Globalization and Health Inequities in Latin America

Ligia Malagón de Salazar
Roberto Carlos Luján Villar
Editors

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ISBN 978-3-319-67291-5 ISBN 978-3-319-67292-2 (eBook)
https://doi.org/10.1007/978-3-319-67292-2

Library of Congress Control Number: 2017957628

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Printed on acid-free paper

This Springer imprint is published by Springer Nature
The registered company is Springer International Publishing AG
The registered company address is: Gewerbestrasse 11, 6330 Cham, Switzerland

Preface

The picture of health is quite varied among the countries of Latin America. In general, it pales in comparison to other countries in the world that have similar economies and development. Latin America countries have distinct and unique inequities in health care services and outcomes. To gain an understanding of such a phenomenon, an individual must be introduced to complex explanations. This book carefully explores these complexities in terms of globalization, its influence on policies in low- and middle-income countries, and their resulting impact on inequalities. Investigations into these factors have been the subject of a large body of academic and research literature in the Latin American region; however, they are often underrepresented and unappreciated in much of the Western literature, which tends to focus on Europe and North America. Now, fortunately, we have a English-language text from leading scholars from the Latin American region. This book brings into focus the challenges in addressing health inequities in the Latin American context, as well as recent achievements that were made possible by emerging health promotion strategies.

Few people would doubt the impact of globalization over the past few decades. The economic concerns of nations across the globe are now tied closely together through intricate transportation channels as well as by the modern electronic means of communication. At no previous time was the global population so closely connected. However, despite this amazing level of connection among all peoples, differences in health disparities are still highly tied to the economic, social, and political decisions of nation-states around the globe. In addition, these social, political, and economic differences greatly affect efforts to promote better health and reduce inequities at the population level. As this book well illustrates, the Latin American situation represents a diversity of approaches for addressing health inequities in the many countries represented. In large countries such as Brazil and Argentina and small island nations of the Caribbean, complex and often subtle differences have to be considered if health promotion efforts are to succeed. This book offers numerous examples of these efforts to address the differences among them.

This book is instructive for individuals working in the Western/North American health promotion traditions as well as those in Latin America. It will inform

researchers and practitioners on the progressive efforts occurring in the Latin American region and illustrate well-thought-out alternate approaches that need to be incorporated into all health promotion approaches used worldwide. As the reader will see, many critical threads in health promotion need to take a broader, global focus. Chief among these is health policy, which is well covered this book. The chapters within reveal the components in health promotion that are culturally specific and need to be respected within a particular national plan, in contrast to the components that appear to be universal regardless of nation-state or culture. Finally, the book outlines the importance of monitoring population health as a mechanism to evaluate programs and as the foundation for a learning approach to better enable health promotion efforts. It is my pleasure to recommend this book as a means to increase one's understanding of the challenges of health promotion.

September 2017

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Book Presentation

This publication sets itself an ambitious objective: to provide inputs in answer to a question posed by many authors but poorly analyzed with the depth and time required to produce feasible and timely answers. The question is this: Why, despite the valuable efforts made by low and middle-income countries (LMICs) to reduce health inequities, have the expected results not materialized so far? In this regard, there is a special interest in analyzing the situation in Latin America where, despite the sustained efforts made by social and academic movements in defense of human rights, we are still far from achieving the expected results. Theoretical inputs and health strategies have been developed mainly by European and North American countries, which, though boasting higher standards of living than LMICs, have also experienced uneven and, in some cases, undesirable developments.

For the analysis of this and other subsidiary questions, the 15 chapters composing this book are organized into three parts, which are briefly described in what follows. In general, the chapters deal with related and complementary issues, all of them underlying the central question. The answer to the previous question involves several disciplines, forming a set of interactions of different complexity.

The limited (apparent) capacity of LMICs is due not only to internal variables but also to external situations, motivated by international policies such as globalization embodied in neoliberal policies, as well as in international health guidelines, where LMICs do not have enough power to incorporate their needs and priorities in these international agendas. Likewise, the weak or insufficient response to the consequences of social inequities is reflected in the phenomena of poverty, underemployment, lack of housing, and a lack of control over resources (land, technology, raw materials), among others.

Globalization, understood as an economic phenomenon and an explanatory category of great transformations at the planetary level, is also understood as a process of processes. The multidimensional integration of the process of globalization's progressive acceleration has demanded that we think about its effects in different fields such as health. In this sense, globalization has been considered an underlying determinant of enormous complexity and impact on health. The content focuses on unveiling the effects of globalization in the theory and practice of strategies to reduce

social and health inequities. A synthesis of the extensive and complex concept of globalization is presented using relational thinking, not only in glocalizations (the globe, specific territories, and different socioeconomic and political realities) but in orientations that are reproduced through traditional institutional practices of adoption and adaptation under centralized implementation and execution logics.

Many countries on several continents have suffered from the unequal conditions (precedent and emergent) imposed by globalization, contributing to the perpetuation of unjust accumulations of inequalities and inequities.

Part One presents different definitions of globalization and its characteristics, as well as reflections related to the following questions: What has been globalized, and what are the advantages and disadvantages of this process? How does globalization affect health equity? Is there a relationship between international guidelines and the progress achieved in the Latin American region—compatibility with the different realities of the countries of the region? Finally, how feasible will it be to reduce health inequities without addressing social inequalities?

The evolution and scope of policies and programs aimed at reducing health inequities have been mediated by the emergence of new theoretical approaches to health and ways of creating and maintaining it. In this sense, the implementation of primary health care (PHC), health promotion (HP), and health in all policies (HiAP) strategies has not been autonomous but, on the contrary, has been influenced by known and unknown external factors.

Part One also shows the tremendous efforts being made by countries, through international cooperation, financing agencies, and nongovernmental organizations (NGOs), to create conditions conducive to human health and well-being. It presents the theoretical evolution of such efforts and the technical challenges to overcome to put them into practice, reflecting on the most recent efforts—the successes, limitations, and gaps compared with the past. The authors claim that although these efforts are part of a continuum, recent options largely ignore the past. This fact is a product of the fragmentation of the structures that drive them.

To go beyond the theoretical postulates of the different strategies for facing health inequities, individuals and institutions that were developing or had developed concrete experiences on the subject of social and health equity were invited to present their experiences following a previously developed format. Four Latin American countries participated, with 15 experiences, in addition to one representative with experience in the Latin American and Caribbean Network RedLacPromsa, which is made up of national directors of health promotion. It is important to acknowledge that the experiences presented are diverse and differ in the topics they cover as well as in their complexity and explicit approach to social and health inequities. It is clear that these authors have made incursions into sectors other than healthcare, which is a breakthrough compared to previous experiences.

As an alternative to the challenges posed in previous chapters, we present in Part Three a proposal whose focus is the municipality, where social dynamics are generated to prevent or reduce social and health inequities; likewise, these localities are the most vulnerable to the consequences of these inequities owing to their socioeconomic, political, geographical, and response capacity, among others.

The proposed strategy is based on three pillars: (a) strengthening the local territories, meaning interventions are based on existing culture and local structures and resources to strengthen or transform them; (b) increasing the community and institutional capacity to undertake sustainable development processes; (c) evaluation as an instrument and a mean for collective learning, action, and participation in municipal management. The proposal addresses a broad field of action in which territorial sectors interact, mediated by power relationship and political interest, the capacity for negotiation, and opportunities to qualify their participation. As will become clear, these transformative processes require support tools such as information and monitoring systems, monitoring, and evaluation, as well as more appropriate processes and instruments for planning, communicating, and negotiating that favor intersectoral policies and actions.

Acknowledgment

Our undying gratitude goes to the communities with whom we have worked, who have given us the opportunity to acquire knowledge not recorded in books or at international events but that undoubtedly reflect ancestral wisdom. Thanks are also due for allowing us to delve into their work and for teaching principles of building useful knowledge. These include respect for others, humility to recognize that they have other knowledge, pragmatism to accept that they are not the problem but a key part of the solution, and, finally, the wisdom to recognize that without them, no initiative is sustainable. We also acknowledge the students, researchers, and managers with whom we have had enriching debates, the results of which are well reflected in this publication. We must acknowledge the several institutions, professionals, and international agencies that provided opportunities for study and learning.

Finally, we express our gratitude to the Foundation for the Development of Public Health (FUNDESALUD) and the Center for the Development and Evaluation of Policies and Technology in Public Health (CEDETES), which not only allowed us to use the results of their experiences but also the physical support to produce this publication.

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Part I
Introduction

Chapter 1
Equity, Globalization, and Health

Ligia Malagón de Salazar and Roberto Carlos Luján Villar

Introduction

Latin American literature contains a variety and richness of social movements advocating for health, development, and social justice. Similarly, European countries and international agencies have contributed to strengthening theoretical developments and guidelines for appropriate implementation. It is necessary to recognize that, despite the theoretical advances, low- and middle-income countries (LMICs) do not always have the political will and sufficient financial, technological, and structural capacity to cope with the demands that a successful implementation of these strategies implies.

Global advances are undeniable; however, the scope of the changes is not equally represented among all countries. It is striking that most achievements in LMICs correspond to aspects that do not demand significant changes in the power structures of these countries. Latin America and generally LMICs have faced permanent contradictions and internal conflicts to meet the goal of reducing health inequities. Advances and challenges coexist, so there is a need to identify and analyze the factors that produce and maintain them as well as the interactions among them.

The analysis of the aforementioned situation will be guided by questions such as the following. There are more questions than answers, so it would be presumptuous to expect that in a publication like this we would be able to cover in depth all the topics mentioned. For this reason, the editors have agreed that this publication should focus on making visible the challenges, opportunities,

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L. Malagón de Salazar, R.C. Luján Villar (eds.), *Globalization and Health Inequities in Latin America*, https://doi.org/10.1007/978-3-319-67292-2_1

and deficiencies in order to strengthen the local country's capacity to reduce social and health inequities. In this sense, the identification and analysis of interventions will be focused on the following aspects: relevance and feasibility of applying the strategies to reduce health inequities—primary health care (PHC), health promotion (HP), and health in all policies (HiAP); the availability of structures and the local capacity to perform intersectoral actions according to the political and organizational structure of the territories; and the needs of the population that inhabits a given territory. This, in practical terms, means that the analysis of the advances must be contextualized according to the particular practice, in an attempt to unveil and understand the main reasons for action or inaction (outside the scope of the health sector), as well as the limited results in those actions of the health sector that require the participation of other sectors.

- Why, despite the importance of the advances in reducing health and social inequalities, have the achievements been modest compared to expectations?
- Why are successful initiatives often pilot projects, most of which are not sustainable?
- Why have health promotion and health in all policy strategies permeated health sector structures but not other sectors?
- Are the three strategies of primary health care (PHC), health promotion (HP), and health in all policies (HiAP) viable strategies for reducing health inequities in LMICs?
- What are the main challenges?

This analysis will be used to identify priorities in terms of the capacity of Latin American countries to implement international and national guidelines to reduce health inequities and to establish a new agenda to close the gaps. The intention is to bring to the reader's attention the complexity of actions required to reduce health inequities and their consequences in the context of sustainable development processes of change. We hope that this effort will allow the identification of issues that have not been sufficiently explored or that require further study. More importantly, we intend to use the results of this analysis to set priorities and formulate recommendations adjusted to the reality of the Latin America region.

