Integrated Approaches to Address the Social Determinants of Health for Reducing Health Inequity

Françoise Barten, Diana Mitlin, Catherine Mulholland, Ana Hardoy, and Ruth Stern

ABSTRACT *The social and physical environments have long since been recognized as important determinants of health. People in urban settings are exposed to a variety of health hazards that are interconnected with their health effects. The Millennium Development Goals (MDGs) have underlined the multidimensional nature of poverty and the connections between health and social conditions and present an opportunity to move beyond narrow sectoral interventions and to develop comprehensive social responses and participatory processes that address the root causes of health inequity. Considering the complexity and magnitude of health, poverty, and environmental issues in cities, it is clear that improvements in health and health equity demand not only changes in the physical and social environment of cities, but also an integrated approach that takes into account the wider socioeconomic and contextual factors affecting health. Integrated or multilevel approaches should address not only the immediate, but also the underlying and particularly the fundamental causes at societal level of related health issues. The political and legal organization of the policy-making process has been identified as a major determinant of urban and global health, as a result of the role it plays in creating possibilities for participation, empowerment, and its influence on the content of public policies and the distribution of scarce resources. This paper argues that it is essential to adopt a long-term multisectoral approach to address the social determinants of health in urban settings. For comprehensive approaches to address the social determinants of health effectively and at multiple levels, they need explicitly to tackle issues of participation, governance, and the politics of power, decision making, and empowerment.*

KEYWORDS *Empowerment, Governance, Health inequity, Integrated approaches, Participation, Poverty, Social determinants of health, Urban settings.*

INTRODUCTION

This paper draws on an earlier review paper on the effectiveness of WHO Healthy Settings approaches for the WHO Kobe Center and a background paper on *Integrated approaches to address the social determinants of health for reducing health inequity* written for the Knowledge Network on Urban Settings.[1] The focus

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is on the role of meaningful participation, empowerment, and participatory governance in enhancing the social determinants of health. The discussion also considers integrated approaches that strengthen capacity and contribute to organization as essential elements enabling the participatory governance and empowerment required for improved health equity. We first clarify the concepts of participation, participatory governance, empowerment, and of "Healthy Cities" and "healthy settings". The second section describes universal features of urban settings and derives implications for empowerment. The following section examines some experiences of "healthy cities" and "healthy settings" and highlights access to information as an important precondition for participation. We conclude the paper with a discussion on constraints, barriers, opportunities and by acknowledging the need for sustained social mobilization.

THE CONCEPTS

In 1978, the Alma Ata conference endorsed the notion that health is linked to the living and working conditions of the population and acknowledged the role of community participation in health.[2] This was followed by the Ottawa Charter for Health Promotion in 1986, which focused on processes of advocacy, enablement, and mediation, and on strategies to build healthy public policy, empower communities, create supportive environments, and reorient health services.[3] Out of this grew Healthy Cities and healthy settings (including districts, neighborhoods, islands, workplaces, schools, markets, and prisons), approaches which are seen as "a means to take these broad concepts and strategies and applying them at the local level."[4] Health promotion is "a process of enabling people to increase control over, and to improve their health."[5] This participatory process in which people gain more power is called empowerment. Healthy Cities is therefore a political program in that it is about changes in the power relations concerned with health and illness, and health rights with associated social rights.[6]

Although the relevance of participation has been recognized by many agencies, in practice it has been more difficult to achieve. Often participation takes place in name only, whereas in reality professionals, public officials, and bureaucracies manipulate the concept. As already argued by Sherry Arnstein over 30 years ago in her classical article on participation, "...there is a critical difference between going through the empty ritual of participation and having the real power to affect the outcome of the process..."[7]

More recently the concept of local governance has underlined the move toward participatory processes of public policy making and involves devolving influence and power to local communities.[8] Healthy governance aiming at health equity and inclusive urban settings is by definition participatory governance. "If governance refers to the processes and systems of government, including negotiations with a range of significant groups, then participatory governance places a particular emphasis on the inclusion of the people, especially the poor."[9]

