Optimizing the impact of social determinants of health on exposed populations in urban settings in Chile

Professor Gabriela Charnes Cars

Senior Researcher, Department of Public Health of the University of Valparaíso, Chile

Pathways to better nutrition Series 2

NICK

Nutritional **I**mprovement for children in urban **C**hile and **K**enya

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Urbanisation can bring many benefits but in many cities the rate of change has been so fast and so dramatic that local and national governments have been unable to cope. Urban growth has outpaced their ability to build essential infrastructures leading to widespread social inequity and social stratification environmental degradation, heavy migrant inflows, and a breakdown of the social support systems and networks. In these poor urban areas there is a strong and well established link between the various dimensions of disadvantage and child malnutrition (both undernutrition and overnutrition).

NICK (Nutritional Improvement for children in urban Chile and Kenya) is a three year study that started in October 2010 with funding from the UK Government Department for International Development (DFID) through the Economic and Social Research Council. This study helps the cities of Mombasa in Kenya and Valparaíso in Chile reduce child malnutrition using participatory action research to broaden stakeholder participation at municipal level to change the social determinants. These determinants control the everyday conditions in which people are living and include education, income, working conditions, housing, neighbourhood and community conditions, and social inclusion. It is envisaged that this study will contribute to existing knowledge and also serve as a useful guide for action not only in Kenya and Chile but also in other countries with high levels of child malnutrition.

The partners

The research team is led from the Department of Humanities and Social Science, Institute of Education, University of London and the research is being developed collaboratively with partners in Chile and Kenya.

Lead partner

The Department of Humanities and Social Science, Institute of Education, University of London:
Dr. Pat Pridmore, Dr Tristan McCowan and Professor Roy Carr-Hill

Collaborating partners

Department of Public Health of the University of Valparaíso: Prof. Gabriela Charnes Cars and Dr. Beatriz Salgado Diez

The International Centre for Reproductive Health (ICRH), Kenya: Dr. Mary Amuyunzu-Nyamongo and Mr. Daniel Lang'o

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NICK
Department of Humanities and Social Science
Institute of Education

20 Bedford Way
London
WC1H OAL
United Kingdom

Tel: + 44 (0) 20 3073 8341
Website: http://nick.ioe.ac.uk

Email: p.pridmore@ioe.ac.uk

Abstract

This paper presents an analysis of the documentation on the Healthy Urbanisation Project in Chile (known as the HUP Chile), which was implemented from 2006-2009 with the aim of*'Optimizing the Impact of Social Determinants of Health on Exposed Populations in Urban Settings'*. The author of this paper was the Technical Director of the HUP Chile between 2007 and 2009.

The first stage of the project, in 2006, was financed and sponsored by the WHO Health Development Center in Kobe (WKC), Japan and carried out by the Faculty of Psychology of the University Diego Portales (UDP) and the School of Public Health of the University of Chile. The second stage, financed by the Chilean Ministry of Health, was conceived as an up scaling process to 9 regions of the country. It was implemented between 2007 and 2009, by an interdisciplinary team led by the Faculty of Psychology of the University Diego Portales.

The purpose of this paper is to give an overview of the different phases and methodological challenges faced by the HUP Chile and to share information and insight.. It also reviews some of the lessons learned from the WHO HUP and HUP Chile experience, analyzing the difficulties encountered in the different phases of implementation.

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1. Introduction

In 2005 the WHO Health Development Center in Kobe (WKC), initiated an initiative to improve the health of disadvantaged communities living in poor urban areas. This initiative was called the *"Healthy Urbanization Project: Optimizing the Impact of Social Determinants of Health on Exposed Populations in Urban Settings" (WHO HUP). The HUP was implemented in seven countries including Chile where,* in line with global project, it took on the overall goal of "promoting health equity in urban settings, by developing a basis of evidences on both effective strategies and interventions, in order to demonstrate applicability of such strategies in various scenarios, as well as building public health leadership to enhance governance in health and thus promote equity in health" (WHO, 2006).

The first stage of the project, in 2006, was financed and sponsored by WKC. It was carried out in the Municipality of San Joaquin in the Metropolitan Region in Chile and developed its actions through the three components defined by the overall project: *Training, Research* and *Advocacy*.

These actions were coordinated by the local Project Board with membership from the

- Learning Consortium (School of Psychology of the University Diego Portales-UDP- and the School of Public Health of the University of Chile);
- Ministry of Health (MoH);
- Regional Representative of the PAHO;
- Regional Representative of WKC;
- San Joaquin team.

These actions were carried out by the Faculty of Psychology of the University Diego Portales (UDP) and the School of Public Health of the University of Chile.

The second stage of the project, financed by the Chilean MOH between 2007 and 2009 was carried out by the the MoH, with the technical assistance of the School of Psychology of the UDP, scaled up the Project into 9 regions and their respective communes. This project, known as the "Healthy Urbanisation Project and Social Determinants of Health on the Local Level (HUP Chile)" enriched the original conceptual framework of WHO HUP and introduced methodological challenges based on the experiences and lessons learned from the WHO project and the needs of the regional and local teams (Charnes, 2010, 2007).