The readers of this publication are governments, members of civil society organizations, civil servants, the academic community, and agencies of cooperation and financing. They represent a relatively homogeneous public, in terms of the needs and challenges in complying with international strategies to reduce social and health inequities, but heterogeneous in its nature and capacity, forms, and mechanisms to adapt or reformulate actions in favor of equity, social justice, and the exercise of rights, three closely related issues.

The Pursuit of Social Equity: A Pending and Unstoppable Purpose

This part focuses on exploring the scope of theoretical and practical meanings of the equity concept as well as the implication of those meanings on strategies to reduce health inequities in Latin American countries. Conceptually, philosophically, and legally, equity has a clear valuation from the point of view of justice. Understanding equity from a multidimensional perspective puts it in a wider framework of social justice. The analysis presented here takes into account the dynamic and reactive nature of these strategies as influenced by context and political conjuncture. We do not try to perform a complete and in-depth analysis of the equity concept, which remains a topic of debate, but identify implications of the term in actions to reduce health inequities, which in our opinion must take place in the context of territorial development processes.

Equity Meanings

The main idea behind equity is that all people in the same circumstances should receive the same opportunity. According to Mokate (2002:15), "vertical equity" contemplates equal treatment for all groups and individuals in society, and "horizontal equity" entails "equal treatment for equals." Vertical equity implies that equity is equivalent to absolute equality.

> In the 1960s, Barry argued that equity is a comparative concept between human groups and would be realized when "equals are treated in the same way and the unequal are treated unequally." Culyer and Wagstaff later adopted this proposal as the two dimensions of equity: horizontal and vertical. (authors' translation) (Hernández-Álvarez 2008:74)

Davis (2007:31–32) questioned the possible mechanism to advance in terms of an integral equity: how are the two goals of growth and equity achieved? The obvious answer comes up against the obstacles of incomprehension and lack of government will: "The approach is only feasible if there is sustained success in both dimensions if public policies manage to be complementary. Growing up with equity means that income and profits are distributed among small and medium-sized entrepreneurs and workers of varying qualifications, with increasing remuneration over time."

Distributive inequality is the basic and obvious expression of injustice. In this sense, it is very important to clarify the processes that produce it. Different authors conceptualize inequalities and inequities differently.

Some authors consider that equity is the absence of disparities between groups (characterized by particular social, economic, and geographic aspects) in disadvantage, particularly with regard to health. Social equity is related to concepts such as justice (freedom and equality), cohesion, and social integration. Some authors associate health equity with a moral position (Blas and Kurup 2010). The multidimensional

character and the high value complexity of equity make the elaboration of a unitary concept more difficult.

Equity "as per Aristotle in his Theory of Justice (1959:395) is the blissful rectification of strict legal justice" (Spinelli et al. 2002:7). In the context of social equity, the different policies and social programs that need to be strengthened, and the different ways of measuring equality (access, inputs, impacts, and capacities) and fine-tuning procedures, have traditionally been mentioned. Equity implicitly retains the fundamental idea of parity and a similar distribution of different elements (socio-economic, power relationships) and benefits available to a population, without distinction of social class, ethnicity, sex, or age. According to ECLAC (2007:12), "Policies to promote social equity, together with employment, educational systems, and ownership of rights, and policies to promote equity, well-being, and social protection are considered mechanisms of social inclusion necessary for the strengthening of social cohesion".

The concept of equity is based on three social values: equality, fulfillment of rights, and justice. The relatively universal recognition of the goodness of these three values allows for the concept of "equity"—at least rhetorically—to enjoy some universal acceptance. There is broad consensus on the priority to be given to equity as a guideline or standard for public policy. However, this universal acceptance is sustained in part by the ambiguity with which we typically understand these values (Mokate 2002:14).

Social and Health Inequalities: A Value Judgment

Social inequalities are complex in nature owing to the accumulation of disadvantages contained by different groups, such as low social capital and, consequently, weak social cohesion, as well as the precariousness of their situation and limited opportunities to reverse this situation. In this sense, inequalities, instead of being reduced, diversify, taking on changing forms that intensify over time. Determining the differences between equality and inequality depends on a value judgment. In this way, inequalities are often measured (income) and inequities judged. "To speak of inequality is not the same as talking about inequity; the last one incorporates the value of justice" (PAHO 1998:2). "In order to qualify an unequal situation as inequitable it is necessary to know its determinant causes and to form a judgment on the justice or injustice of such causes" (Ministry of Social Protection and University of Antioquia 2010:45). No single factor determines inequalities; there are multiple dimensions (e.g., possession of production resources, accumulated wealth, use of assets owned, access to knowledge), which makes it difficult to counteract them appropriately, adequately, and permanently, mainly because they obey an insurmountable system of power relations.

The gap between the richest and poorest is scandalous. The poorest 10% have such low levels of income that in 2013 it barely reached 1.3% of the regional total. Meanwhile, the top 10% income earners in Latin American households earned 37%

of the total. The data become even more extreme when we come to wealth and assets. By 2014, the richest 10% of the region accounted for 71% of wealth and assets. The concentration was so extreme that in that same year, 70% of the poorest segments of the population barely managed to accumulate 10% of the wealth, and this trend is continuing (Lustig 2016:10). Reygadas (2008) pointed out the existence of matrices generating inequalities (colonial, modern, and postmodern), which emerged at different times, that, rather than disappearing with certain societal achievements, are transformed and acquire new forms within neoliberal policies. These matrices and their mechanisms that produce inequalities have come about through a common denominator: legitimacy under institutional complicities.

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Chapter 2
Global Response to Social and Health Inequities

Roberto Carlos Luján Villar and Ligia Malagón de Salazar

International technical and cooperation agencies, such as the World Health Organization (WHO)/Pan American Health Organization (PAHO), the International Union for Health Promotion and Education, and the Economic Commission for Latin America and the Caribbean (ECLAC), among others, have provided a valuable impulse to strive for social equity, which, according to López Arellano et al. (2008:326), "is a fundamental objective of global development programs, which use a framework based on indicators of social determinants to measure the accomplished goals."

Oxfam's report emphasizes the need to measure the impact of public policies aimed at reducing inequality, expand the state's redistributive capacity through the treasury, end legislation and regulation that protect the privileges of the few, and advance the empowerment and democratic participation of vulnerable and excluded groups; these are essential elements in reducing the intergenerational transmission of inequality in the region (Lustig 2016). Latin America has long fought for human rights and equity; however, its adoption on the regional agenda has yielded results that fall far short of expectations, and sometimes the decisions taken have intensified inequities.

Health must be understood as a result of interconnected sociopolitical phenomena that operate under multidimensional and complex power structures. In the following paragraphs, more inputs will be presented to perform analyses that are closer to our particular reality. Development as a universal right places the human being as the central subject. The development notion is composed of several levels (local, departmental, regional, national), spatial areas (territory), and approaches (decentralized, sustainable, participatory), which should not be separated from the notion

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L. Malagón de Salazar, R.C. Luján Villar (eds.), *Globalization and Health Inequities in Latin America*, https://doi.org/10.1007/978-3-319-67292-2_2

of individual development, empowerment, and active social participation. The dimensions (population, environmental, economic, and social) essential for development require a broad perspective and a systematic approach that involves interactions among constituent elements, the whole and the parts.

The evolution and scope of policies and programs aimed at reducing health inequities have been mediated by the emergence of new theoretical approaches and strategies for creating and maintaining a population's health, as well as new approaches and mechanisms adapted to each country's particular conditions. In this sense, the implementation of primary healthcare (PHC), health promotion (HP), and health in all policies (HiAP), among other strategies, has not been autonomous but, on the contrary, has been influenced by global socioeconomic contexts, embodied in neoliberal policies on which the globalization phenomenon rests.

> Despite some empirical studies that show significant correlation between the efforts of the globalization process and the specific impact on health, the existing weaknesses in the empirical evidence are more linked to the problem of globalization and health. Mention of the conceptual framework could make a major contribution to further empirical research that should serve as a well structured model for further consideration. This clearly shows the need of interdisciplinary approach towards globalization and health, which will draw knowledge from relevant fields, such as medicine, epidemiology, sociology, political science, health, education, the science of ecology and economy. (Kovačić 2014:694)

Global Response to Social and Health Inequities

Improving Income and Health Outcomes

According to Chossudovsky (2002), "a dollar a day" (poverty threshold) is part of the ambiguous standards of "scientific" poverty measurement, inconsistent with the real situation of various countries. In this regard, the author mentions some factors (unreliable systems in the quality of the data obtained) and argues for the existence of adjustments of parameters or estimates of poverty deliberately convenient for some institutions and interest groups, which are not in line with the reality of a huge part of the world's population:

> The World Bank and United Nations poverty assessments are, to a large extent, desk exercises conducted in Washington and New York with insufficient information on the local reality. For example, the UNDP Poverty Report points to a one-third or one-half drop in child mortality in sub-Saharan Africa, where poverty has actually increased and public health programs have collapsed. What the report does not mention is that as a result of the closure of health clinics and the massive layoffs of health professionals (often replaced by semi-illiterate volunteers) responsible for compiling mortality data, the computation of mortality is what has been reduced. These are the realities deliberately hidden by the poverty studies from the World Bank and UNDP. Their indicators blatantly misrepresent the social reality of the different countries, as well as the seriousness of poverty in the world. The "free market" system is seen as the most effective means of alleviating poverty, while the impacts of macroeconomic reforms are denied. Both institutions point to the benefits of the technological revolution and the contribution of foreign investment and trade liberalization, but they do not indicate how these global trends increase the poverty levels. (2002:43)

Studies from ECLAC show that employment opportunities arising from market reforms and trade liberalization are concentrated in low-productivity sectors, and therefore, these reforms tend to further widen the gap between winners (i.e., skilled workers in successful enterprises) and losers (i.e., unskilled workers or employees in low-productivity enterprises in the informal sector). According to this interpretation, the opening of the region's economies to globalization produced higher incomes for those with higher education while harming those with less formal education (Korzeniewicz and Smith 2000:394). These facts indicate the urgent need to eradicate poverty in our countries. Most Latin American countries in the 1980s and 1990s developed policies and programs to combat poverty. The results achieved brought not only the gradual incorporation of complementary aspects such as the identification of risk factors, balance of power relations, methodological issues about measurements, and analysis, among others, but the introduction of new conceptual and methodological approaches.

The poverty–vulnerability relation has generated two radical changes in the policies of poverty reduction: (a) emphasis on enhancing the available resources of poor sectors, rather than the observation of what is not possessed; and (b) the vulnerability assumed as the risk of a fall in well-being levels, an immediate step to impoverishment, must be faced by these sectors through a mobilization of resources and activation of strategies to prevent and reverse impoverishment (Busso 2005:16).

There is an imperative need to eradicate or reduce poverty if substantive changes are to be made to the health conditions of populations. Perhaps one of the most important aspects is to identify how to narrow the gap between rhetoric and the real and effective commitments of states.

Extreme Poverty Eradication in Latin American and Caribbean Countries

The World Bank defines extreme poverty based on the available economic range of people who live on less than US$1.25 per day. The World Bank estimates that, by this definition, 1.4 billion people lived in poverty in 2008. Poverty is also treated as a state of scarcity of economic, social, cultural, institutional, and political resources that affects populations with the greatest accumulated disadvantages, who therefore live with minimal basic capacities to reverse unfavorable conditions. This reality is mainly associated with labor market conditions, instability, informality, low wages, and job insecurity.