Not all participatory projects or processes, even participation involving governments with citizens in localized decision-making, can be considered as "participatory governance." There is a need to specify the different spheres of influence. A group or organization may acquire a relatively large degree of power or influence within one sphere—for instance, a neighborhood—and yet have little control over the municipal decision-making process and allocation of resources at this higher level.[10] If participation is limited in scope, scale, space, and sphere of

influence—and the arena of action does not go beyond a specific neighborhood or single intervention—it might be considered as good governance, but does not constitute participatory governance. Participatory governance requires sufficient scope, scale, and space and implies "the engagement of government with a group with some interests beyond those of a single individual (although members may not benefit equally)".[9] For this to occur, there is a need for institutions on the community side able to operate above the level of the household, ensuring a collective rather than individualized response.

This paper acknowledges that participation is not only about sharing responsibilities, but also about power and privileges. The discussion considers that increased participation in local policy-making processes, and empowerment through improved governance, can contribute to addressing the social determinants of health and reducing health inequity.

URBAN SETTINGS: IMPLICATIONS FOR EMPOWERMENT AND HEALTH EQUITY

Our world is urbanizing rapidly and, whereas there are important regional differences, poverty is growing and living conditions are deteriorating in *all* cities.[11] Inequalities are generally higher in urban relative to rural areas, with the exception of countries where rural economies are structured around plantation agriculture.[9] The twin processes of *increasing poverty and deepening inequity* need to be understood as part of a process of increased socioeconomic differentiation in urban settings that is occurring in cities within developed and developing economies.[12] This deepening inequity and polarization both *within* and *between* urban settings appears to be increasingly associated with conflict and insecurity.[13] An important institutional impact of globalization on cities has been the weakening of national and local public institutions, relative to the increasing power and influence of private agents. Urban social movements may be important agents for social change: raising awareness on people's health rights and challenging both the process and the outcome of social and political decision making at local and global levels.[14–16]

A recent WHO review on effectiveness of empowerment to improve health concludes that "while participatory processes make up the base of empowerment, participation alone is insufficient if strategies do not build capacity of community organizations and individuals in decision-making and advocacy."[17] Genuine empowerment depends on the control that community-based organizations ultimately acquire, and meaningful participation requires certain preconditions such as access to information; possibilities, mechanisms, and opportunities for participation should be taken into account. Participation without the involvement of participatory institutions, owned and controlled by their members, is unlikely to lead to empowerment. It is the institutions that embody learning, enabling the poor to act strategically, and in solidarity, ensuring the collective action necessary for substantive resource redistribution.[14,18]

HEALTHY SETTINGS, MUNICIPALITIES AND CITIES

The "healthy settings" approach, including WHO's "Healthy Cities" program, has been important in reorienting thinking away from an approach to health based on health services, toward one emphasizing the role of other sectors and associated agencies in the promotion of health by influencing its upstream determinants. This

healthy-settings approach has contributed to urban policy change in different contexts (Cerqueira, Tsouros, Ogawa, Rice and Taylor, 2005 and 2006, personal communication).[19]

Evidence of the effectiveness of such approaches, is, however, still sparse caused mainly by the absence of rigorous monitoring and evaluation systems that would allow for tracking of both qualitative and quantitative change. Other reasons include: the complexity of evaluating health promotion and empowering strategies as highlighted in numerous publications;[20] the context-specific, complex, and process-oriented nature of these comprehensive approaches that hinders attempts to develop criteria, methods, and indicators.[21] Other factors that make assessment of effectiveness difficult include different understanding of key principles such as participation, empowerment, equity, and governance. For example, within many multilateral organizations participation is an instrument to increase transparency, accountability, and voice.[22] However, Souza[23] recalls that for the worker's party PT in Porto Alegre, participation implies more than only the right to be heard: "participation implies empowering the poor to become aware of inequalities and injustices (political consciousness-raising), and to reform the political and social systems through collective action."

There is a large variation in the scope, nature, and outcomes of "Healthy Cities" and "healthy settings" and a wide variety in the organizational structures. Some initiatives are entirely controlled by NGOs and communities and seek to influence the policies and practices from the outside and/or by involving the government. Others are initiated by and are part of the structure of government and progressively involve the community.

