used in psychiatry and clinical psychology. The biopsychosocial model posits a multi-dimensional understanding of health and illness, emphasizing the dynamic interplay between biological factors (genetics, physiology), psychological factors (emotions, behavior, cognitions), and social factors (socioeconomic status, culture, relationships) in shaping individual experiences and outcomes. This holistic approach recognizes that these factors are not isolated, but rather continuously interact and influence each other, providing a more comprehensive lens for understanding health phenomena compared to solely biological models (Benning, 2015). The most recent biopsychopolitical model of mental disorders and related somatic diseases emphasizes on the shortcomings of the biopsychosocial model that do not fully address the origins of social distress which is embedded in contemporary political systems, which are mostly authoritative and dictatorial especially in poor and developing countries (Sebahutu, 2023b). Almost all modern social processes are man-made; in fact they are shaped and driven by economic and political agendas. The Political Economy Theory of Health suggests that through what I call "normal" economic processes, primarily shaped by neoliberal economic policies, resources are distributed, wealth is accumulated, and access to a healthy life is determined. However, these processes inherently produce structural inequalities, leading to the unequal distribution of resources and social determinants of health. As a result, marginalized populations experience disparities in healthcare access, living conditions, and overall well-being. In response to these inequities, humanitarian and social movements emerge, advocating for health justice, policy reforms, and equitable access to essential services (Harvey, 2021; Jasim, 2021).

### Strengths and weaknesses of existing theories

Primitive theories of health and diseases causation such as the demonic theory, punitive theory, miasmatic theory and the contagion theory, shaped the understanding of diseases causation for a long period of time. They were rejected due to the lack of a scientific foundation, and this happened after the discovery of microorganisms as causative agents for diseases, hence the germ theory of diseases causation. While the Fracastoro's contagion and his seeds of contagion may be considered precursors of the germs theory, Lips-Castro (2015) argues that he was not able to explain if the seeds were living or inert matter. While the biomedical model has had a huge success in infectious diseases, Hewa (2015) argues that the weakness of the model lies in its inability to account for social, environmental, behavioral, and psychological dimensions of health and illness. Accordingly, mental and behavioral disorders also result from biochemical and neuropsychological deficiencies. The model is criticized for its reductionist approach to diseases phenomena, the cause and effect. Engel's biopsychosocial model of health and diseases has been criticized for its oversimplification of the complex interactions between biological, psychological, and social factors. While it successfully acknowledges the importance of these elements in understanding health and diseases, the model fails to fully address the deep structural and political forces that shape health outcomes. It tends to categorize health determinants too broadly, often missing the nuances of power, inequality, and systemic oppression. Moreover, the model struggles with clear operationalization and practical application in diverse settings, making it challenging to use consistently. Sebahutu's biopsychopolitical model offers a solution by incorporating the political dimension, emphasizing how power structures, including state policies, social inequalities, and cultural narratives, influence health and diseases. By integrating political factors into the biopsychosocial framework, the biopsychopolitical model provides a more comprehensive and contextually sensitive approach to health, addressing the systemic forces that Engel's model overlooks. The political economy theory, while recognizing the interrelationship between politics and economics in shaping health outcomes, it falls short in integrating