The average unemployment rate in Latin America has decreased according to ECLAC (2015), which, together with the International Labor Organization (ILO), affirmed that the unemployment rate in Latin America and the Caribbean in 2012, at 6.4%, had been the lowest in recent decades, after declining from 6.7% in 2011, a positive figure considering the difficult labor situation in other regions of the world. According to ECLAC (2015), the average of the official unemployment rates in the countries of the region fell again, from 6.2% in 2013 to 5.9% in 2014, bringing it to a new historical low (López Segrera 2016:27).

Poverty analysis requires a systemic view (underlying macroeconomic and structural causes of monetary and nonmonetary poverty), accounting for its multifactor

character: economic, social, political, cultural, historical, and territorial. An increase in poverty is dynamic; it does not occur through a single pathway or in a unidimensional way; its impact affects different vital areas of individual lives and social groups. Therefore, a multidimensional poverty index is used to quantify it.

In this perspective, ECLAC has insisted that social policy must have the capacity to influence the structural determinants through which poverty and inequality are transmitted from generation to generation: misdistribution of educational and occupational opportunities, the pronounced inequality in the distribution of wealth, high demographic dependency, and the ethnic and gender dimensions of poverty. Education is a mandatory route for equitable growth, democratic development, citizenship consolidation, and personal development. However, this set of virtuous relationships should not hide the fact that in a segmented society, education is also an instrument of social segmentation and cannot be approached apart from the influence of the other structural factors mentioned, particularly the generation of quality jobs that effectively make possible the use of human capital (ECLAC 2003:27).

In this sense, the technical teams of ECLAC and the United Nations produced a document (2013) to facilitate and support discussions among countries in the follow-up to the agenda for post-2015 development and Rio + 20. One of the seven central messages referred to the need to raise the minimum well-being threshold for populations, for which "change must be based on universalist state policies (social protection, health, education and employment)…" (ECLAC 2013:9). There is growing evidence that supports the existence of a link between income inequality and health results. These results should alert authorities, officials, and the public to the need to fight income inequality and rethink the role of international financial institutions that dictate state policies (Cruz Ferré 2016:501).

The economic poverty of individuals, together with the exclusion of some fundamental social relations, increases social vulnerability. Exclusion must be understood as an expression of the process of social disaffiliation (Castells 1995 in De Roux 2008), a factor that is part of the set of disadvantages accumulated along the trajectory of thousands of vulnerable individuals for an indefinite period with a historical incapacity for individual and collective response. Income distribution should be a matter of concern for ethical considerations of social justice. If the distribution of income exclusively reflected personal preferences for work, effort, and saving, it would not have to constitute an ethical problem from the point of view of distributive justice. If the differences between individuals were limited to the scope of their personal responsibilities and preferences, it would be morally reprehensible to interfere in their behavior to improve income distribution. Inequality and poverty become an ethical issue that demands external intervention when it is recognized that the conditions generating them are not a result of individuals' choices but the legacy of the past or circumstances beyond their control.

> Once it is recognized that effort and attitudes towards education, work, risk and savings are not independent of the initial conditions of each individual, it opens space for other concerns. It is not simply about ensuring "equality of opportunities." If equality of opportunity is understood as equality of access (free basic education), this will not be enough to ensure equality in the use of capacities (school attendance), and even less equality in the results

> (academic achievement). According to the objectives of social justice pursued by the society in each field, policy actions should be directed to altering the distribution of the capacities of use (school subsidies, for example) or the distribution of results (leveling programs and other supports). (IPES 1999:23)

By the updated poverty line of $1.90 a day, the estimate for 2012 indicates that 900 million people, or 12.7% of the worlds' population, lived under conditions of extreme poverty in that year (Global Monitoring Report 2015/2016 2015:3). In the case of Latin America and the Caribbean, there was a decrease in the proportion of the population that lived on less than US$1.90 per day according to purchasing power parity values (2011), with results of 17.8 (1990), 13.9 (1999), and 5.9 (2011). Despite these figures indicating progress in poverty reduction, enormous, permanent, and timely efforts are required, together with the empowerment and implementation of strategies to "end poverty in a sustainable manner and promote shared prosperity, taking into account the demographics as the countries promote broad-based growth, invest in human development, and insure against emerging risks" (Global Monitoring Report 2015/2016 2015:22).

López Segrera (2016) stated that "poverty reduction and middle-class growth in the last ten years is related to the dynamics of growth and job creation, as well as to the social policies of progressive post-neo-liberal governments." Employment and health are considered primary aspects of the category of human well-being. Thus, increasing job offers (improving those of temporary nature and remunerative precariousness) is one of the main concerns of the countries of the Latin American region.

In 2002, 225 million people were living in poverty. From 2008 to 2014, this number decreased by 58 million people, but the millions of people living in indigence or left homeless grew by five million in the period 2012–2014. Poverty was reduced, but indigence gradually increased. Perhaps this information on the reduction of poverty is due to two specific developments. The first has to do with the intervention and sustainability of social assistance programs and the second with the adjustment of parameters or new estimates of poverty (threshold) in recent years.

Millennium Development Goals

The millennium development goals (MDGs) and sustainable development objectives (SDOs) were established to reduce or eradicate key aspects in the living conditions of the poorest people. In 2015, the United Nations coordinated efforts toward sustainable development goals to strengthen the effects of the millennium goals. The central purpose was to minimize poverty, promote prosperity and well-being for all, protect the environment, and address climate change. In addition to the human aspects, the sustainable development objectives considered a wide range of related aspects such as security, disaster risk reduction, well-paid work, conflict prevention, and animal diseases.

> The MDGs have been successful at reducing income poverty but not so much at improving non-income deprivation, such as access to quality education or basic health services. Few countries have combined growth with a reduction in the level of environmental externalities and carbon emissions and the increase in environmental degradation, overfishing, deforestation, extreme weather events and air pollution in the cities, all of which threatens recent progress. Looking to the future, three challenges stand out: the continuing depth of poverty, inequality in shared prosperity, and persistent disparities in non-income aspects of development. (United Nations 2013:1)

The year 2015 marked the transition from the MDGs to SDOs, whose goals are aimed to reaching the highest levels of reduction of social inequities through various processes and strategies, established within a framework of integral sustainable development as the central idea. The SDOs address not only poverty reduction but also other phenomena that deeply affect millions of lives, projecting an ideal "end of poverty" scenario. However, the accomplishment of an objective of this complexity exceeds the possibilities of individuals and collectivities—and sometimes of entire countries; it demands a long-term process that focuses on political-economic policies capable of generating structural changes that are not dependent on changes in government.

> The road map–as the SDO underlines–goes through a more synergistic approach among the various aspects of development. Three ingredients will form the political agenda: broad-based sustainable growth, investment in human development, and measures to protect the poorest and most vulnerable against emerging risks. These strategies must be sensitive to demographic issues. Countries at the epicenter of global poverty need to accelerate their demographic transition, invest in their youth and growing populations, and lay the foundations of sustained growth to capture demographic dividends. (Global Monitoring Report 2015/2016 2015:2)

Sustainable Development Objectives

The MDGs constitute a key opportunity to reduce the negative effects of socioeconomic and political phenomena such as poverty, vulnerability, social exclusion, and social and health inequities, with the strong political support of various governments of the world. The world met the MDG of halving the global poverty rate by 2010, 5 years before the original target date. Recent data suggest that extreme poverty has continued its downward trend in recent decades. However, poverty remains unacceptably high, with an estimated 900 million people living below US$1.90 per day in 2012—the new international poverty line; in 2015, the estimated figure according to the new threshold is 700 million (Global Monitoring Report 2015/2016:1).

A review of key indicators reveals that Latin America and the Caribbean have made significant progress toward the achievement of the MDGs, particularly in reducing extreme poverty, hunger and malnutrition, child mortality, and access to water. These developments, however, are not enough to close the gaps between rich and poor and overcome the lags that have characterized the region (United Nations 2013:12).

Main Agents of Change
Small producers,
Family farmers,
Rural women,
Fishermen,
Indigenous communities,
Youth and other vulnerable or marginalized groups.

FAO and SDG (2015:1)

The Food and Agriculture Organization of the United Nations (FAO) documents and the 17 Sustainable Development Goals (2015) emphasize the need to achieve a reduction or elimination of hunger and malnutrition to reach the SDOs. They also point out the need to focus on a particular part of a given territory and on specific actors to put into operation processes of change.

In this way, the rural zone is the key area in which interventions must be carried out, based on the existence of a political will; as for actors, the following have been identified as the main agents of change: small producers, family farmers, rural women, fishermen, indigenous communities, youth, and other vulnerable or marginalized groups (2015:1). The FAO document identified some measures that should be considered for the eradication of extreme poverty and hunger by the year 2030: combining pro-poor investment in sustainable agriculture and rural development; transformation of existing food systems, which employ a large amount of inputs, to make them more sustainable—including by reducing food waste—through better management and better techniques in agriculture, livestock, fisheries, and forestry (2013:1).

> FAO has identified five strategic objectives to refine its focus on the fight against hunger and to create food systems that are more sustainable. This places the Organization in a strong position to support countries that are taking the lead in implementing the Sustainable Development Goals. Through its international experience, FAO is also well positioned to provide support to broad regional and international partnerships, including South-South cooperation, needed to achieve zero hunger by 2030. (2015:7)

The capacity exists to produce enough food to eradicate the chronic hunger of hundreds of millions. However, that capacity cannot be guaranteed because of a lack of access to stable and decent jobs that would make it possible to earn income enabling people to purchase basic food items.

Global Health

Global health is defined by Frenk and Gómez-Dantes (2007:162) as "a field of knowledge [that] involves the interdisciplinary study of the health-disease process at the global level and the social responses generated to deal with this process." PAHO

(2013), quoted by Franco (2016:128), proposes the following definition: “transdisciplinary approach that addresses health from the perspective of the universal right to health and social welfare.” Global health is population health in a planetary context, defined as an area of study, research, and practice that emphasizes health improvements through the achievement of equity in health for all and protection against global threats that cross national borders. It shows three determinant tendencies that mark the distance from the central idea of international health, historically nested in the interrelations between countries of a region or at the intercontinental level:

(a) The increasing international transfer of risks and opportunities for health; (b) greater pluralism in the arena of international health, with an accelerated growth in the number of actors; (c) the increasingly critical role of health within the agenda of economic development, global security and democracy.

> The global health approach in Latin America should take as its starting point a characterization of the phenomenon of economic globalization and its impact on equity in access to health services and general well-being of the population. (Solimano and Valdivia 2014:360–362)

The global health concept has shifted its focus, moving from the problems of the developing world to health problems with a global impact. These approaches recontextualize key aspects such as health inequities, human health, the global environment, and climate change. Global health requires thinking about the immediacy of interactions in an interconnected world, threats to it, and its simultaneous and unavoidable opportunities. Daulaire (2003) argues about the importance of acting in the present with regard to global health promotion in order to predict optimal results in the medium and long term:

> To view global health promotion as a means to ensure optimal market access, the forces that drive globalization can be channeled to promote global health, regardless of their motivations for taking action. If solutions are devised to meet the social and economic needs of the current decade, it will be easier to meet (and exceed) those of successive decades. All sectors have the opportunity to join the global alliance of organizations bound by a self-sustaining commitment to promote global health. It is the task of this alliance to ensure that health is placed—by public and private demand—at the top of the global agenda. (2003)

Global health is also understood as a global category (Franco-Giraldo 2016); it differs from international health, which focuses on developing nations and foreign aid for these countries. Koplan et al. (1994) in Clavier and De Leeuw (2013) established a comparison between the concepts of global health, international health, and public health. Through geographic scope they identify direct and indirect issues that affect health; by transcending national borders, health-related issues could further

affect low- and middle-income countries (LMICs). Therefore, the joint development and implementation of solutions are required in a global instance of cooperation. This is a measurable objective and a category of health status connected to risk factors that are variously cross-border, transnational, or global in nature. These risk factors are loosely grouped under the heading globalization, and in such terms, globalization is viewed as a process capable of generating an equally loose category of global health, which incorporates a specific set of crises and problems that can be characterized as a global system of disease (Kay and Williams 2009).