Box 1	Newcastle Healthy City Project

Newcastle is one of the poorest cities in the UK, ranked the 19th most deprived city according to the 1998 Index of Local Deprivation.[24] Similar to trends throughout the country, the gap between the people with the best and worst health in the city is increasing.[25] The Newcastle Healthy City Project (http://www.newcastlehealthycity.org.uk) was established in 1988 as an independent body with the aim of promoting the health of Newcastle citizens, and reducing the inequities in health between communities. The work programme includes a combination of a proactive, "bottom–up" lead role in some areas of work, and a coordinating or supportive role in initiatives that are set up or driven by the authorities—that is the "top-down" component.

One of the community-driven programs that comes under the umbrella of Newcastle Healthy Cities Project is the Ban Waste initiative (http://www.newnet.org.uk/banwaste/who.htm). Ban Waste describes itself as a community-led and open group that welcomes and facilitates participation from all interested members of the public. It was formed after a public meeting in January 2000, called in response to public concerns about waste management in the city. Of particular concern was the emission of polluted ash from an incineration plant over allotments and footpaths, and the cost for Byker residents of the District Heating System that is supplied from the plant. The meeting called for a public inquiry into the plant and a working group, comprising residents, council officers, councilors, public health specialists, academics, and other involved agencies, was established. The concern of the residents, supported by experts in the field, was vindicated, as tests found the ash to have particularly dangerous levels of dioxins. As a result, a major clean-up operation was instigated, and both the City Council and the plant operators have subsequently pleaded guilty to charges brought against them by the Environment Agency.

Box 2   Empowerment and the Reduction of Youth Violence In Aguablanca, Cali

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The district of Aguablanca is one of the largest marginalized areas (informal settlements) in the east
    of Cali. It is divided into three *comunas* and its population, approximately 450,000 inhabitants
    who are nearly all migrants from other parts of the country, has high levels of poverty and social
    exclusion. The age/sex distribution is 51.6% female (48.4% male) and 28% of the population is
    within the 15–25 age range. Only 13% of the inhabitants have health insurance and 15% have
    had formal employment. The infant mortality rate (14.5 per 1,000) is the highest in the city
    (Secretaria de Salud, 2004). Only 27.1% of young people achieve secondary education.
    Aguablanca has the highest homicide rate in Cali, with 856 homicides reported in 2004 by the
    Interinstitutional Municipal Group to monitor violence.
FUNDAPS is a nongovernmental organization that has spent the past 10 years promoting the
    organization of young people in the most violent low-income areas in Cali to reduce youth
    violence and to improve health of youth in the District of Aguablanca. The program started by
    focusing on sexual and reproductive health, ensuring access to essential health care, providing
    support within the family environment, and tackling abuse and violence. Health has been a key
    aspect in the dialogue that has been promoted, and the involvement with local government and
    health institutions has enabled the youth groups to address other key issues. These include: their
    capacity to organize; to raise their concerns in a nonviolent way; to enhance ownership of the
    public space; to ensure food security, essential health care, primary education, access to
    microcredits; and to elaborate and manage community-based projects and resources. Concrete
    outcomes of the process have been stronger youth organizations, increased effectiveness of
    collective youth activities, improved relations between youth groups and the wider community,
    and enhanced influence of youth organizations in the policy-making process contributing to a
    reduction in youth violence in Cali.[26]

Box 3   Basic Development Needs Approach—Economic Empowerment of Women

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Since the 1980s, the WHO Regional Office for the Eastern Mediterranean (EMRO) promotes the
    basic development needs (BDN)[27] approach, which effectively encompasses healthy cities,
    healthy villages, and women in health and development programs throughout the region. The
    low status of women is one of the key underlying social determinants of health in this region,
    and the BDN programs since 1988 have helped to enable women by giving them the
    opportunity to earn money through loans and training, and by increasing access to basic services
    (essential health care, shelter, safe water, and sanitation). Programs now exist in 12 countries
    and cover a population of almost three million in over 250 sites.[28]

Not all programs enable empowerment, and much depends on the definition of
roles and responsibilities in respect to the identification of priorities, planning, and
implementation of the programs. Professionals often impose their views and models
without taking into account local history, existing decision-making capabilities, and
without engaging the knowledge of the urban poor.[29] One of the basic tensions is
between "top–down approaches" (in which outside agents define the issue, develop
strategies, and invite the community to assist in implementing the programs) and
"bottom–up" approaches (in which communities work with outside agents on
issues they both believe are important) (see box 2). In reality often a mixed
approach is found (see box 1).