or emphasizing on malignant economico-political processes intentionally inflicted on the population by the same governments supposed to be working in favor of that same population. Building on the successful formulation of the Biopsychopolitical Model of Mental Health and Diseases, which illuminated the overwhelming interrelationship between the biological, psychological, and political factors in shaping mental health and outcomes and causing somatic disorders such as hypertension, deeper analysis revealed an even more profound influence of politics on broader health outcomes. This realization catalyzed the expansion of the original model into the comprehensive "Sociopolitical Health Hegemony Theory (SPHHT) of Health and Diseases." The SPHHT broadens the scope to encompass the full spectrum of modern communicable and non-communicable diseases, highlighting how political determinants, governance structures, commerce (of pharmaceuticals especially) and socio-economic inequities shape health outcomes at both individual and population levels. This theory not only underscores the interconnectedness between human activities and the emergence of diseases but also serves as a framework to guide both curative efforts and, more critically, preventive interventions. By integrating sociopolitical dimensions with health science, SPHHT aims to unveil and address systemic root causes of health disparities and foster strategies that prioritize sustainability and equity in global health outcomes. The Sociopolitical Health Hegemony Theory (SPHHT) also acknowledges an alarming modern phenomenon: the compromise of biomedicine through what was termed "Hippocratic Bioterrorism." This concept describes a scenario in which global elites encompassing political, financial, and pharmaceutical powers manipulate biomedical interventions and global institutions, such as the World Health Organization, national governments, and their subsidiaries, to directly harm populations under the guise of public health interventions. These actors deploy pseudoscience-backed biomedical interventions and even bioweapons, motivated by the pursuit of financial gains and the consolidation of political power. SPHHT examines how this exploitation of biomedicine undermines the foundational principles of the Hippocratic Oath,

transforming health interventions into tools of control and profit at the expense of human well-being. By integrating this dimension, the theory provides a critical lens to analyze and address the misuse of scientific authority in perpetuating global health issues and fostering mistrust in public health systems.

### Rationale for a New Theory

A major shortcoming of existing theories of health and disease is their failure to capture the wide range of modern practices through which biomedicine is compromised by political and economic interests. These practices include over-commercialization of care, the crippling of public health systems, cryptopharmacy, and pharmacodeception, among others. Together, they represent mechanisms by which global elites: political, financial, and pharmaceutical; exploit biomedical authority and international institutions such as the World Health Organization, national governments, and their subsidiaries, often causing harm under the guise of public health. In such contexts, pseudoscience-backed interventions and even bioweapons may be deployed, driven not by the Hippocratic principle of protecting life but by the pursuit of financial gains and political dominance. These realities expose critical blind spots in traditional theoretical frameworks, which do not account for the political determinants of disease or the systemic misuse of biomedical science. This recognition underscores the urgent need for a comprehensive framework: the Sociopolitical Health Hegemony Theory (SPHHT); to explain how political decisions and indecisions shape modern health outcomes and perpetuate the global burden of disease.

### Theoretical framework

The formulation of the Sociopolitical Health Hegemony Theory (SPHHT) of Health and Diseases involves a comprehensive exploration of how modern sociopolitical processes are the main factors that contribute to health outcomes and the prevalence of diseases. Drawing from political science, sociology, and public health, in the following paragraphs, we will shed light on the complex relationships between political decisions, health policies, and environmental changes, highlighting their impact on health and outcomes. By integrating secondary

data with theoretical frameworks, we aim to elucidate the mechanisms through which economic decisions, governance structures, social inequities, and politically induced human activities such as deforestation and urbanization drive the emergence and spread of diseases. The theory posits that human actions, influenced by political and economic imperatives, significantly alter microbial ecosystems and contribute to the rise of both infectious and non-communicable diseases, genetic disorders, and cancers. This theoretical foundation provides a basis for understanding health disparities and guiding policy interventions to create a healthier world. The power of elite decision-making and vision over citizens originates from a system intended to oversee and safeguard the well-being and possessions of all members of society. This foundation gave rise to governance and modern governments, built upon what is commonly referred to as the social contract (Elahi, 2005; Seabright et al., 2021; Youvan, 2023). However, as Thomas Hobbes theorized in his 1651 Leviathan (Brassey, 2009), human selfishness and greed have been persistent throughout history. Within this context, elites have repeatedly compromised the social contract, manipulating it in ways that jeopardize public health and well-being.