> The concept of "global health" has become a mainstay of the scholarly discourse since the late 20th century. This has happened because governments and the aid industry abandoned the notion of "international health", which was considered by many to be limited....Global health appears to have greater appeal, greater urgency, and more forceful mobilization than its predecessors do. (Clavier and De Leeuw et al. 2013:104)

Thinking about global health involves thinking about the ways in which it can be regulated globally. According to Clavier and De Leeuw (2013), "If individuals, NGOs, and national governments, as well as international organizations, can drive the global governance of health, then traditional theories of international relations alone cannot predict how this governance will work. This means that analysts need new sets of theoretical tools to analyze global health governance." New sets of theoretical tools are therefore needed to analyze global health governance. In that sense, it is important to define what is understood as governance. According to Rasanathan (2011:13), the term *governance* "refers to the way governments (including their different constituent sectors) and other social organizations interact, in the way these agencies relate to citizens and how they make decisions in a complex and globalized world." Global health occupies a very high place in the international political agenda, but in Latin America it is still considered a field under construction, according to Solimano and Valdivia (2014) and Franco-Giraldo (2016).

Urban Health and Healthy Cities Movement

These two strategies have similarities in their theoretical basis but differ in their implementation, which is bound to the political, geographic, and economic contexts. Thus, different demands, challenges, and, therefore, mechanisms, as well as circumstances and conjunctures, influence the processes, methodological tools, and impacts. Therefore, we will take a quick look at the dynamics of these processes from the perspective of practical experience to meet the established criteria concerning public policies, legislative intersectoral work, inclusive participation to balance power relations, agreements supported in budgets to undertake operational plans, and local capacity.

The need to address social, economic, and environmental factors to improve health outcomes has been recognized in international and country meetings and agreements, country policies, and published articles; at the same time that by politician, researcher and health practitioner (WHO 2017). Despite this recognition, the

advances have not met expectations, mainly in LMICs. This is not the case for developed countries according to a WHO Europe publication, which clearly shows structural advances in small cities to address intersectoral actions to improve health:

> Effective intersectoral action is crucial to address today's biggest public health challenges. Health and well-being are affected by social, economic and environmental determinants. A successful policy response to address these determinants therefore necessitates an approach that is intersectoral. Increased involvement and coherent cooperation between actors in different sectors are necessary to achieve strategic goals. Intersectoral action is both a precondition for and an outcome of all dimensions of sustainable development.…Many sectors were involved in the country case stories, with the health sector taking the lead in most cases, coordinating action and engaging other players. The other main sectors involved in intersectoral action were agriculture, education, family affairs, interior, labour, justice, sports and tourism. Non-governmental organizations played active roles in intersectoral actions in addition to private entities such as the media. (WHO 2016: xi)

Big differences in the progress achieved between developed and developing countries, as well as within municipalities and countries of the same region, are well documented. According to the study "Healthy cities. Promoting health and equity—evidence for local policy and practice" by De Leeuw et al. (2014), progress among cities and networks differs in scale and quality. LMICs have experienced structural failures, but this does not mean that nothing has been done; on the contrary, there is regional movement to strengthen the capacity of cities and municipalities to intervene.

Within this movement, one critical aspect is the study of experiences in terms of satisfying principles, highlighting favorable and limiting factors.

> A vision, project, and movement engages local governments in health development through a process of political commitment, institutional change, capacity building, partnership-based planning, and innovative projects (De Leeuw et al. 2014).
>
> The healthy cities movement promotes comprehensive and systematic policy and planning for health and emphasizes the need to address inequality in health and urban poverty, the needs of vulnerable groups, participatory governance, and the social, economic, and environmental determinants of health (De Leeuw et al. 2014).

According to Caicedo-Velásquez et al. (2016:75), "Urban governance promotes well-being and health as it provides platforms that enable citizens to improve their social and economic conditions using their own capabilities."

> Governance will provide the normative, technical and administrative guidance for the different levels of public administration (MSPS, Department/District and municipalities), as well as health insurers and providers, to organize their management processes to achieve health results, based on the articulated action of the sectors involved. (MINSALUD 2016:32)

If individuals, NGOs, and national governments, as well as international organizations, can drive the global governance of health, then traditional theories of international relations alone cannot predict how this governance will work. This means that analysts need new sets of theoretical tools to analyze global health governance. (Clavier and De Leeuw 2013).

Theoretical Approaches and Strategies to Reduce Health Inequities

Different perspectives and theoretical approaches of interventions are aimed at reducing health inequities. This search has led to several ideological positions that reflect a certain conception of health and its relation to equity. In addition, a real willingness to transform power structures and public policies related to the asymmetric distribution of resources and opportunities in the population. The diverse and complex issues concerning the application of these theoretical approaches and strategies demand from governments and society as a whole commitments and responsibilities that go far beyond what has been done until now in terms of policies, legislation, regulation, health system transformation, and relations among territorial structures. Multidisciplinary and interdisciplinary research approaches are important for understanding this issue.

The main responses to health inequities from the health sector are represented by PHC, HP, and HiAP strategies. These strategies have revolutionized the paradigms of public health, mainly in two dimensions: first, through preventive basic care and universal coverage and, second, by addressing political and social dimensions, centered on the determinants of health inequities. The difference between these approaches as will be seen subsequently is on their scope and complexity as well as their capability to establish strong and permanent links between actions and social and economic development plans.

The appropriate definition of the problem contributes to defining the nature and scope of these strategies, as well as the mechanisms and resources that guarantee an implementation in line with needs, expectations, and territorial context. Territorial development plans must be coherent with the cultural and sociopolitical context of each region, revealing through them the philosophical and political orientation that underlies any option chosen. With different paradigmatic perspectives, intervention models cannot be subjected to the same mechanism of valuation, validation, or application, as usually happens under so-called good practices, without taking into account the context.

Although there are differences between the three strategies, they do complement each other. PHC, HP, and HiAP, rather than theoretical formulations, are philosophical and political positions about health expressed in governmental and social strategies and programs.

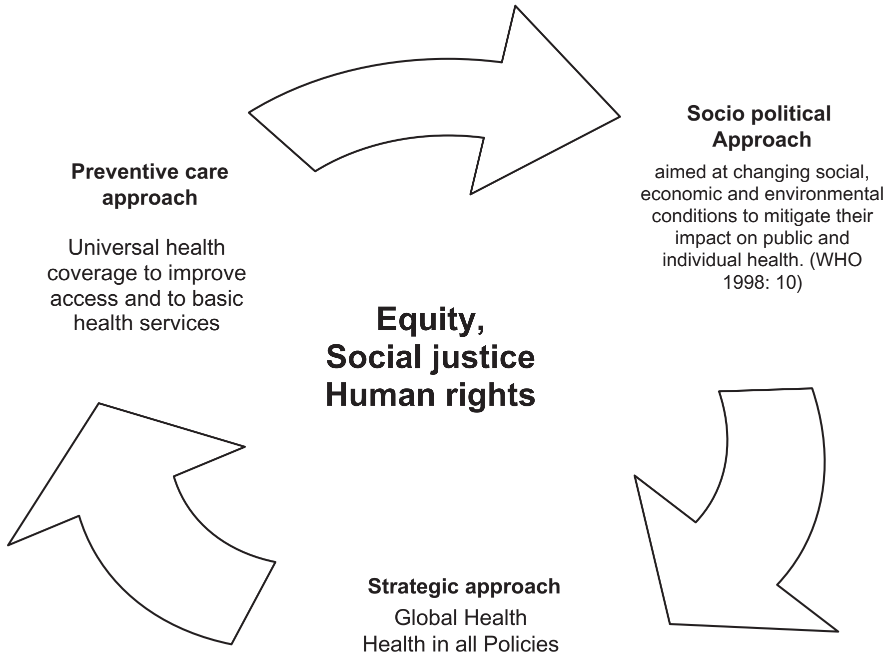

Fig. 2.1 Main focus of strategies to address health inequities (Source: authors' elaboration)

The strategies (PHC, HP, and HiAP) differ in, among other things, their origin, scope, actions, actors, application scenarios, results, and impacts. The analysis of these approaches, as indicated earlier, represents a valuable input to monitor, value, and strengthen processes of change. A critical and contextualized discussion of the approaches and their implementations will show that they are connected and complement each other. Hence, it is necessary to integrate them in order to act in a coordinated manner, taking into account their differences, scope, and requirements for their application.

Figure 2.1 shows different strategies oriented to the search for equity in health, social justice, and human rights, differentiating them by their origin, scope, actions, actors, and results, among other factors. The analysis of these approaches constitutes a valuable input to coordinate, monitor, and evaluate the processes of change and results.

Different authors define the scope of these strategies from two perspectives: one perspective focuses on risk factors associated with behavior, lifestyles, and access to basic care consistent with the notion of free choice; the second focus emphasizes the determinants of health, specifically the determinants of inequities (structural). Emerson (2013:1499), regarding health inequities, said, "Some health disparities may be attributable to biological variations or free choice. Others may

be attributable to environmental conditions beyond the control of individuals concerned. In these instances, the uneven distribution of health may be considered unnecessary, avoidable, unjust, and unfair."

The three strategies aimed at reducing health inequities (PHC, HP, and HiAP) represent a social policy approach, each of which, as already indicated, acts on different aspects and levels of complexity. It would not be an exaggeration to say that each one is a response to the degree of progress, results, and gaps that preceded it. This permanent renewal has taken place in the theoretical dimension, and very little in the practical realm. Hence, it has not necessarily been useful to close gaps between and within countries, such as in the results, impacts, and capacity of responses to satisfy the demands implied by their application. The reorientation of services would seem to be the strategic bridge for transforming health systems, oriented to the health promotion of (glimpsed from Ottawa, Canada); politics, its substantial element; and the sempowerment of the community, is the driving force behind the action. In addition, in neoliberal times the change in the sense of the public (need to build "public value") is an obligation to fill the gap (Franco-Giraldo 2009).

What follows is a description of what has been the practice of the strategies (PHC, HP and HiAP), based on their theoretical definition, scope, complexity, and practical meaning. Although the analysis of each strategy was done separately, it is necessary to take into account that the factors that have facilitated or limited their implementation are common to all, based on the territory where they are implemented.

Universal Coverage Through Primary Health Care

The definition expressed in the Declaration of Alma Ata (1978) considers PHC to be "an integral part of both the National Health System, from which constitutes the central function and the main nucleus, and of the overall social and economic development of the community." International evidence suggests that health systems organized based on strong PHC orientation achieve better and more equitable health outcomes, are more efficient, have lower costs of care, and achieve higher user satisfaction compared to systems that have a weak PHC orientation.