The main purpose of the HUP Chile project has been that of promoting networks of multisectoral and interdisciplinary teams that will undertake action research projects at a city level. This is guided through a process of *investigation (assessment) –action- reflection and participation (IRAP- in Spanish)* and a capacity building programme for improving health governance and reducing the impact of social determinants of health (SDH) that create inequity in the urban settings. The main audiences of this program have been authorities from regional and municipal governments who guide efforts to promote health at the local level.

Through a guided methodological process the different regional and commune teams built *multisectoral learning communities* (MLC). The different actors learned to share visions and strategies; came to consensus about core concepts (equity in health, SDH and inequity, urbanisation, governance); worked on an integrated approach to address long term results;

shared expectations, experiences and commitments amidst technical, political and social factors; assessed local health inequities; designed, implemented and evaluated small scale action projects.

The MLC aimed at holistic multisectoral improvements, rather than "sector" based solutions and articulated a vision of what they want for their community, considering and what the communities feel they need. In this approach the MLC integrated and articulated the training, research and advocacy components in all of their actions.

In this paper we critically review the different phases of implementation of the project, analysing the difficulties encountered and highlighting the lessons learned in order to produce sustainable results.

2. Setting up the HUP

2.1. Start up phase: setting the context

In this phase the different parties involved seek consensus on the roles and responsibilities of the various actors involved in Project planning and innumerable logistical details; issues such as number and profile of project participants, dates, duration; agreement on the contents and the preparation of training material, as well as evaluation and follow up instruments.

The time allocated to the start up phase considers advocacy and briefing with local actors. Time constraints was one of the main difficulties faced in the HUP Projects, limiting detailed revision of strategies, contents and training materials, as well as its adaptation to the different local cultures and organizational realities. The highly prescriptive nature of the training WHO-HUP package left little room for adaptation and creativity by the local team.

Another major difficulty was the diversity of visions and expectations on the project in general and on the training task in particular. These difficulties were exacerbated by limited financial resources for the established objectives; *lack of knowledge of local reality*; lack of definition of time allocation and lack of clarity on roles and responsibilities among the various Project decision makers (Charnes, 2007).

2.2. Creating partnership

In the process of creating conditions for effective stakeholder commitment with local teams the experience made evident several omissions that hindered the process of creating effective partnership between the Ministry of Health, the University, the Regional health authorities and the Municipal teams.

From the outset, it was clear that *the visions and expectations among all the interested parties were very diverse and even contradicting at times*. The pressure and the difficulties found in the process, the need to fulfill the program in a defined time frame made it very

difficult to work with the relevant stakeholders in the identification and prioritization of relevant issues for them.

We learned that building a shared vision requires infinite patience and skill. Many times the meetings carried out with the different stakeholders, were simply a technical exercise in order to carry out the program. The opportunity of building successful advocacy for the HUP project, ensuring decision-making for testing new ideas, policies and strategies seem to be very much dependent on building shared understanding of the meaning of social determinants of health, healthy urbanization, as well as the meaning and shared strategies for action-research. The framing, transformation and introduction of these contents across different organizational contexts seem to be a central component of building and maintaining partnerships for action.

Another crucial component *in promoting partnership is clarity in relationship to the type of resources that the Project offers.* Often, we found that organizations collaborate simply in order to gain financial resources or prestige. Regional and local governments get involved and pledge to provide support for the project but do not consider the necessary time dedication required by the staff members, nor do they visualize or reflect on the probable changes that the project will introduce. On various occasions, participants expressed concern about the difficulties in carrying out the project within the context of a municipal government. Among their concerns was the high demand on the time in their day-to-day tasks and the extra demands posed by the political interests of the local authorities.

It is very important to be very clear about the goal of the project, as well as the timing considered. Along with this *it is also important to have clear understanding of what it means when speaking about "stimulating change" and "solving problems".*

The HUP project was very ambitious: it was conceived as a capacity building programme for *improving health governance* and *reducing the impact of social determinants of health (SDH)* that create inequity in the urban setting. Because of the complexity of this goal it was necessary to develop an on-going consensus building process to enable all partners to understand how partnerships work, the different roles that the different actors play and how to gear their experience (its concepts and language) so they are meaningful and articulated into their governance processes. The MLC members exercised systems thinking, analytical and critical thinking processes, visioning of potential futures, strategic and tactical assessment and communication and change dynamics.

The partnership building process also had to consider that the complexity of major community health problems extend beyond the scope of any single group, community unit, profession or discipline, organization, or government unit, thus requiring conditions and leaders with the skills to be effective beyond their organizational boundaries. The effects of the capacity building program was compromised and limited where there was, for example, an unsupported mandate for action (lack of clear policies between local, regional, and national levels), lack of willingness to collaborate across sectors and boundaries, lack of flexibility, mismatch between local demand, policy objectives and program outcomes or inadequate management processes. Many times rigid, bureaucratic structures conspired against effective actions. "Passivity and powerlessness are actively produced through bureaucratic processes and discourses" (Reinelt, 1994).