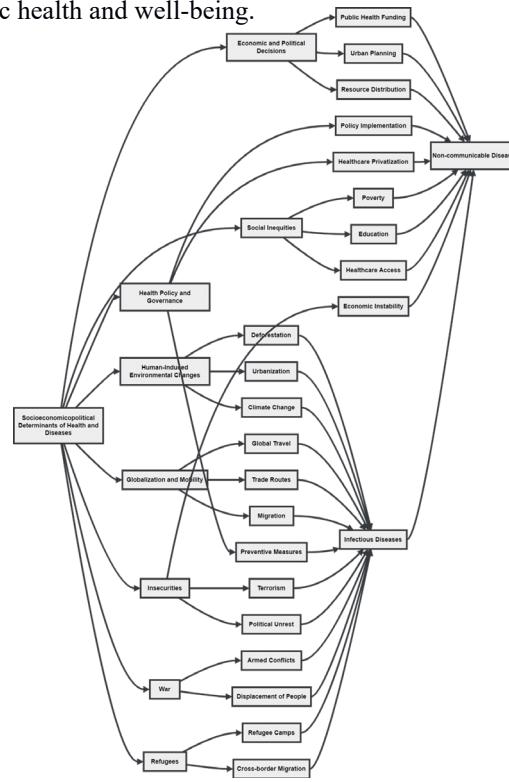


Figure 2. Socioeconomicpolitical origins of modern disease

Economic and political decisions that inadequately address public health funding, urban planning, and resource distribution create conditions that foster the emergence and escalation of non-communicable diseases (NCDs). Insufficient health funding limits access to preventive care, public health education, and early treatment, while poor urban planning discourages physical activity, promotes sedentary lifestyles, and exposes populations to environmental toxins. Furthermore, unequal resource allocation exacerbates health inequities, leaving marginalized communities vulnerable to conditions like hypertension, obesity, and respiratory diseases (Braveman & Gottlieb, 2014). Health policy and governance play a critical role in shaping disease outcomes, with gaps in policy implementation and the effects of healthcare privatization driving the rise of non-communicable diseases (NCDs). Poorly enforced policies fail to address underlying risk factors like unhealthy diets and pollution, while privatized healthcare often prioritizes profit over equitable access, leaving vulnerable populations without preventive care or treatment for chronic conditions (Labonté et al., 2011; Navarro, 2007). Similarly, inadequate preventive measures, such as underfunded vaccination programs and weak public health campaigns, contribute to the spread of infectious diseases. Social inequality, encompassing poverty, limited education, and inadequate healthcare access, plays a significant role in the rise of non-communicable diseases (NCDs). Poverty limits individuals' ability to afford nutritious food, safe housing, and healthcare services, increasing their exposure to risk factors like unhealthy diets, environmental toxins, and untreated conditions. Limited education further exacerbates this issue (Ross & Wu, 1995), as individuals with less knowledge about healthy behaviors and disease prevention are more likely to adopt lifestyles that contribute to NCDs, such as physical inactivity and poor dietary choices. Inadequate healthcare access compounds these challenges, preventing early detection, timely treatment, and effective management of conditions like hypertension, diabetes, and cardiovascular diseases. Insecurities, particularly economic instability, contribute significantly to the development of non-communicable diseases (NCDs) (Lund et al., 2013). Economic instability creates chronic stress,

which disrupts hormonal balance and increases the risk of conditions like hypertension, diabetes, and cardiovascular diseases. The financial unpredictability associated with unstable economies forces individuals to prioritize immediate survival over long-term health, often leading to poor dietary choices, limited physical activity, and delayed medical care. Furthermore, economic instability exacerbates mental health challenges, which are a very important class of NCDs in the modern world. On the side of infectious diseases, human-induced environmental changes such as deforestation, urbanization, and climate change significantly contribute to their emergence and spread. Deforestation disrupts ecosystems, forcing wildlife into closer contact with human populations and increasing the risk of zoonotic diseases like Ebola and Lyme disease. Urbanization, often poorly managed, creates densely populated areas with inadequate sanitation and water systems, providing ideal conditions for the spread of diseases like cholera and dengue fever. Climate change further exacerbates these risks by altering ecosystems, extending the habitats of disease vectors such as mosquitoes, and increasing the frequency of extreme weather events that lead to overcrowded shelters and compromised sanitation (Prüss-Ustün et al., 2017).