According to Apráez (2010:370), "the history and development of primary health care and Health Policy for All in 2000 do not originate from Alma Ata (Litsios 2002:17) but have roots in 'social medicine' with the movement led by Rudolf Virchow and Jules Guerin, among others (Waitzkin 2006:31)." PHC is also considered a movement that competes with a set of diverse actors with activities directed to the promotion of broad citizen participation (Rojas Ochoa 2003). For Franco-Giraldo (2012) "PHC is an operational strategy (currently a world policy) needed to make urgent changes in health systems." Barten (2012), regarding the scant explanation of PHC, makes the following observation:

> The lack of a common and shared vision of the meaning and purpose of PHC was/is a great challenge. It has been suggested that a solution might be to insist that the use of the PHC concept should always be followed by a clarification of it: level, program, strategy or philosophy. (2012:349)

The WHO (2003) document states that PHC evolves according to the economic, sociocultural, and political characteristics of each country. Although there is not a single operational definition of PHC, there are nonnegotiable principles as well as mechanisms that should help to create the conditions for compliance with them. This raises several questions: Is it appropriate to expect a reproducibility of results? To use similar indicators to assess progress and results? To refer to the needs of the development of a research and work agenda aimed at strengthening theory and practice in a dialectical, ontological, and transformative way? PHC, HP, and HiAP depend on the possibility of working in politics and making use of power. The results, therefore, are highly influenced by the redirection in the use of power in the world and the implementation of a series of local strategies within the framework of globalization (glocalization).

WHO (2005), citing several examples, argues that the increase in coverage follows a movement that goes from being a typical situation of mass deprivation (low coverage for all, except for high social strata) to a state of marginal exclusion (high coverage for all groups except those in the lowest socioeconomic stratum). Previous results were repeated in later studies. According to the authors, these results warn about universal coverage, which is not achieved easily and in a short time. In developing countries, despite significant progress, universal coverage has not been reached in the 30 years of Alma Ata.

On the other hand, Franco-Giraldo (2012:198) affirms that to achieve population-wide health, the reorientation of services is the means, PHC is the strategy, and population health is the general framework for action; however, some authors point out the advantages and limitations of this approach and the reasons why it have become a constraint rather than a facilitator of health equity. The Brazilian experience is examplary; an inverse hypothesis has emerged in regard to equity, and it argues that new programs initially cover people with high status, and sometime later it reaches the poorest. The preventive care approach is especially represented in the PHC strategy, although in recent decades its scope has been expanded with the so-called renewed primary health care (2007). Therefore, the authors concluded that there is little reason to believe that working on universal coverage will lead to improvements in health equity. Progressive universalism is the alternative proposed by the authors, who observe two initiatives from Brazil and Mexico: Brazil's Family Health Program (1994) and Mexico's Popular Insurance initiative (2004). In both, the program began in the most depressed territories and social groups and was applied progressively in other precarious areas. The premise in the proposal is that groups with greater disadvantages at least earn the same as those who are better off at each stage of universal coverage.

Very important advances have been made in PHC within the health system, as mentioned earlier, but to assert that this is due to global economic development is to grant PHC a scope that is far from the reality, for the reasons noted earlier. In response to the lag in accomplishing some objectives, so-called renewed PHC was created, whereby new responsibilities and challenges are theoretically assumed to correct past mistakes, but it continues to operate within the system and structures that have been the main cause of limitations and current gaps. In this sense, Franco-

Giraldo (2009) posed the following questions: What is being renewed from the PHC? More specifically, what should be renewed? The theoretical definition of PHC has evolved, making its implementation more complex. Reference is made to intersectoral actions, the involvement of development sectors and actors, strengthening the participation and self-determination of the community in the planning, organization, operation, and control of available resources, as well as the use of integrated reference systems, which are functionally supported and give priority to the most vulnerable populations. As we will see subsequently, these actions are also present in the HP and HiAP strategies, meaning there is an urgent need to generate processes of change in the structures, mechanisms, and resources in which these strategies develop their full potential.

Health Promotion: A Sociopolitical Approach

A critical look at the fundamentals, advances, and factors that influence the performance of HP will provide inputs to generate proposals that lead to the strengthening of its theory and practice. PAHO in its online publication (2005), quoted by Muñoz and Cabieses (2008), reaffirmed the procedural nature of HP. The political approach was highlighted as it enables the transformation of existing structures. The scope, complementarity, and complexity of HP can be summarized in the definitions of Ottawa and Jakarta; it also shows the following complementary aspects:

> Health promotion is a process ... that addresses complex health, social and economic problems, and provides a valuable framework to organize social and political action in order to improve health and living conditions. Health promotion is therefore a technical, political, social and academic approach to work with different sectors and improve the quality of life of people. (2008:141)

Table 2.1 describes the conception and some requirements for implementing operate HP initiatives, according to different authors. Although the table does not present all valuable theoretical and practical contributions, it accounts for the key issues and scope given to this strategy that are in some way necessary to implement other, related strategies. A central aspect that we want to highlight is the diversity and breadth of approaches that are based on different conceptions of health and on the evolution and complexity of forms and contexts where health is promoted and modified. This fact also explains the diversity of interventions to implement HP that are linked to the characteristics of the contexts and scenarios of practice. So that there is no single metric or standardized lists of criteria that represent this diversity, what should exist are guidelines that must be adapted to each site and process of improvement. An important, but usually neglected, issue is analyzing the implications and elements of these strategies that need to be in place for these strategies to work. This is precisely where the monitoring and evaluation indicators should be centered. Many of the aspects mentioned in the column of implications are widely known, so we present some implications of these concepts in practice as examples; but this is an exercise that must be performed in each territory or practice scenario.

Table 2.1 Health promotion conceptions and approaches

Definition and scope	Reference	Implications
For the international community health promotion is understood to be (1) a function of public health, (2) a practice, (3) a strategy, (4) a social movement, and (5) a process HP has been defined, sometimes indistinctly and without internal coherence, as a dimension, a strategy, a process, or a set of actions	Mark et al. (2000) Eslava-Castañeda (2006:7–9) Quesada Monge and Picado Herrera (2014:129)	Relational field of action that includes instances of social participation (strengthening of community activities, inclusion of civil society) Coalescence of a perspective that focuses on the elaboration of guidelines according to the execution of specific and efficient actions
HP constitutes a global political and social process, embracing not only actions aimed directly at strengthening the abilities and capacities of individuals but also those aimed at changing social, environmental, and economic conditions in order to mitigate their impact on public and individual health It addresses complex problems and provides a valuable framework in which to organize social and political action in order to improve health and living conditions HP is a technical, political, social, and scholarly approach to working with different sectors and improving the quality of human life HP is a process that enables people to control their health in order to improve it by acting on the determinants of health to create the greatest health benefits for people, to make significant contributions to the reduction of health inequalities, ensure human rights, and build social capital	WHO (1998:10) Sapag and Kawachi (2007:144)	Global political and social process requiring structural reforms of vertical/horizontal ordering Concrete structures, but flexible enough to allow for the dynamism of the context Appropriate structures and legislation for the implementation of intersectoral strategies, so individuals and civil society can have greater control over health
A strategy and a social movement, field of knowledge, scenario of action, and "methodological practice of current or international movement"	Chapela (2001) in Díaz-Mosquera et al. (2015:34)	Oriented to social and political actions; it is permanent, therefore sustainable
Provided to people by the necessary means to improve their health and exercise greater control over it		Demands an appropriate long-term and sustainable process supported by structures and resources for the implementation of intersectoral strategies
HP in practice should be a product of alliances between different bodies responsible for its development Research and academic centers, governments, society, and international collaborative health agencies, among others	De Salazar (2009:40–41)	The alliances should integrate or articulate not only sectors but fields of knowledge as well as political and social actions Interdisciplinary and transdisciplinary approaches must be consolidated to achieve greater and timely achievements without redoubling efforts between sectors

Community effort directed to … the education of individuals in the principles of personal hygiene … the development of the social machinery to ensure each individual in the community a standard of living adequate for the maintenance of health	Robledo-Martínez and Agudelo-Calderón (2011:1035)	Alliances with academic institutions; innovative training approaches of different stakeholders to meet goals; reorientation of power relations between partners and participants in working teams; redefinition of scope and responsibilities of institution, sectors Transdisciplinary approach to develop and socialize health issues, in an integral way, based on three systems of knowledge: scientific, individual, and collective
Most of these strategies should have the territory as their setting and a scenario of negotiation and practice (territorial identity) Adoption of foreign models, after studying their relevance and territorial feasibility, taking into account cultural, social, political, and economic characteristics of the territory	De Salazar (2011:19–20)	Adjustments and adaptations of the international guidelines to the particular Latin American realities Alignment of sectoral plans with territorial ones through common objectives, financing, and articulation of working areas to fulfill objectives Policies, legislation, regulation, and mechanisms to strengthen intersectoral actions, with autonomy and active social and community participation in territorial agendas
The strategies must be monitored, understood, visualized, and revitalized to account for the relevance, performance, and coherence of transformative territorial processes	De Salazar (2011) De Salazar (2012:43)	To address structural causes policy, geographic, organizational actions. The processes of change, in this way, would focus on intervening causes of inequities rather than on their consequences. This characteristic differentiates these interventions from other risk prevention and disease care. In this way, processes of change and transformation are more sustainable The question is how a fragmented and service-oriented health sector can contribute to changes in raising the level of education, promote policies to guarantee equity access to opportunities and goods, improve food and nutrition, and increase access to safe employment and dignified income
The existence of a new logic of HP, oriented to the social sphere, which is synthesized, according to the authors, by five strategic lines: elaboration of healthy public policies, strengthening of social participation, strengthening of individual and collective skills, creation of healthy environments, and reorientation of health services	Quesada Monge and Picado Herrera (2014:130)	Social logic complementary to traditional health actions; action based on lessons learned from practice, supported by a sustained process of learning and capacity building

In an effort to synthesize HP definitions formulated in different studies, Eslava-Castañeda (2006) identified three different but complementary meanings. First, it is an international health policy that seeks to intervene in lifestyles and conditions that in a way that enables individuals to make healthier choices. Second, HP is a set of actions and processes designed to help communities and individuals exercise greater control over the determinants of health, thereby maintaining or improving their "health condition." Finally, health is conceived as a positive state, and not disease, so actions are focused on maintaining health conditions and ensuring the well-being of individuals and populations (2006:108).

> It is difficult and sometimes unwise to pontificate about the core values of health promotion, but since most nations at least pay lip service to the canons of the World Health Organization, we may confidently identify the following key values: Health is holistic and not solely concerned with disease and its prevention; health is about equity and social justice; and health is about empowerment (Tones 2005:27).

The Ottawa Charter (WHO 1986) promulgated a set of HP actions that have been gradually adopted and adapted in Latin America. It is important to highlight that these actions are permanently reinforced around the generation of public policies in favor of health and well-being, the creation of support environments in the territory, the reorientation of services, the responsible and coordinated participation of other sectors around health and life conditions, and the strengthening of local capacity to address challenges related to the social determinants of health. The close relationship between equity, well-being, and health led to the emergence of new approaches integrating economic and social dimensions more tightly. In 1991, the World Bank supported the reinforcement of the principles incorporating the issue of economic and social development as an extrasectoral component of health.