The process of bringing together key stakeholders in a new form of decision-making on particular issues was based on the recognition of the importance of achieving equity and accountability in communication between stakeholders. This involved allowing equitable representation of all stakeholders and their views, regardless of their status, also based on democratic governance and principles of transparency and participation.

The shifting of internal power bases and serious demands on an already stressed system, required a conducive environment where stakeholders looked to collaborate with each other in an atmosphere of open-mindedness and flexibility. The building of a collaborative organizing environment permitted effective communication, networking, shared knowledge and visionary leadership.

2.3. Capacity Building Programme: The Multisectoral Learning Community[1]

The challenge faced in the scaling up programme, carried out in 8 new regions, necessarily obligated the project team to study and discuss the diverse learning mechanisms underlying multisectoral learning communities and take into account the complexity of the HUP and the need to understand how to effectively address SDH causing inequity in population health outcomes.

This also led the team to analyze the concept of health governance and the need to influence the thinking of policy makers and managers who do not necessarily consider health and equity as part of their agendas and responsibilities.

The challenge for the Capacity Building Programme was that of creating conditions for the so-called *integration of thinking, feeling and action* in which information analysis (cognition) motivates action. Integration involves also managing learning opportunities, taking advantage of all the different learning settings, whether formal face-to-face learning situations or informal group activities where significant learning takes place, through the exchange of knowledge, practice, attitudes and behavior.

The integration of knowledge, thinking and feeling with action has significant consequences for a training programme. It has meant the permanent adaptation of models and training proposals to local realities. *It also has meant understanding participants as active self regulating learners that add value to the training process through attitudes that require constant modification and change.*

The introduction of a new conceptual framework, the management of complex issues as part of the learning process, the facilitation of effective mechanisms that turn knowledge into action, has led us to deepen and revise the following learning mechanisms:

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[1] Many of the actions taken and analyzed in the HUP Chile programme were adapted from "Democratic Dialogue – A Handbook for Practitioners", General Secretariat of the Organization of American States (OAS), International Institute for Democracy and Electoral Assistance (IDEA), United Nations Development Programme (UNDP), 2007.

2.3.1. Dealing with complexity

Complex issues such as equity, social determinants of health, governance require responses that take into account their full complexity (Roth et al., 1995, Senge et al., 2004, UNDP, 2006, Senge, 1983)**.** Bearing in mind the experience of Peter Senge, George Roth and Otto Scharmer (www.solonline.org) in building the multisectoral learning communities we have considered three dimensions according to their level of complexity:

i. Social complexity: in a situation with high social complexity, actors have diverse perspectives and interests. Such situations need more time in order to be addressed through *the direct involvement of the actors or stakeholders.*

ii. Dynamic complexity: in a situation with high dynamic complexity, causes are not obvious and cannot readily be determined through first hand experience. Such situations cannot be addressed piece by piece, but only by looking at the system as a whole. It is necessary to have clearness in relation to objectives and articulation of components.

iii. Generative complexity: in a situation with high generative complexity, the future or possible solutions are unfamiliar and undetermined. The concept of urban health is in discussion. It cannot be addressed by applying lessons or rules from the past, but only by tuning into emerging futures such as governance principles, a holistic understanding of health, social capital, social cohesion and participation.

Social problems that involve many different parts of the population call for solutions that engage and include everyone in the 'problem system'. Only then can analyses and plans of action integrate all the perspectives and roles that make the situation what it is. And only then can people begin to understand and act on the multiple factors influencing problem situations and agree on which changes will have the greatest impact on them.

The conceptual map shown in figure 1 is an attempt to represent the complexity of the different processes and dynamics involved in HUP Chile.