Globalization and mobility, characterized by global travel, trade routes (Tatem et al., 2006), and migration (Gushulak & MacPherson, 2004), play a pivotal role in the spread of infectious diseases. Global travel enables pathogens to cross borders rapidly, turning local outbreaks into global pandemics, as seen with COVID-19. Trade routes facilitate the movement of goods, including contaminated products, and inadvertently transport disease vectors like mosquitoes and rats, contributing to the spread of diseases such as malaria and the plague. Migration, whether due to economic opportunities, conflict, or natural disasters, often leads to overcrowded and unsanitary living conditions, creating hotspots for outbreaks of infectious diseases like tuberculosis and measles. Insecurities, particularly terrorism and political unrest, significantly contribute to the spread of infectious diseases. Terrorism often disrupts public health infrastructure, leaving communities without access to clean water, sanitation, and healthcare services, creating conditions favorable for outbreaks

of infectious diseases like cholera and dysentery. Similarly, political unrest destabilizes societies, leading to mass displacement of populations into overcrowded refugee camps or conflict zones where infectious diseases such as measles, tuberculosis, and malaria thrive due to poor hygiene and limited medical care (Topluoglu et al., 2023). War and forced displacement, including the movement of refugees across borders and their settlement in camps, significantly contribute to the spread of infectious diseases. Armed conflicts destroy healthcare infrastructure, disrupt vaccination programs, and limit access to clean water and sanitation, creating ideal conditions for outbreaks of diseases like cholera, typhoid, and respiratory infections. The displacement of people due to war forces large populations into overcrowded and unsanitary conditions, increasing the transmission of diseases such as tuberculosis, measles, and diarrheal diseases. Similarly, refugee camps, often lacking adequate healthcare services, clean water, and sanitation, become breeding grounds for infectious diseases, exacerbating public health crises. Cross-border migration further spreads

infections as displaced populations carry pathogens into new regions, overwhelming fragile health systems (Topluoglu et al., 2023).

Certain infectious diseases contribute to the development of chronic diseases, creating a long-term burden on public health (De Martel et al., 2012). Persistent infections caused by viruses, bacteria, and parasites can trigger chronic inflammation, tissue damage, and immune system dysregulation, leading to non-communicable diseases (NCDs). For example, human papillomavirus (HPV) infections are a major cause of cervical cancer, while hepatitis B and C viruses significantly increase the risk of liver cancer and cirrhosis. Similarly, chronic Helicobacter pylori infection is linked to stomach ulcers and gastric cancer, and tuberculosis (TB) can result in permanent lung damage, contributing to chronic respiratory diseases. Additionally, some infectious diseases, like HIV/AIDS, weaken the immune system, making individuals more susceptible to other chronic conditions such as cardiovascular disease and diabetes.