Healthy lifestyle[1] and the ability to enhance human development, according to Quesada Monge and Picado Herrera (2014:137), have been identified as dominant theoretical-methodological approaches in HP. The first approach, associated with the behavioral modes of individuals based on self-care and the various kinds of socialized and internalized knowledge. The responsibility of promoting these lifestyles falls on the institutions providing health services; however, the intentionality of engaging in healthy actions entails complex operational logics whose effectiveness depends on the viability of intersectoral work and the political wills that

[1] De Salazar (2012:6) emphasizes that "the vast majority of studies on health promotion have been presented at national and international events, focus on approaching lifestyles, dying, with very few giving an account of the social determination, its effects on the health conditions of the populations and the impact and effectiveness of the responses."

generate certain social and economic conditions. The second approach aims at strengthening human talent and its development and community participation, through which an effective balance of power relations is achieved. This last approach was proposed in the Declaration of Santiago 2016, as a means to effectively address equity in health.

Key aspects of the strategies and how they emerge from the most holistic conceptions of health are theoretically complementary, but efforts are needed to integrate them into territorial systems and structures. Instead of competing, they should be mutually supportive and reinforcing so they do not end up redoubling each other's efforts. Likewise, it can be said that each new strategy, besides pointing to theoretical advances in addressing health inequities, is a reflection of the failures of previous ones. Thus, understanding the causes of success or failure is mandatory so that the mistakes of the past are not repeated and present opportunities are seized. It is important at this point to analyze the influence of globalization and international policies and guidelines, as well as national policy systems of operative HP definitions. It is striking that many drawbacks of policies are found in both developed and developing countries.

One common problem, mainly in LMICs, is that traditionally governments do not usually prioritize health among their political objectives. Beyond improvements in health services, actions relating to the transformation of living and working conditions and knowledge leading to sustainable well-being processes are not part of a country's political agenda.

In addition to structural and functional changes in state institutions and civil organizations, permanent, active, and informed participation of the population is required. The question is whether a given type of participation meets these criteria or whether, on the contrary, it is an instrumental, reactive, conjectural, and sporadic type of participation. Likewise, it is necessary to reflect on whether there are organizational and functional structures that favor the fulfillment of these criteria and contribute to equally balance the power relations within the different forms of participation in localities.

(Díez et al. 2016:76) argue that the concept of "causes of causes" is poorly understood by authorities, the general population, and even public health staff. Society is mobilized by and for care resources, and hence the absence of preventive public policies is not the object of popular demand.

Health in All Policies: A Sociopolitical Approach at a Higher Level

The roadmap document for the Plan of Action on Health in All Policies (PAHO 2016) recalls that the HiAP "was defined for the first time in the 2010 Declaration of Adelaide and, subsequently, it was presented in a global framework for action in

the countries in the Helsinki Declaration of 2013." HiAP is understood as a political strategy and practice directed at encouraging a greater political commitment to achieve structural transformations for health equity.

> Health in all policies is the political practice aiming to include, integrate or internalize health in other policies that shape or have any influence on the SHD.….Health in all policies focused more in the "large issues" and less in those programs or individual projects. Depending on the institutional context of each country, these political practices can start at the national, regional, local level, or even distributed in the different levels of government. The political practice "requires a form of governance in which there is a joint leadership between governments, between all sectors and between different levels of government." (Adelaide Agreement 2010 in McQueen et al. 2012:15)

To identify, analyze, and intervene to reduce health inequities, it is necessary to dig into the deeper causes interwoven in the fabric of society and the mechanisms of human biology in clinical aspects related to the way people cope with disease and disability. In the nineteenth century, wherever there was observed a combination of critical epidemiological thinking, availability of health data, and well-organized public health movements, there emerged a growing interest in the social, physical, and biological causes of epidemic diseases (Beaglehole and Bonita Diderichsen 1997 et al., in Evans et al. 2002:13). In the context of the eight World Conference of Health Promotion (PAHO 2016), HiAP is defined as "an approach for all the public policies and sectors involved in decisions that affect equity and health conditions." These policies take place at national, regional, local, or even distributed in different levels of government.

Some Considerations for Reflection

It is important to highlight two aspects of the foregoing definitions: (1) the responsibility for a strategy's implementation is placed with the health sector/national health systems; (2) the strategy's relation to social and economic development processes must be clearly articulated. In the first case, it is has been observed that reforms of health systems are not always in line with the necessary changes for an appropriate implementation of the given strategy, and even less has the strategy's relation to economic development processes been articulated, given the lack of plans and agendas commonly associated with territorial development. Most regional reports and publications reflect this problem, as will be shown subsequently.

A country's response to a previous situation can be to make minor changes that do not represent threats to the power structures, much like following the guidelines of cooperation and financing international agencies, whose agenda has been formulated with insufficient participation of countries (differential participation). This is not to say that the participation of these agencies is bad or good; rather, these agencies also reflect the imbalance of power relations and the effects of globalization. Such a situation requires that regions, countries, and populations be

given the capacity to argue for and defend their policies in a way that is more in line with the needs of their inhabitants. In this manner, people can not only take advantage of the opportunities offered but also participate in the construction of agendas that affect them.

There are undeniable theoretical developments and contributions that can be applied to strengthen existing strategies (renewed PHC) or formulate new strategies to fill the gaps left by previous ones. However, we must ask ourselves on the following questions: What is the capacity of our country/region to respond to the challenges of a strategy's implementation? What is the coherence between the international and national agendas and our reality? What are our country's priorities? The clarity and depth that will come from reflecting on these questions will be valuable inputs to reorient practice, research, policies and programs, and, especially, operational plans (priorities and funding).

Although the experiences related in what follows do not represent the situation of all Latin American countries, they give an idea of the topics of interest, as well as the advances achieved and limitations that have had to be overcome in practice. As can be observed, there are differences in the presentation and depth of the cases, although the format of the questions was designed to allow standardization the contents of the reports. It is understandable that the directions given could be difficult to follow because the particular experiences were in different stages of development.

Key aspects for addressing health inequities were explored, comparing theory and practice through an analysis of international guidelines and advances in the "real world." One of these aspects is related to intersectoral work, which is behind the strategies studied in this publication. The countries belonging to the Latin American and Caribbean Network for Health Promotion were invited to participate; not all of them responded, but one of the members presented the experience of the network. In addition, experiences were presented from Brazil, Peru, Mexico, and Colombia. What follow are some of the questions addressed. At the end a critical analysis and lessons learned will be presented.

Are There Ongoing Intersectoral Initiatives?

Description of intersectoral initiative

How, when, and why did it arise?

What advances have been made? What is the time horizon?

What motivates such initiatives?

What situation motivated intersectoral work?

Who are the partners? What responsibilities do they have?

What equity issues were addressed?

Were inequity aspects taken into account in the formulation of the problem?

Did the intersectoral work take place in the intervention planning, only in practice, or in both?

A sample of the questions follows:

Key Aspects of International Guidelines for Developing and Operating Intersectoral Initiatives
Are the international guidelines on intersectorality taken into account?
How much?
What factors have helped/limited their implementation?
Have changes been made to the initial intervention design to address difficulties?
What changes have been made or should be made?

Rebuilding the Practice as a Learning Tool to Strengthen Territorial Capacity to Increase the Feasibility, Effectiveness, and Impact of Interventions

In the previous section, we pointed out critical aspects related to the implementation of strategies aimed at reducing health inequities, and we highlighted the fact that whatever the name of the strategy for addressing this problem, it is necessary to strengthen the territorial capacity (community, institutional, governmental, civil society) to ensure its success. The need for a holistic health approach is another condition; this means a delimitation of the problems and priorities, transcending the clinical perspective, as well as operational approaches consistent with the context (available structures and resources) and, more importantly, putting in place sustainable processes for the permanent strengthening of the capacity to analyze, understand, and transform reality. In this way, practical experience becomes an element of transformation and capacity building. Several concerns arise about "know-how" and the sustainability of these processes.

There is an extensive literature on what needs to change; the challenge is precisely how to achieve it, an consideration that is absent in most publications. This means that, although we are aware of key requirements for carrying out interventions, we cannot be certain that they will be applied because in most cases they are not documented. Governments, as well as funding and international cooperation agencies, have contributed to this situation because most of them emphasize results rather than the process and mechanisms that make results possible. The political and social nature of transformation processes reminds us that these processes are not static and so do not operate in all contexts. The question that emerges from this fact is this: What, how, and when is it appropriate to standardize interventions? There is no doubt that there is a lot of information on what, but very little about how, especially for developing countries. The answer has many facets, so we will not provide a final answer on these issues, but arguments will be provided to build one.

The theoretical concepts could probably be generalized to a certain extent, but not their implementation, which is circumstantial and contextual. The last aspect incorporates and defines the type and importance of the relationships and interac-

tions between the different living forces in the territory and their structural components (e.g., society, culture, organization, communication, power relations, social class, socioeconomic factors, and physical resources). These and other concerns will be the subject of further analysis. Likewise, "the know-how," for reasons of "contextual identity" mentioned earlier, should not necessarily be replicable in all contexts without first making an analysis of the assumptions and conditions that guarantee its applicability. We do not use the term *identity* capriciously, but in defense of a conception of territory, as a social construction with relationships, interactions, relations of power, values, history, and culture within it.

To motivate this analysis, we requested the voluntary participation of institutions and researchers involved in health promotion interventions, mainly those aimed at reducing health inequities. A flexible guideline was shared with those who agreed to participate, and the key issues will be covered (see attached format). Despite this request, not all participants provided the expected reflection but discussed the advances in their work.

As stated earlier, we are aware that the experiences reported do not represent all Latin American countries, which is why we furnish a brief description of the main results found in most representative studies, such as the *State of the Art* and *UNASUR* studies (De Salazar 2012), both of which addressed HP interventions in Latin American countries.

Background

A number of studies have been carried out containing information and evidence on the burden of disease and risks of contracting diseases from a biomedical perspective; however, there is scant information about real problems and the interventions used to deal with them. In addition, information on the interaction of factors arise within the framework implementation of interventions and contribute to the results and effects. No one study mentions which groups felt the effects more acutely or not at all, those that experienced differential effects, those who benefited most/least from the interventions, or, finally, the structures and mechanisms that contribute to the accessibility of opportunities and services. The evaluative studies reported in the UNASUR region (De Salazar 2012) present partial evaluation results focused on problems related to disease and risk events from a disciplinary and sectoral perspective. These evaluations emphasize the performance of programs in terms of compliance with scheduled activities, without interpreting this information in the light of the specific context and circumstances in which the findings were obtained. Theoretically, primary health care and HP strategies demand changes in the structures that historically have influenced the implementation of interventions to fulfill the two principles mentioned earlier (the right to health and equity).

It is striking that, although there is continuity in the work deployed in fields closely related to health promotion, these findings are not treated as actions of HP because they develop outside the health sector. This is the case of public policies for the reduction of poverty and improvement of access to education, housing, and

employment. The evaluative proposals reflect large gaps in concepts, theoretical and methodological approaches to assessing other aspects that directly influence outcomes, such as the quality of the intervention design according to intentionality and objective, the performance, and the methodological approaches to valuing the effectiveness and impact of these interventions (De Salazar 2012).

This indicates the limited scope of evaluation and indicators to account for equity and social determination in health. Likewise, it shows that there are insufficient inputs to use the results of evaluation in strengthening the theory and practice of policies and programs. The promoters of these initiatives recognize gaps in the theoretical foundations, the context, and the processes for the implantation and implementation necessary for the achievement of objectives. With their high social and political content, most interventions in HP have their own dynamics, not necessarily reproducible. There is also no record for monitoring and evaluation processes or, more importantly, the use of this information to strengthen or reorient interventions (De Salazar 2012). The situation described exists in several countries, and LMICs are not the exception, as reported in the following studies.