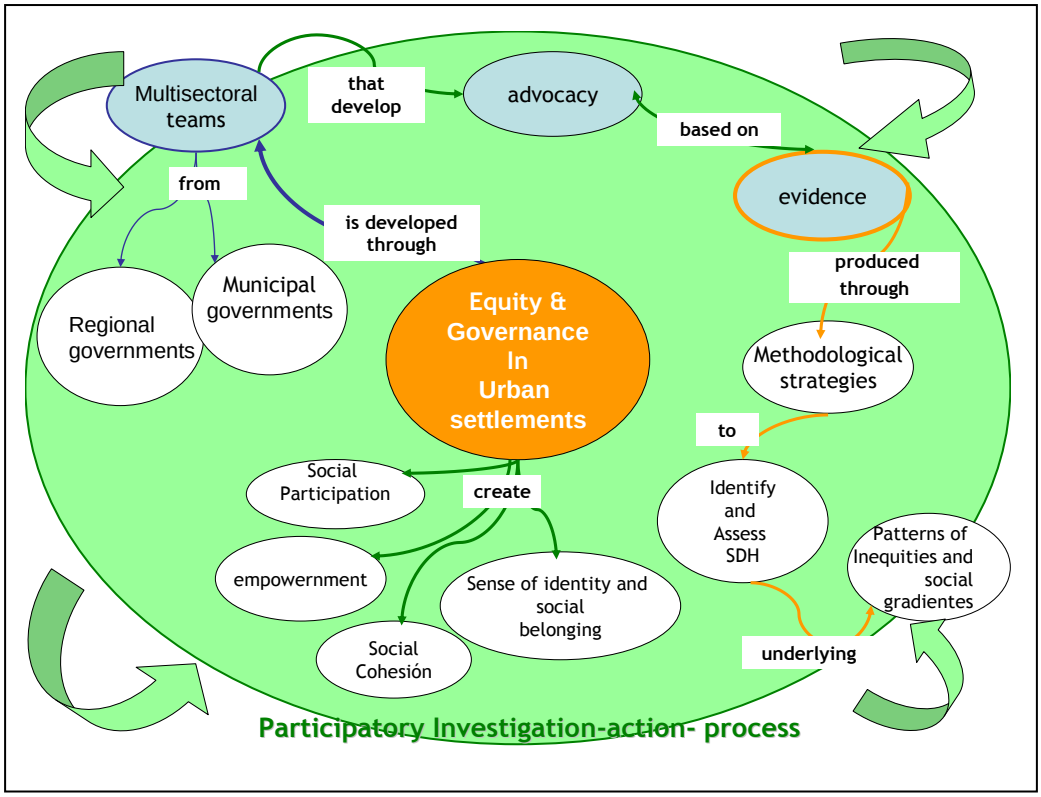

Figure 1 The processes and dynamics involved in the Healthy Urbanization Project, Ministry of Health, Chile (Charnes and Torres, powerpoint presentation, April, 2008,).

2.3.2. Creating a safe space

Creating a safe space for learning requires an environment that supports human interaction in a process of "genuine interaction through which human beings listen to each other deeply enough to be changed by what they learn" (Saunders, 1999, p.82). A 'safe space' implies building trust, striving for inclusiveness, managing power and status differences, for example, between regional and local government officials, to ensure that all voices can be heard, and focus on issues that really matter to the participants. They set the stage for the kind of conversations, characterized by learning and humanity that make learning processes possible.

2.3.3. Coordinating meaning and learning (UNDP, 2006)

What is needed in these situations is not necessarily more communication but more *understanding*. Positive outcomes require that participants emerge from the process with a commitment to coordinated action—an agreement to work towards a common goal. To do this, mutual trust and acceptance must be built in order to acknowledge and legitimate thedifferent meanings given to words, actions and events, so that together they can develop a common language, at least around issues of common interest.

The concept of what we understand by health, equity, social determinants, advocacy, and action investigation must be discussed and agreed upon by the different sectors. Only with this more coordinated meaning-making will there be a foundation for coordinated action.

Many authors refer to the need for developing the quality of *'openness'* in the sense that participants open themselves to hearing and reflecting upon what others have to say, to what they themselves are saying, and to the new insight and perspective they may gain as a result.

In *Dialogue and the Art of Thinking Together*, William Isaacs (Isaacs, 1999) describes key behaviours or skills that create this kind of interaction as '*listening*—without resistance or imposition; *respecting*—awareness of the integrity of another's position and the impossibility of fully understanding it; and *suspending*—suspension of assumptions, judgment, and certainty'. The nature of the process expressed as openness points them towards learning; it 'is not about pronouncing judgments or affirming power positions; rather, it is about listening for a deeper understanding and awareness of the issues at stake'.

Enacting the principle of learning by adopting a stance of **inquiry** is another important element of the learning approach. Inquiry involves asking questions to gain understanding.

2.3.4. Levels of change

The core dynamic of change in the learning processes involves people getting some perspective on their own thoughts and thought processes, and on the way those thought processes shape their perceptions of reality.

This has been defined by different authors as a "shift in mental models"[2]—the underlying assumptions that shape the way people experience and interpret the world around them. Increasingly, people have come to the recognition *that concrete steps toward change, such as policy initiatives or legislation, are necessary but often not sufficient to meet the challenges societies are facing. To take hold, they need to be grounded in deeper change at the personal level.*

For example, as a SEREMI official I may not notice that my attitude toward another person may be profoundly affected by my role, my governing ideas, and my government (power) position. Instead, I could suppose that my attitude arises directly from their conduct. The problem of thought is that the kind of attention required to notice this incoherence seems seldom to be available when it is most needed.

[2] The term 'mental models' comes from the field of organizational learning, in which there has been much study of the use of learning as a tool for organizational change. Peter Senge (1983, 2004, 2008), William Isaacs (1999), Chris Argyris (1974,1990, 1993), and Donald Schön (1991).

Many people use the image of an iceberg to convey the idea that often the visible characteristics of a determined phenomenon are only a small portion of its totality, and that it is important to be aware of those aspects we cannot readily see.