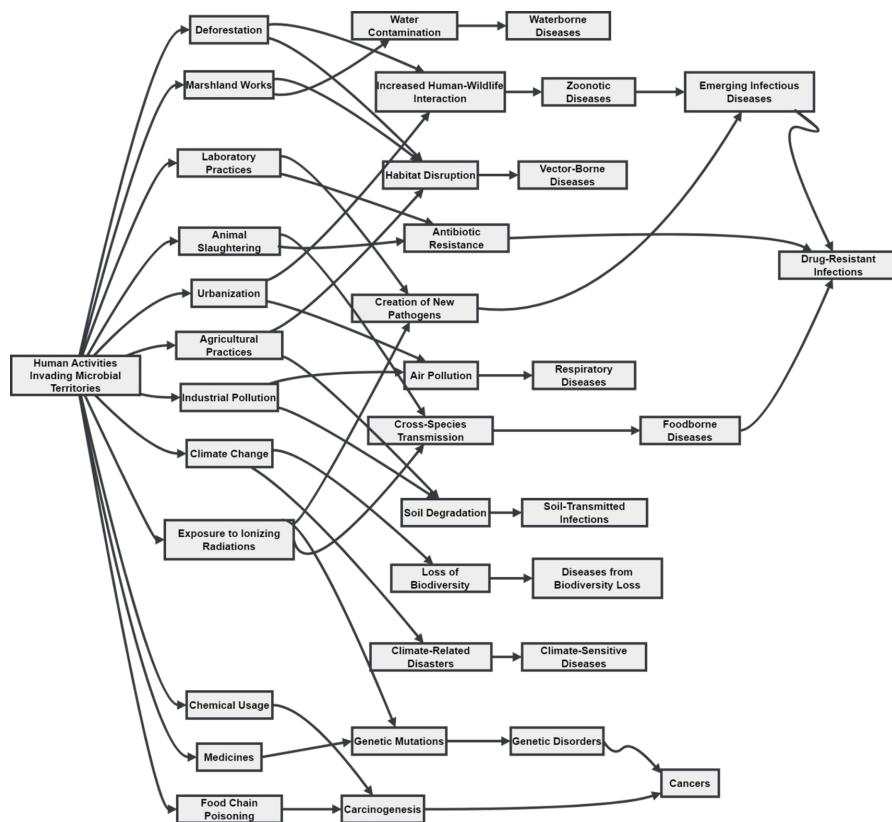


Figure 3. Human activities that invade the microbial world

The expansion of human activities has led to profound disruptions in microbial ecosystems, significantly contributing to the emergence of modern diseases. According to Finlayson et al. (2015), deforestation has increased human-wildlife interactions, creating conditions for zoonotic spillovers such as Ebola and the Nipah virus. The destruction of natural habitats forces animals to migrate toward human settlements, increasing the risk of pathogen transmission. Similarly, marshland destruction disrupts aquatic ecosystems, facilitating the spread of waterborne diseases like cholera and schistosomiasis. Wetlands, which serve as natural filters for pathogens, are often drained for agricultural or urban development, compromising their ecological role in disease prevention. Scientific advancements in biotechnology have also contributed to the alteration of microbial environments. Laboratory practices, including gain-of-function research (Casadevall & Imperiale, 2014) and genetic engineering, have introduced new risks, raising concerns about the potential for accidental or deliberate pathogen release. The overuse of antibiotics in laboratory settings has further accelerated the rise of drug-resistant bacteria, making previously treatable infections more difficult to manage. In parallel, industrial-scale animal farming and wet markets (Woo et al., 2006) have facilitated cross-species transmission of pathogens, as seen in the outbreaks of SARS and COVID-19. The high-density conditions in these environments promote viral mutations and rapid disease evolution. Urbanization further exacerbates these health risks by creating densely populated areas with inadequate sanitation, leading to the rapid spread of infectious diseases such as tuberculosis and dengue fever. Additionally, air pollution, driven by industrialization and vehicular emissions, contributes to the increasing prevalence of respiratory diseases, including asthma, chronic obstructive pulmonary disease (COPD), and lung cancer. Meanwhile, modern agricultural practices, particularly the excessive use of pesticides and chemical fertilizers, disrupt soil microbiomes, fostering the emergence of fungal and bacterial infections that affect both crops and human populations. Industrial pollution, including the release of toxic chemicals into water and air systems, has similarly been linked to a rise in metabolic and neurodegenerative diseases.

Another major contributor to the modern disease burden is climate change (Costello et al., 2009), which alters microbial ecosystems by shifting disease vectors and expanding the geographic range of infectious diseases. Rising global temperatures, for instance, have allowed malaria-carrying mosquitoes to thrive in previously unaffected regions, increasing malaria prevalence in temperate zones. Climate-related disasters, such as floods and droughts, have also contributed to outbreaks of leptospirosis, cholera, and respiratory infections. Furthermore, radiation exposure (Cardis et al., 2006), whether from environmental sources (e.g., nuclear fallout, medical imaging) or occupational hazards, has been shown to induce genetic mutations that predispose individuals to cancers and hereditary disorders.