Capacity development of local authorities in some cities appears to have
contributed to the increased involvement of communities in planning and decision-

making processes and, in some cases, has contributed to empowerment and strengthened community organization and action (see box 3). Achieving pro-equity and participatory governance, however, has often proved more elusive.[1]

Many other programs exist that promote participatory urban management. Although many of these approaches address the social conditions of health, it should be acknowledged that Healthy Cities, healthy settings, and the Global Equity Gauge Alliance (GEGA) are the only approaches that make a moral and political argument for reducing social inequity and make improved health an explicit primary objective. Among the lessons to be learned from other approaches is that information and access to information can change the balance of power. Examples of this include an innovative tool used in the municipality of Moreno, Buenos Aires to map environmental health risks with community participation.[30] Ana Hardoy recalls that an important challenge is how to ensure the representativeness of participatory groups and processes. GEGA is another approach that has been used to address equity issues explicitly at both national and city levels, in Latin America, Asia, and Africa.[31] In Europe, Health Impact Assessments have been used, but the participatory and empowering elements have proved difficult to operationalize because of the time and resource demands of the political process "that limit the extent to which the community can be engaged."[32]

DISCUSSION

A review of experiences demonstrates the important impact that historical and sociopolitical contexts have on the key issues, approaches, and processes considered in this paper. However, a number of common elements can be highlighted.

First, the political ideology and attitude of government are key determinants of the success of initiatives that seek to address the social determinants of health as governments may support, reject, neglect, or manipulate the demands of the urban poor.[33] Political will is sadly often limited.[8,34] Despite the rhetoric about commitment to public participation, and progressive legislative frameworks, in reality participation is often manipulated, found lacking, or even aborted.[35,36]

International donors have been and continue to be a major influence in the direction of health policy and strategies, and in the adoption of decentralization and of participatory local planning processes by governments. It is evident that there is a gap between what is intended and real practice. Higher levels of government, both political and administrative, often are reluctant to surrender power to local governments, and city councils find it difficult to engage with grassroots agency. Here also political will is essential and again often limited.

The power to decide on the allocation of resources and on the directions of policy is often constrained. During an interregional consultation on *Improving Children's Environmental Health in Settings* held in Entebbe, Uganda in 2005, participants agreed on the relevance, strengths, and need for integrated settings-based approaches. However, they also acknowledged the difficulty in obtaining donor funding for working upstream (policy) and for bottom–up participatory processes in a context where donor preference appears to favor funding selective issues or single and often vertical disease-control programs.[1] Donor dependency, however, is

often high and many civil society organizations fail to take a citywide perspective and/or lack the capacity to engage with national or global decision makers.

Second, decentralization often has not involved the increased allocation of resources.[8] The limit on existing financial resources available for participatory budgeting is a key issue, and Souza[23] describes that, even if municipal governments are committed to redirect resources to low-income areas and "to transform spending on the cities' poorer areas into rights and not favors," in reality there is only the possibility of meeting a fraction of the actual needs of these communities.