The Iceberg Model of change, developed by Katrin Käufer and Otto Scharmer (Nonaka, 2000.) emphasizes the point that visible and invisible changes are connected and often interdependent. At the deepest level, shifts in feelings and perceptions open up people to the possibility of change.

The Iceberg Model, shown in figure 2, provides a visual representation of the explanation of how deep changes in mental models, feelings and perceptions that take place 'below the waterline' provide the foundation for changes that are more concrete and visible. Individual changes are translated into collective learning processes and action and expressed in new thinking patterns, relationships, networks and behaviours.

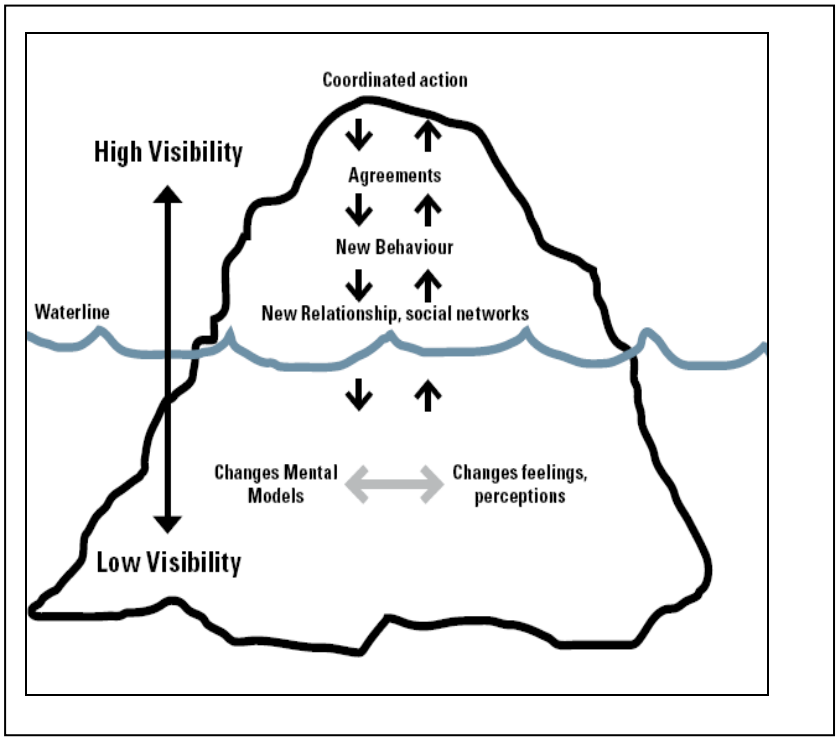

Figure 2 The Iceberg Model: Levels of Change (*Source*: Based on the model of Katrin Käufer, adapted from Otto Scharmer, 1999, pp. 36–60).

Through dialogue and discussion, groups can begin to recognize the feelings and perceptions of the other. The rigidity of their own pictures loosens. Each group becomes more able to listen. In many cases, the telling of personal stories can play a vital role in compelling adult learners to pay attention to facts they would rather ignore. In the post evaluation of workshops we were able to see the initial process of participants that begin to modify their own pictures of reality, and open up to new ways of understanding, learning and acting.

Chris Argyris and Donald Schön (1974) propose the double loop learning theory, shown in figure 3, which involves learning to change underlying values and assumptions. *Double loop learning* implies deep reflection that questions underlying assumptions. The following

figure shows that '*single-loop learning*' takes for granted the starting assumptions about the issues, the context and the goals. It evaluates the strategies used and, to the extent that the stated outcomes have not been achieved, focuses learning on how to improve the strategies—to do the same, only better.

The first Who-HUP projects proposed by the MLC addressed solutions referred to "environmental problems"[3] such as the improvement of community gardens, improving road infrastructure, expanded coverage of certain services, such as increased policing, etc.

In contrast, double loop learning involves re-examining the initial thinking behind the definition of the problem, strategy and desired results. *It aims at thinking differently, as opposed to simply doing something differently.*