The widespread use of chemical agents in industrial and consumer products has also been linked to rising rates of chronic diseases. Carcinogenic compounds found in plastics, pesticides, and household items have been associated with increased cancer incidence, while endocrine-disrupting chemicals affect reproductive health and metabolism. Similarly, pharmaceutical interventions, particularly the misuse of medications, have contributed to the development of drug-resistant infections and adverse metabolic effects. The contamination of the food chain with toxic substances, such as heavy metals and synthetic hormones, further exacerbates the burden of non-communicable diseases, including cardiovascular disorders and neurodevelopmental abnormalities (Ajibade et al., 2020; Landrigan et al., 2018).

### **The Consequences of Human-Induced Ecosystem Disruptions**

The cumulative effects of these human activities have led to a profound shift in disease patterns, accelerating the emergence of both infectious and non-communicable diseases. Zoonotic diseases, once confined to specific ecological niches, have now become global threats due to habitat destruction and increased human-wildlife interactions. The introduction of antibiotic-resistant pathogens into healthcare settings has further complicated disease management, rendering many conventional treatments ineffective. At the same time, the proliferation of synthetic chemicals, industrial pollutants, and radiation exposure has fueled an

unprecedented rise in cancers and genetic disorders. The transformation of microbial ecosystems, driven by pollution, antibiotic overuse, industrial agriculture, and climate change, has significantly contributed to biodiversity loss, thereby undermining the ecological balance that regulates disease dynamics (Cavicchioli et al., 2019). This microbial disruption compromises natural pathogen suppression, increases susceptibility to infections, and facilitates the emergence and spread of both zoonotic and antimicrobial-resistant diseases. Similarly, climate-induced shifts in disease vector populations have led to the resurgence of vector-borne diseases, affecting populations that were previously unexposed to such health threats. The interconnected nature of these processes underscores the urgency of addressing the root causes of disease emergence, rather than merely focusing on symptomatic treatments.

### **Modern gender dynamics: Emerging future public health threat**

It's all politics: either a direct products or byproducts of politics or a tools for political agendas. Contemporary gender dynamics have undergone rapid transformations due to shifts in social roles, economic independence, evolving norms around sexuality, and the politicization of gender identity. While such developments may reflect progress in equity and autonomy, they have also introduced complex and often destabilizing challenges to interpersonal relationships, family structures, and broader societal cohesion. Any disruption of social order cannot go without consequences. In recent years, feminist movements have significantly shaped contemporary gender dynamics, but the consequences of these shifts have been the subject of extensive debate. Both (Kaylee, 2014)'s critique in *To Hell... And Back?* and (Hamilton, 2022) analysis in *TOXIC: How Modern Feminism Has Destroyed American Society*, emphasizes the disruptive social effects of feminism, particularly in the realms of traditional gender roles, family structures, and moral values. Kaylee and Hamilton argue that feminism undermines the stability of the family unit, encourages individualism over communal responsibilities, and fosters gender conflict, contributing to social fragmentation and ideological divisions. These ideological tensions lead to psychosocial stress among individuals navigating

conflicting societal expectations, often resulting in mental health challenges such as the currently reported Relationship Disappointment Stress Syndrome (RDSS) (Mutuyimana, 2025), identity crises, and social distress—a pattern clearly visible in modern sociopolitical discourse. The consequences of feminist movements, as explored through various theoretical lenses, reveal a dynamic interrelationship between empowerment and conflict. While feminism has been instrumental in advancing gender equality, its impact on mental health, social cohesion, and public health outcomes cannot be ignored. As gender identities continue to evolve and challenge traditional norms, the sociopolitical and health implications of these shifts demand further exploration, particularly within frameworks that consider the biopsychopolitical consequences of ideological changes in modern society. The consequences of deteriorating relationship stability extend into more violent and structural forms of harm. Marital and intimate partner homicides often rooted in possessiveness, betrayal, or perceived disempowerment, have become alarmingly prevalent in both developing and developed settings. Extramarital relationships, driven by emotional neglect or shifting moral landscapes, contribute not only to RDSS but also increase the risk of sexually transmitted infections (STIs), domestic violence, and family dissolution. The sociopolitical response to such crises has often been inadequate or selectively biased, failing to address root causes such as socioeconomic strain, lack of mental health support, or hegemonic gender narratives.