> Burlandy (2009) and Jorquera (2011) describe the influence of health systems management on interventions; Carmichael et al. (2012) identify barriers and limitations to integrating sectors and agendas in a territory. Grundya et al. (2009) compare current health needs with the relevance of health system responses. Sosa et al. (2013) believe that health planning should incorporate other sectors. Castell-Florit Serrate and Abreu (2012) find that the identified sectors were different compared to what evidence shows (2012).

In summary, a significant volume of studies focus on the justification of advances concerning the reduction of the magnitude of biological-clinical problems in order to justify interventions. A very brief description was given on how changes have been achieved, and in a few cases the results were attributed to intervention. This, in practical terms, means that the analysis of the advances is not contextualized according to each scenario, in an attempt to unveil and understand the main factors "responsible" for the results.

Additionally, programs in which actions fall outside the scope of the health sector were not considered. Although it is not possible to cover all subjects in sufficient depth, we hope that this exercise will allow the identification of areas that require further analysis. As mentioned previously, the recipients of this publication are government workers, civil society organizations, civil servants, and agencies of cooperation and financing of Latin American countries. A public, relatively homogeneous with respect to the need and challenge to comply with international strategies to reduce social and health inequities but heterogeneous in many respects such as capacity, forms, and mechanisms to adapt or reformulate actions in favor of equity, social justice, and the exercise of rights, three closely related aspects.

An outline was developed to guide the construction of cases that focused on practice as a learning tool, strengthening the production of territorial capacity, increasing the viability and effectiveness of interventions (see appendix, Table 2.2).

Appendix

Table 2.2 Interventions aimed at reducing inequities in health

Intervention: Policy/program/project/strategy		Observations according to list of questions
Rationale of formulation of problem intended to respond with intervention	The types of health inequities that have been identified and their consequences must be modified or reduced by: Context: Socioeconomic, political, demographic, and geographical characteristics of the territory Inequities underlying health inequalities Which social groups or more vulnerable clusters (ethnic minorities, women, children, the elderly, the disabled)? Potential causes (social, economic, cultural, environmental)	The nature of the problem: Who participated in defining the problem (government institutions, civil society, church)? Who is a problem for? Who is most affected? Is the formulation of the problem clear and complete? What information and evidence (type of evidence: scientific (analytical, documentary) or testimonial) were available to define the problem? What is the probability of being modified?
Type and scope of intervention Results	Explain what the intervention consists of: Background: Description of context of intervention considering information available on aspects that in the opinion of those responsible and beneficiaries of the intervention could influence the implementation of intervention and the results, taking into account components: historical, political, geographical, demographic, social, cultural, and economic. Different tensions that have arisen in the past but are influential in the present and determinants for the future welfare of a population, in a negative scenario with populations that are not empowered in any dimension. Design of intervention: Justification: Why and how did the intervention arise? Who determines the need for its execution? Actors involved: state, civil society, private Desired change: conjunctural situation, chronic, structural, or a momentary solution What results/impacts are expected? (Short, medium, or long term) What kind of indicators are used to measure success? Theoretical framework Theoretical support References to successful or failed studies that help in the identification of key elements in intervention planning through a strategic design to implement properly Strategies Indicators of success (by process stages, results, for the indicator of impact the reduction or of the prevalence, for example) Objective(s) Describe the general and specific initial objective and whether it changed Operational plan for implementation: Identification of factors favoring and limiting the results Which sectors, institutions, NGOs participate and in what capacity? Factors that could influence the results obtained Identification of primary and secondary data sources: people, institutions (e.g., records of organizations, government and welfare institutions, community registries, information systems)	(Preevaluation of design or planning of institutions, actors, and resources involved in the process) How the intervention is defined: Scope, relevance, and consistency with the problem: Population, focused Levels (individual-family-community, territorial) Sectors: Rural and urban (feasibility, budget, area recognition, previous immersion) Approach (sectoral–intersectoral) Time horizon Is the theoretical framework of the intervention based on evidence from studies with similar objectives and conditions? Is the intervention guided by strategies such as APS, SeTP? (Emphasis) What guiding principles and components of previous strategies were considered? Who is most interested in this intervention? What interests you? Was a theoretical framework worked out to support the design of the intervention? Where does it come from? International, national, and local guidelines Were these guidelines adapted to the conditions of the territory? Has the objective of the intervention been properly defined? Is it achievable? (viability) Do the specific objectives meet the general objective? Did they change? How does it take to meet the objective? Were consideration for the design aspects of the context that could influence both the implementation Strategic/operational plan Was an operational plan formulated to implement the intervention? Was the plan monitored? Were the planned activities developed? If not, why did this situation arise? Was the change process documented? Were the resources identified according to sufficiency and relevance for carrying out the proposed activities? Were the assumptions made explicit for the intervention to work? Are the key actors of the intervention explained? Functions, times, resources?

(continued)

Table 2.2 (continued)

Intervention: Policy/program/project/strategy		Observations according to list of questions
	Expected results according to the degree of implementation Were monitoring and follow-up included in the implementation process? Was it participatory? Were the views of potential beneficiaries taken into account? Identified progress: strengths and limitations? Were the main factors favoring and hindering implementation identified? Critical analysis of process and results (final/intermediate) Were they expected? Did they get additional? Were links established between problem, intervention, and results? Did the formulation of indicators take into account the nature and scope of the intervention? The time to produce the expected results? Performance during the intervention? What and for whom? How should the approximate results be presented to decision makers? What key aspects should be weighed in the context of this presentation? What would you change about the intervention to achieve the expected progress? Are they satisfied with what has been accomplished? What is missing? Why did it not happen? Lessons learned from this analysis: Aspects that contributed to or limited the accomplishment of activities and achievement of the objective, especially the components of the strategies to reduce health inequities: Political Economic Social Cultural Infrastructure Legislation and regulations Capacity Did the professionals who participated in the intervention meet expectations, or are professionals from another area or field required for subsequent interventions in order to complement aspects not developed?	Are indicators clearly identified and defined to assess the success of the intervention: design, implementation process, effectiveness, and impact? Do the indicators respond to the objective and nature of the intervention? Is the relation between problem/intervention/expected results taken into account in the analysis of the results? Was the influence of the time variable on the results analyzed? Was the increased dollar variable, its price fluctuation compared to what was presupposed in an initial stage of the proposal and its lag before the intervention, taken into account? If not, there will be a budget shortfall Were monitoring and evaluation protocols followed? Was the intervention implemented as planned? Have aspects such as objective, subject population, time, resources, and strategies been adjusted in the course of the intervention? (Imponderables of nature, climate change, accessibility) What should be changed? Why? If the intervention were repeated again, what would it change and why? Were the reasons for success/failure collectively analyzed? Was this information used to establish corrective measures? Were the initial assumptions met to achieve the objective of the intervention? What key players participated in the intervention and how? Current/available information Did the group analyze the feasibility of meeting the objective in the light of changes in the results, context, and conditions under which the intervention was implemented? Concluding remarks about: Relevant theoretical reasoning/insufficient Structures (required) Priority: low/high; for whom? (resource sufficiency in terms of quantity and preparation) Legislation—normativity Contribution of information systems, monitoring and evaluation, and type of intersectoral management Performance of strategies related to intersectoral action and participation and empowerment of actors; balance of power relations; sustainability

Suggested scheme for construction of cases

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Chapter 3
Main Challenges to Reduce Health Inequities in Latin America

Ligia Malagón de Salazar and Roberto Carlos Luján Villar

Introduction

Before beginning the analysis on the evolution, progress, and impact of strategies to address health inequities in Latin American countries, it is necessary to review policies and strategies. The aim of this chapter is to draw attention to the structural challenges faced as a result of the glacial pace of change in most low- and middle-income countries (LMICs) since such challenges are among the reasons actual changes always fall short of expectations. To this end, the arguments put forth by scholars on the subject, especially leaders of the Latin American region, are outlined. Neoliberal policies promoted by international agencies, such as the International Monetary Fund (IMF) and World Bank, social policies such as the eradication of extreme poverty, employment policies, and food security, and territorial initiatives as expressed in global health and urban health programs are critical issues when it comes to understanding and strengthening processes of change.

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© Springer International Publishing AG, part of Springer Nature 2018

L. Malagón de Salazar, R.C. Luján Villar (eds.), *Globalization and Health Inequities in Latin America*, https://doi.org/10.1007/978-3-319-67292-2_3

This paper does not present an in-depth analysis of these policies because, first, they do not constitute the central theme of this publication and, second, there already exists a wealth of reports and publications on these topics.

Equity is not an objective itself; it needs to be inserted in a wider context of a search

- Do Latin American countries have the knowledge, political will, structures, and capacity to deal with health inequities?
- Why do pilot projects achieve greater progress than government programs?
- Do we create bubble situations decontextualized from reality to please international community, or to justify the money invested?

for social justice where the dimension of power becomes a central variable. This approach is inescapable because health equity has to do with "social, economic and political determinants outside the health sector, which profoundly affect the health status of the population" (Diderichsen et al. 2002:4). A deeper understanding of the factors influencing the processes is needed. Equity should not only be a goal but a sociopolitic process of sustainable change: it would not be possible to achieve sustainable development without it. To drive a development process, the broad support of successful policies is required, and this will be difficult to achieve if the benefits of development are not widely shared (IPES 1999:8–9).

The study of the relevance and feasibility of previous recommendations should be done in the context of each country, local territory, and region. It is recognized that local action generates change; however, change is influenced relationally by the global economy, relationships among countries, and power relations. In this sense, the impact of local action can sometimes be limited, until changes are made in the asymmetric distribution of power and resources that perpetuate inequities in health and until concrete actions are taken aimed at reducing vulnerability and negative effects on health conditions of the most vulnerable and exposed individuals, groups, and communities.

A critical review of the nature and fundamentals of the theoretical bases of each strategy and its advances and factors that influence its performance will produce inputs to help identify the mechanisms contributing to a successful implementation based on the identity of each country/region.

Globalization has been defined in various ways, although most of the definitions address similar principles and characteristics. According to Melucci (1996:295), it is neoliberal economic globalization or universalization. Beck (1998), cited by Pazos Beceiro (2002), describes it as a "process (formerly a dialectic process) that creates links and social and transnational spaces, and revalues local cultures." Giddens (2000:25). Caldbick et al. (2014) argue that globalization is not only a process, but "complex processes that operate in contradictory and unethical manner." It is important to point out that some of these processes are related to the market economy, transnational corporations, consumerism, and free trade, among others (Franco-Giraldo 2006).

Globalization is also understood as an explanatory category of major transformations, at the global level in recent decades; as per Laurell (2014:854), "globalization means that the organization of societies on the principle of the market and under the dominion of the transnational capital is currently leading." For Stiglitz (2002:308) "globalization seems to replace the old dictatorships of national elites, by new dictatorships of international finance." Under globalization, capital promotes projects of global reordering based on the precepts of neoclassical economics and neoliberal ideology; it has among its characteristics the primacy and unrestricted mobility of financial capital and the transnationalization of economies, where a small group of companies define world production and trade (López Arellano et al. 2008:325).

> For most of the remaining countries, many of them in Africa, Latin America, and Eastern Europe, globalization has not lived up to its promises owing to a combination of poor domestic conditions, an unequal distribution of foreign investments, and the imposition of new conditions further limiting the access of their exports to the OECD markets. In these developing countries, the last twenty years have brought about a slow, unstable, and unequal pattern of growth and stagnation in health indicators (Cornia 2001:834).