Third, low-income urban households living in neighborhoods without adequate tenure security and services do not compartmentalize their needs. External interventions that are helpful are those that are respectful of the people's ability to analyze their needs and interests, and which are flexible in the face of their strategic choices. The need for an integrated approach and comprehensive public health and development plans is as much because of the need to provide "windows" for support that respond to the people's own vision and struggle, as it is to recognize that poverty cannot be reduced through simple sectoral interventions.[37]

Fourth, time continues to be an important factor, and the development of sustained popular participation and the change in the balance of power requires more time than allotted in the projects funded by donors or the time-span of elected local governments. Ana Hardoy, referring to a participatory planning process in a low-income settlement of Buenos Aires, stressed the importance of an *open* process and the fact that each stage produced definite outcomes, e.g., in increased leadership of women, increased equity in access to basic services essential to health, reduced exposure to risk through changes in the environmental determinants, improved participatory mechanisms, and even political capabilities to negotiate and ensure access to external resources. These processes took a long time and some results are clearly visible. Essential in this particular case was the long-term commitment by a local organization that helped strengthen the capacity of local Community Based Organizations (CBO's) in the negotiations with the government and other actors to achieve policy change.[30,38]

Lack of policy coherence,[36] lack of strategic vision, lack of donor interest in ensuring integrated approaches at multiple levels, lack of funding for long-term participatory processes,[34] lack of coordination including among UN agencies, and the increased fragmentation of sector programs and efforts at local levels pose problems for settings-based approaches. However, interest in comprehensive PHC is rising again on international and national policy agenda and may provide an opportunity for addressing at least some of these issues. Others, however, are related to global governance.[36]

Fifth, increasingly difficult economic circumstances, and individualized market-based relationships may reduce capacities to act collectively and develop the institutions required for effective participatory governance. A recent study in seven cities found that solidarity and collaboration among NGOs (and CBOs) is often lacking.[34] This impacts the likelihood of advocacy success as alliances are more likely to produce policy change. The concerted efforts of many organizations in producing the Global Health Watch are an encouraging example of the opposite.

Lastly, although the term "equity" has become a part of the development lexicon, there is a wide difference in the understanding of its meaning,[39] implications, and determinants. Progress toward equity is difficult given entrenched

patterns of disadvantage and inappropriate resource allocation as well as the increasing impact of global and political determinants that operate beyond the influence of city decision makers.[40]

CONCLUSION

Comprehensive approaches to address the social determinants of health effectively need explicitly to tackle issues of participation, equity, governance, and the politics of power, decision making, and empowerment. There is a need to increase strategies that deepen participation in governance in many different settings. Essential preconditions and mechanisms include access to information, a more people-centered and rights-based perspective, an enabling environment, and a responsive government.

However, there are still too few participatory initiatives and many are limited as they are neither sufficiently broad in scope nor sufficiently maintained. Participatory processes may be focused simply on ill health or control of a specific disease, without taking into account the need to redesign housing and neighborhoods and/or transform livelihood opportunities. In many cases, the participation is focused over a short period, at a local level, without building institutional capacity among excluded populations to maintain their involvement over time and without building on local initiatives to develop national frameworks or influence the determinants for healthy global governance.

Nevertheless, there have been substantive initiatives where local citizens have developed mechanisms of participatory governance and persuaded their local authorities to collaborate on finding ways to secure basic services and the rights of citizenship for many, even with a lack of state resources and within a context that may not be favorable to participatory initiatives. Approaches such as "Healthy Cities" seek to improve systems, public policies, and to strengthen capacity for community engagement in addressing the social determinants of health at different levels. Further research should assess to what extent innovations in institutional frameworks and mechanisms such as participatory budgeting enhance the power to decide on the directions of policies and strategies and the allocation of resources, in particular of low-income and marginalized populations. It is equally important to evaluate to what extent selective disease-specific interventions, promoted as entry-points in low-income settlements,[41] enable meaningful participation and sustained effective integrated approaches. Legislative frameworks are important but appear not to offer a guarantee,[34] whereas the concept of "partnership" may obscure existing differences in interests, power, and resources.

There is an urgent need to move beyond analysis and promise toward progress toward health equity. Leonard Duhl in his seminal article on Healthy Cities (1984) argued for the need to conceive a *city as a whole*. Within the current context, it appears necessary not only to conceive the urban setting as a whole, but also to take a *global perspective* on the social and the political determinants of health.[42] As historical knowledge of public health teaches,[43] empowerment and sustained social mobilization aiming at local and *national* policy changes played a crucial role in achieving health improvements. In the year 2007 these lessons still appear relevant to ensure that integrated approaches effectively address the social determinants of Health for All.

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