Furthermore, unresolved relational stress and gender conflict have led to a number of secondary public health crises. Alcoholism and other substance abuse disorders often function as coping mechanisms in environments where emotional regulation and psychosocial services are lacking. In many low- and middle-income countries, the consequences spill over to the next generation—manifesting in the rising number of street children, many of whom are products of broken homes, domestic violence, or parental neglect. These children face heightened exposure to abuse, infectious diseases, malnutrition, and psychosocial trauma, perpetuating cycles of structural vulnerability. The SPHHT framework argues that these patterns are not incidental, but rather reflective

of deeper systemic neglect and political failure to prioritize relational and household-level well-being as integral to national development.

### Politics and Public Health at a Crossroads

The politicization of public health interventions exposes a deeply troubling dimension of governance and health policy. When health measures are selectively implemented based on ethnicity or other forms of structural racism (Bailey et al., 2017), socioeconomic status, or political affiliation, they perpetuate systemic inequities and leave marginalized populations disproportionately vulnerable to preventable diseases. Public funds misuse (Vian, 2008), often through corruption and misallocation, weakens health systems by diverting resources away from essential services like vaccinations, sanitation, and disease surveillance. Even more alarming is the deliberate targeting of populations through oppression and psychological operations (psyops), where regimes manipulate health crises to control or weaken dissenting groups (Regilme & Parthenay, 2024). This may manifest through the restriction of medical aid, misinformation campaigns, or even engineered crises that exacerbate disease outbreaks. The Sociopolitical Health Hegemony Theory (SPHHT) of Health and Diseases provides a comprehensive framework for understanding how political and economic structures shape global health trends. Unlike conventional biomedical models that focus primarily on pathogens and host responses, SPHHT emphasizes the role of human activities—driven by political, financial, and corporate interests—in altering disease landscapes. The theory posits that modern health crises are not merely the result of natural microbial evolution but are actively shaped by political agendas, governance failures, economic incentives, and environmental exploitation. A critical component of SPHHT is the concept of Hippocratic Bioterrorism, which highlights the deliberate misuse of biomedical science for financial and political gain. Global health institutions, including the World Health Organization, national governments, and pharmaceutical corporations, have been implicated in promoting pseudoscientific medical interventions that serve economic and geopolitical interests rather than public health needs. The theory contends that these actors manipulate

health policies to expand markets for pharmaceutical products while downplaying the environmental and political determinants of disease. This dynamic not only exacerbates health disparities but also erodes public trust in medical institutions. SPHHT also underscores the necessity of a preventive approach to global health governance. By identifying the political determinants of disease, the theory advocates for policies that address environmental degradation, regulate corporate influence over health systems, and prioritize equitable healthcare access. Rather than relying solely on curative interventions, a shift toward structural prevention—including sustainable urban planning, biodiversity conservation, and strict oversight of industrial pollutants—can mitigate the root causes of modern diseases.

### Conclusion and Call to Action

The escalating burden of modern diseases — both infectious and non-communicable — cannot be fully understood, let alone addressed, without confronting the human systems that fuel them. Our integrated model highlights how human activities that disrupt the microbial world, combined with deeply entrenched socioeconomic and political structures, are not peripheral but central determinants of disease emergence, distribution, and persistence. From the forced displacement of vulnerable populations to the commodification of healthcare and the ecological violence embedded in extractive economic policies, the root causes of ill health are profoundly political. These are not accidental outcomes but often consequences of deliberate decisions made by governments, corporate actors, and global institutions that prioritize profit, power, or ideology over human life and dignity. While displaced populations, particularly refugees, are often portrayed as vectors or burdens in global epidemiological discourse, there is nothing inherently blameworthy in their condition. The health vulnerabilities observed among refugee communities are not due to any intrinsic traits, but to the structural violence they endure, forced migration, statelessness, inadequate shelter, trauma, and exclusion from healthcare systems. Blaming refugees for public health challenges is not only

scientifically inaccurate but ethically indefensible. It deflects attention from the true architects of global health insecurity: the systems and decisions that create displacement in the first place.