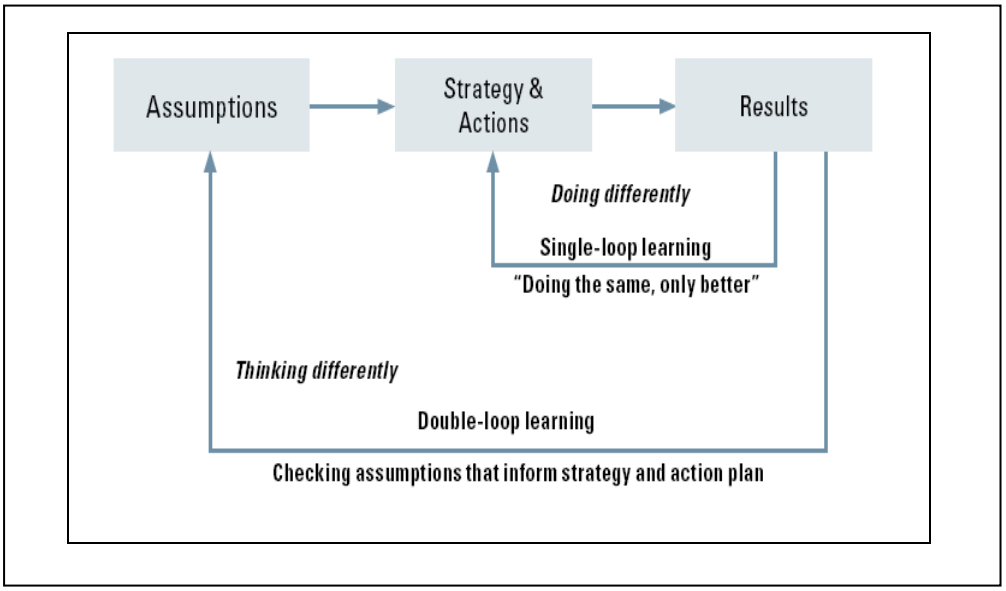

Figure 3 Double loop Learning (Argyris, 1993)

Source: Illustration taken from: UNDP. (2006) *Democratic Dialogue – A Handbook for Practitioners*, CIDA, International IDEA, the GS/OAS and UNDP, p.145

Double loop learning means for example, understanding and having a commitment to the value of equity, appraising methodological diversity or acknowledging and understanding the dynamics of social structure, involving others and establishing partnerships in meaningful relations, understanding multisectoral work as joint ownership.

In HUP Chile this was expressed in actions that addressed an understanding of health as a phenomenon that goes beyond specific biomedical care; the generation of structural and sectoral initiatives to address health inequities; new approaches to health promotion, focusing on people and lifestyles; initiatives that recognize health as a responsibility of all sectors and consider how to influence other public policies that have an impact on health; collaborate learning initiatives with other stakeholders.

[3] The UNDP Programme for Chile, in its 2009 Report, studies "The ways things are done" by Chileans and defines a clear difference between "environmental problems" and those that take into consideration the " logic behind actions", which seem to correspond to "double –loop learning".

2.3.5. Producing innovation:

To produce innovation, national, regional and local projects must create the basis for a systemic *long term approach* and construct aligned, collective action. These processes must empower participants to question the status quo, challenge prevailing assumptions and envision significant change at all levels through double-loop learning.

The Iceberg Model depicts various kinds of change outcomes that permit innovation:

- individual, internal changes in mental models, feelings and perceptions
- the formation of new relationships and social networks
- new behaviour
- agreements
- coordinated action.

In our training experience we observed the difficulty of the Communes in integrating and developing the HUP. San Joaquin permanently mentioned their difficulties of disposing of the necessary time and funds; the teams described the centralized decision making process which determine Annual Plans and limit health promotion programmes. Nevertheless, many representatives from the Regional Secretariat sustained that great part of the required changes and the conditions for developing HUP were more related to understanding things differently.

The HUP is not a traditional project, it requires the visualization of a holistic and multisectoral initiative. This visualization means learning to think differently in order to really create the conditions needed do things in a different way, this means “double loop learning”.

2.3.6. Building monitoring and evaluation into the learning process

The training team had the intention of integrating M&E into the learning design from the beginning of the Project. It has not been easy, especially considering some of the difficulties that the Project has encountered.

We understand that M&E serves three important functions. It provides the necessary inputs for *learning and adaptation* during the different phases of the project, and over the longer term, is the basis for improving practice and contributing to process knowledge and it is the basis for *accountability* to the institutions that provide resources to make the Projects possible.

But most important, M&E are two integrated processes of learning, project design and implementation. We understand *monitoring* as a continuous process that focuses on data gathering; and *evaluation*, focuses on analysing and drawing conclusions from the data.

A useful definition is:

"*Monitoring and evaluation is an integrated process of continual gathering and assessing of information to make judgements about progress towards particular goals and objectives, identify unintended positive or negative consequences of action, and provide insight into why success or failure has occurred*".(Roschke, 2002, p. 107)

It was conceived as a process *integrated* into the projects of the Regional and Communal teams that take the responsibility for analysing and interpreting information in order to act on it. The flow of the Monitoring, Evaluation and learning process is illustrated in Figure 4:

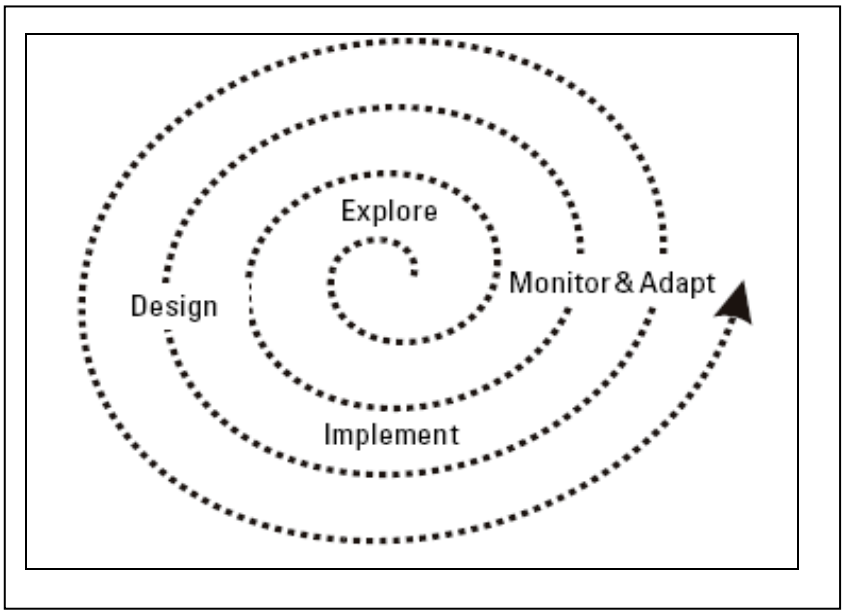

Figure 4 The flow of the monitoring, evaluation and learning process during the project cycle
(Source: "Democratic Dialogues" Democratic Dialogue: A Handbook for Practitioners p.53)

The **"coaching"** process is conceived as a learning strategy that seeks to deepen generative learning and reflection in action, creating opportunities for tacit knowledge (experience) to be incorporated as explicit knowledge. It is based on a constructivist conception of the learning process whereby knowledge is generated from the learner's experience. Learning only occurs when the learning constructs meaning from the subject matter, thus learning has to be significant, independent, collaborative and project based.

The MLC coaching (be this face to face or distant) has the following characteristics:

- Values: it promotes the understanding and consensus on MLC underlying values and principles. Namely, imparting capacity not just theoretical knowledge, promoting strategic thinking in the promotion of healthy urban settings and focusing on SDH and good governance principles for decision making.

- Results: it is a result oriented process geared to strengthening learning and enhancing the training multiplying effect among the action research teams. It is focused on the production of action research projects and multisectoral action.

- Discipline: to achieve the continuing improvement goal, the MLC e-coaching creates the necessary conditions to learn and apply critical capabilities and feedback as a means to improve the learning processes.

- Training: it is understood as capacity building through action. It is conceived as a process of generating knowledge through action and it is constructed from the learners experience and through collective learning.

- The Capacity Building Programme with the integration of the Investigation-Action Process is illustrated in Figure 5:

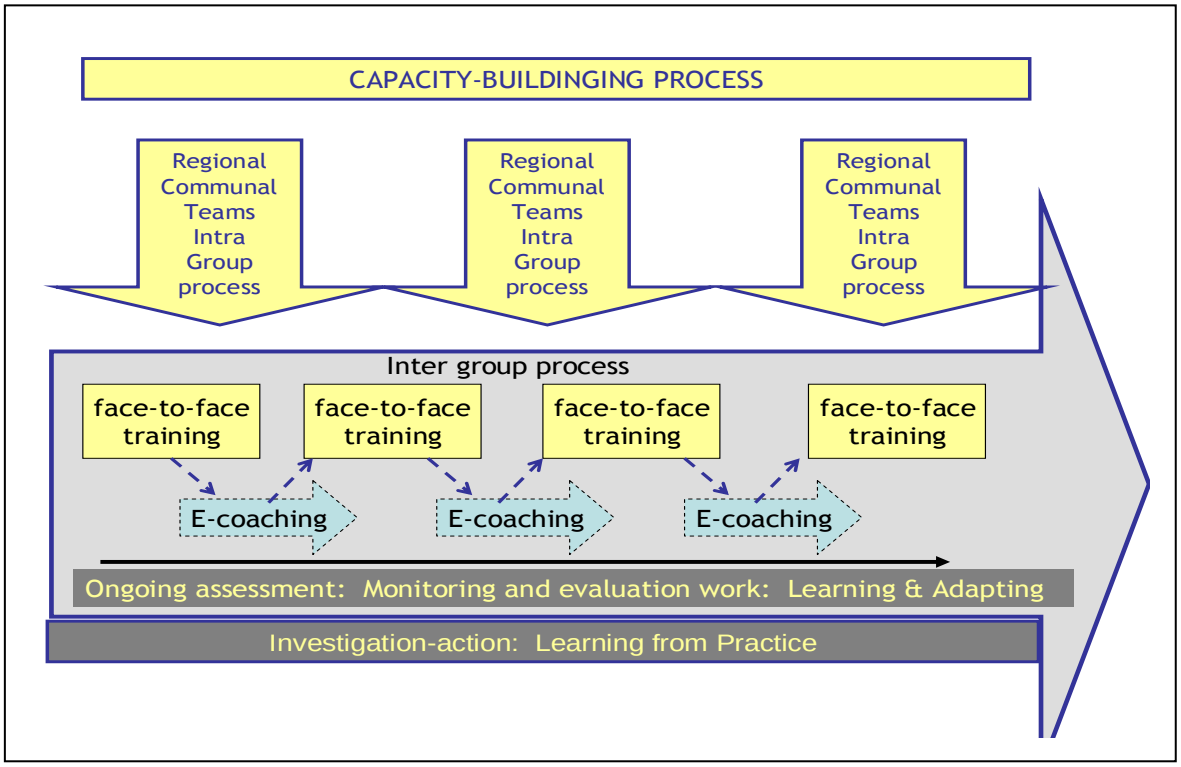

Figure 5 The Capacity Building Programme with the integration of the Investigation-Action Process (Adapted from PRUITT, B. &. THOMAS, P.,.UNDP, 2006, p. 103)

2.3.7. Developing Evidence

The investigation-reflection-action-participation process is based on the recollection of information (for context analysis, mapping of territory, stakeholder analysis) and generation of evidence (on health gradients, SDH entry points, etc.)

The Communal and Regional Teams in their projects generated multidisciplinary knowledge from different methodological roots; quantitative, as well as qualitative approaches; with diverse epistemological positions, that have demanded many discussions. These are part of the learning process, but it is necessary to reflect on the

type of information that should be collected and on how to assess the quality of different sources of evidence, among other things.

3. Methodological Challenges: The complexity of interventions aiming to address SDH

We have learnt that the measurement of SDH is complex and that measuring enables us to understand differences in health outcomes between groups. We have also learnt different methodologies to measure SDH, but we still have felt the need to better understand how the major determinants relate to each other and how to determine in a more precise way interventions orientated to modify structural and intermediate determinants of health causing inequities.

From David Vlahov (Vlahov, 2005, Galea and Vlahov, 2005, Freudenberg et al., 2006), we have learnt of a variety of qualitative and quantitative methods that have been used to examine the relations between SDH in urban settings and health outcomes (case studies, ecological analyses, and multilevel Methods). From Josiane Bonnefoy (CSDH, 2007) , who generously counselled us, we learnt of the need of methodological diversity and the nature and measurement of health inequity gradients, health equity auditing, health impact assessment. We have also investigated the European Policy Health Impact Assessment (EPHIA Project and Guide) (IMPACT, May 2004).

Link and Phelan (Blankenship, 2006) represent one of the clearest examples of the social determinants perspective with implications for structural interventions. They offer a theory of fundamental cause in which they argue that to truly understand health and disease it is necessary to identify their fundamental causes, not the behavioural or proximate risk factors that serve as the typical focus of research. In their view, proximate causes are merely the particular mechanisms through which more fundamental causes operate and as such, they will change over time, while the influence of fundamental causes will persist. Addressing these proximate causes will do little, in the long term, to eliminate disease and promote health. Instead, they argue that it is necessary to confront fundamental causes themselves.

In this perspective in the HUP Chile experience in 2007, we introduced the Analytical Framework, adapted from the Commission on Priority Public Health Conditions of the CSDH (CSDH, January 2007) which studied the different causal pathways for health action, identifying:

1. Social determinants at play and their contribution to inequity, for example, main path-ways, magnitude and social gradients
2. Promising entry points for intervention
3. Potential side-effect of eventual change
4. Possible sources of resistance to change

As a result of this analysis the MLC designed interesting interventions focussed mainly on introducing modifications on structural and intermediate determinants of health underlying inequities.

The more we investigate, the more evident becomes the need to further deepen our knowledge and experience in relation to methodological challenges. Without a full domain and transference of a wide range of methodological options to the Chilean teams, we feel we will not make "the necessary difference" for impacting inequities.

As David Vlalov says in the document quoted (p.46) before, "It is not enough to document if an intervention works; rather, it is important to understand how it works and who it works for… it is also necessary to monitor impacts on SDH and ensure that the positive effects of a program are experienced by all".

4. Producing sustainable results

In approaching complex long-term problems such as inequity and SDH policy makers have an understandable sense of urgency to deliver quick results. In such circumstances the natural impulse is to propose solutions to the visible symptoms rather than devise a longer-term initiative to address its underlying causes.

Sustainable results demand longer-term perspectives that require that the full spectrum of people involved in the outcome be engaged, that the underlying problems be tackled, and that this be done in a way that gives people the motivation and skills to continue working on the deeper issues.

Such an approach takes more time than a 'quick fix', but it offers greater hope of producing sustainable results that address the current problem *and* build social capacity to deal with future challenges when they arise.

The two levels described are complementary. On the one hand, the need for effective governance to develop sustainable approaches to societal challenges demand processes that engage and empower people to tackle their own problems. On the other hand, the need to build the culture of democratic governance requires strengthening the very capacities that such processes demand.

But this is not easy. Experience has shown us that one of the most common barriers to producing sustainable results seems to be politics. We need to learn to deal with political agendas in one way or another and interact with bureaucratic values and structures of power that dominate society and can prove to be quite disempowering. This is still an ongoing challenge.

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NICK

Department of Humanities and
Social Science

Institute of Education
20 Bedford Way
London WC1H OAL
United Kingdom

Tel: + 44 (0) 20 3073 8341
Email: p.pridmore@ioe.ac.uk
Website: http://nick.ioe.ac.uk

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