We assert that disease is no longer solely a matter of biological pathology; it is a sociopolitical event. Health is no longer merely a medical concern; it is a human rights imperative. Governments must be held accountable for policies and practices that knowingly generate or sustain the conditions for mass illness, from war and forced displacement to the underfunding of public health systems and environmental degradation. These actions amount to biopolitical negligence, and in some cases, Hippocratic bioterrorism, the knowing abandonment or manipulation of health for political and economic ends.

#### We therefore call upon:

- Health and human rights activists, scholars, and organizations to unite in evidence-based advocacy, collecting and presenting data that exposes the structural violence embedded in disease patterns.
- Epidemiologists, social scientists, and public health professionals to adopt critical frameworks such as the SPHHT and integrate political and economic determinants into disease surveillance, response, and prevention strategies.
- International bodies and funding agencies to recognize and prioritize accountability mechanisms for state-level failures or abuses that directly endanger public health.
- The global publics to reject narratives that individualize blame for health crises and instead demand political transparency and justice in matters of disease and health governance.

It is time to reclaim health not as a privilege for the few, but as a collective right rooted in justice, equity, and truth. The evidence is clear. The systems are visible. The moral imperative is urgent.

## Recommendations

To effectively confront the complex and politically rooted determinants of modern health challenges, a dual-level response is required: one that addresses both downstream and upstream factors. As suggested by our Biopsychopolitical (BPP) model of mental health

and related somatic disease (Sebahutu, 2023b), health outcomes are shaped not only by biological processes but by the interplay of psychological suffering, social conditions, and political structures. We offer the following recommendations to health professionals, governments, and global health institutions:

#### For Health Professionals: Engage the Downstream Determinants with Dignity and Justice

- Health practitioners, especially in public and community health, must respond not only to biological symptoms but to the social suffering and psychosocial traumas that patients carry, especially among displaced and marginalized populations.
- Clinical and public health interventions must be designed with cultural humility, trauma-informed care, and community engagement, recognizing that patient preferences, lived experience, and dignity are not optional but essential.
- Lessons from the COVID-19 pandemic reveal that coercion and top-down mandates, even when scientifically grounded, often produce mistrust, resistance, and inequity. Professionals must strive to inform, empower, and collaborate rather than enforce.
- Health education, vaccine campaigns, and treatment efforts must be ethically grounded, emphasizing dialogue, consent, and shared decision-making over fear-based messaging or punitive enforcement.

#### For Governments and Policy-Makers: Address the Upstream Determinants with Accountability

- Governments must be held morally and politically accountable for the structural conditions that foster disease, including poverty, conflict, environmental degradation, and institutional neglect.
- Public health cannot be separated from governance. Addressing housing, employment, education, social protection, and peacebuilding is as essential to disease prevention as any clinical intervention.
- Refugees and displaced populations must be included in national health plans, given access to health and mental health services, and protected from discriminatory policies that weaponize health systems against them.
- The recent COVID-19 pandemic exposed the fragility of centralized, coercive health strategies that overlook social contexts and human dignity, preferences and agency. Governments must now

shift toward participatory public health, where communities are co-creators of policies that affect them.

#### **Cross-Cutting Principle: Recenter Public Health on People, Not Power**

- Across all levels, we urge a return to people-centered health governance: one that prioritizes equity, dignity, and justice over control, profits, or political gain.
- A new era of public health is needed: one that aligns with the principles of the Sociopolitical Health Hegemony Theory (SPHHT), where the root causes of illness are challenged, not merely managed.

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