> Liberalization refers specifically to the marketization of healthcare and involves shifting from state modes of governance to the market mode for the distribution of healthcare provision. There is evidence that suggests that liberalization in healthcare creates inequities in terms of access to health and health outcomes in many developing countries, with the poor unable to afford basic healthcare or medicines. (Barrientos and Lloyd Sherlock 2000, 2003; Hutton 2004; Mackintosh and Koivusalo 2005 are part of the meeting cited for Kay and Williams 2009:6)

The multidimensional integration of the progressively accelerating globalization process demands critical thought on its effects in the health field. In this sense, globalization has been considered a determinant of enormous complexity having a major impact for health, aside from other factors such as urbanization, poverty, education, gender, ethnicity, and access to services (Hospedales and Jané-Llopis 2011).

In the case of the globalization of health promotion (HP) strategies, a process of extension and planetary management has been noticed in different dimensions. Implicitly it allows for relating glocalities (the orb, specific territories, socioeconomic realities, and different policies, but oriented by central guidelines that reproduce themselves through traditional institutional practices of adoption and adaptation, under centralized logics of implementation and execution) and glocalizations (temporalities and practices).

> Never before was greater intelligence required as well as an imaginative and creative ability of governors and academics to renew conceptions, effective actions of HP strategy that create new spaces for public health in the world of globalization. Certainly, the concern about the ineffectiveness of HP actions has been great. Insistently real and effective experiences are sought to strengthen evidence based on HP (Franco-Giraldo 2012:194).
>
> Globalization provides new opportunities of collaboration to improve health and decrease transnational risks that threaten it. These opportunities include advances on information, technologies and communications; and availability of the best mechanisms for global governance and the exchange of experiences (WHO 2005:2).

The aforementioned document recommends that all sectors and fields act in accordance with "strategies of health promotion in a globalized world" through the following measures:

> Advocating for health based on the human rights and solidarity; invest in policies; measurement and sustainable infrastructure to address the determinants of health factors; create capacity for the development of policies, leadership, knowledge exchange and to conduct research; establish regulatory standards and laws that ensure a high grade of protection facing possible damage and the equality of opportunities for health and well-being of all persons; conduct partnering and alliances with public, private, non-governmental and international organizations and civil society to promote sustainable outcomes. (WHO, 2005:3).

Franco-Giraldo (2012:200) identified critical aspects associated with the "lack of effectiveness of HP in the context of globalization." For Salazar (2012:26) the current international order does not guarantee the effectiveness of social actions aimed at reducing health inequities; "the evidence on the effectiveness of these initiatives does not account for their complex nature given their multidimensional, intersectoral, and intergovernmental actions. Meanwhile, Woodward et al. (2002:37) assert that "at the national level, policies should be designed to explicitly increase the well-being of the population, rather than assuming that it is achieved automatically through policies aimed at economic growth."

It is not easy to find studies that establish the required clarity with respect to the economic benefits of globalization versus concrete benefits for health development (links between national economies and health systems) in LMICs. Globalization also threatens the identity and cultural values of populations. It has driven transformations that have increased differences and intensified permanent disparities among various social groups, which represents opportunities to improve health in the context of globalization, according to various authors:

> Social groups had very uneven resources to deal with the opportunities and the risks created by these transformations, so it is not surprising that sectors with greater economic resources, the best social networking and the best educational capital would take ownership of a significant portion of the benefits created by globalization. (Reygadas 2008:111)

Franco-Giraldo (2016:130) proposes to delineate the scope of a "Latin American global health perspective" based on some analytical axes and practices, such as "governance, accountability (transparency, accountability, etc.), social justice, human rights, reduction of inequalities, processes of reform of the health sector, universal coverage and quality of services (perspective of health rights)."

Potential Impact of Globalization on Strategies Aimed at Reducing Health Inequities

Globalization with respect to health has different connotations and implications, leading to the idea of health "without borders" as promoted by all sectors of development; additionally, it is associated with migrant phenomena (involuntary), which have generated many concerns and fostered new coresponsibilities in terms of containing, for example, at the planetary level, the emergence of contagious diseases, the resurgence of infectious diseases, and the intensification of chronic diseases. Some authors have presented globalization in value terms, perhaps without

considering the underlying national processes (Feachem 2001; Dollar 2002). Thus, questions such as what kind of globalization is good and what kind is bad for human health, the growing concerns about the impact of globalization on health equity, the diseases associated with globalization, and the effects on health equity in a world marching toward globalization must be addressed. Chen and Berlinguer (2002) have identified at least three interactive links:

> First is the clear transmissibility of health determinants and risks. Enhanced international linkages in trade, migration, and information flows have accelerated the cross-border transmission of disease and the international transfer of behavioral and environmental health risks. (...) A second criterion is shared risks and consequences worldwide and over time.Intensified pressures on common-pool global resources of air and water have generated shared environmental threats. Environmental damage due to global warming, ozone depletion, chemical pollution, and the unsafe disposal of toxic wastes are examples. While local and regional contexts may shape the health dimension of environmental insults, many new threats are genuinely global in scale. (...) A final dimension is health change associated with the technological and institutional transformations of globalization. The technological advances underpinning globalization are profoundly altering the landscape of global health. Some examples are the market-driven priorities of private pharmaceutical companies, the penetration of private markets into health services, the neglect of research and development against "orphan diseases" afflicting the poor, and iatrogenesis due to inappropriate application of new and often expensive health technologies. (Chen and Berlinger, 2001: 38–39).

Llambías Wolff (2003) raised the need to progress toward a paradigmatic change, which requires a specific capacity to do so; but what kind of capacity does he refer to: the capacity related to institutional strengthening, which constitutes an enormous challenge, or the capacity to undertake processes of implementation? The execution of policies demands a different type of rationality, mainly if the intention is to raise awareness on the significant importance of health in the context of socioeconomic development. The challenge is not an exclusive responsibility of the health sector; it is a matter of coresponsibilities that requires thinking about equity as a guiding paradigm.

> The challenges are rather in the ability to promote paradigmatic changes to successfully implement policies around a reconceptualization of health, as an integral part of social economic development, and transform it into an ethical and valuable indicator of modernity (Llambías Wolff 2003:237).

Contrary to the widespread idea about international economic integration and the creation of greater inequality between rich and poor countries, as well as within the countries, Dollar (2002) mentioned in his article "Is globalization good for health?" that the existence of an "abundant number of studies that have linked the incomes of the poor to their health situation authorizes us to think that globalization has positive indirect effects on nutrition," "infant mortality and other health aspects related to income." However, Dollar (2002) stressed some harmful effects on health of globalization, based on the idea of "side effects of traveling and migrations, although also the trade of food and other products can spread diseases." According to Dollar (2002), the migratory phenomena of some countries led to the spread of various diseases. Likewise, trade of tobacco products demanded the implementation of health policies to deal with these problems. This controversial article did not go unnoticed by another author, Villa-Caballero (2004), who made the following point:

> While some defenders of the global scheme argue for and underline the existence of benefits in the area of health for poor countries (Dollar 2001, part of the appointment of Villa-Caballero (2004)), the evidence shows that there is no decrease in new cases of AIDS, tuberculosis, and malaria, and that also now these diseases are exported, such as the epidemic of AIDS that is currently observed in countries of Europe and Asia as a result of migration from Africa. Another effect of globalization on health is the spread of harmful patterns of behavior. In addition to the known negative influence from tobacco and alcohol, backed by multinational companies with offices around the world, there is another element of emerging risk to health: nutrition. Adequate nutrition has a determining role in the health of populations. As is known, in a large number of developing countries, the availability and administration of food is compromised, and these countries currently face a new challenge in connection with international commercial exchange without borders. (2004:105).

Following Walt (1998, cited by Chen and Berlinguer 2002) regarding the existence of legitimate concerns about global inequities in health, Chen and Berlinguer (2002) argue that the evidence is inconclusive, so it can be inferred that larger and more timely studies are needed that identify specific structural factors conducive to global inequities in health while at the same time rethinking the strategies to provide appropriate solutions. However, Chen and Berlinguer (2002) put forth hypotheses on some mechanisms of deterioration of equity in health:

> Private markets, unconstrained and inadequately regulated, are perhaps the most powerful globalizing force driving inequities in health Particularly disturbing is the commercialization and commodification of health, for example, the sale of body parts, such as kidneys (sometimes even from live donors) (Berlinguer 1999). Penetration of private markets into health services eat at a time when the state is under attack as inefficient and misused through private "rent-seeking" behavior of politicians and civil servants. (...) The main equity concern in relation to biomedical sciences is the tendency to ignore the diseases suffered by the majority of human beings and to concentrate instead on commercially profitable products (Chen and Berlinger, 2001:40–41).

The direct and indirect effects of globalization on Latin American countries are considerable; one of the most important relates to economic and political constraints, which at the same time produced additional constraints on important dimensions of human development. However, various authors mention some advantages of globalization. On the other hand, Stiglitz (2002) made the following statement:

> Foreign aid, another aspect of the globalized world, although it suffers from many shortcomings, nevertheless has benefited millions of people, often in ways that have not been news: the guerrillas in the Philippines, when they left the weapons, they had jobs, thanks to projects financed by the World Bank; irrigation projects over-duplicated the incomes of farmers, and therefore had access to water; educational projects expanded rural literacy; in a handful of countries projects against AIDS have led to an expansion of the disease. Those who vilify globalization often forget its advantages, but its supporters have been even more biased; for them, globalization in "developing countries must accept it if the objective is to grow and fight effectively against poverty. However, for many in the developing world, globalization has not fulfilled its promises of economic benefit." (2002:29)

Brieger (2002) unraveled the meaning and produced a balance between the implementation of different globalization measures, its discursive (ideological) success and the myth created around neoliberal policies in Latin America, as well as the expectations formulated by the propagandist theorists, based on the idea of overcoming the backwardness into which populism and statism had plunged them,

which did not match the results achieved. This reality has demanded an international rethinking regarding control measures, intensifying strategies such as prevention and HP, coupled with the commitment of the different social actors involved with the actions of prevention and disease reduction:

> The balance parameter for the neo-liberal theories is the quantity and quality of the reforms applied. In this sense, they consider that the decade of the '90s has been a resounding success whose results have already been transferred to the general welfare. (2002:344)

Accordingly, the complexity of health demands the establishment of structurally interrelated aspects (economic, social, and political) through new global policies that encourage the possibility of using greater economic resources and compliance with regulations executed by different development sectors. This has led to tensions that had hitherto not existed between local and national, regional and intercontinental governments and organizations. Gamage (2015) formulated questions related to policies, programs, and mechanisms within a framework of globalization and how all these favor communities with greater vulnerability and risk of being socially excluded.

> One question arising out of the borrowing and lending of globalizing policies as well as the transfer of capital, technologies, goods, personnel, ideologies, and expert knowledge is: whose interests do they serve? In development contexts, we also have to ask whether the policies and programs being launched under the name of globalization are well targeted. And to what extent do they benefit the marginalized sectors and disadvantasged communities of society? Do they contribute to further inequalities? What policies in health, education, welfare, housing, and income generation have been developed in specific countries with a focus on the adversely affected sectors and communities? What mechanisms exist in existing policies and programs that address social equity and social justice, issues pertaining to the affected segments of society? (2015:9)

Chen et al. (1999, cited by Chen and Berlinguer 2002), writing about the central question of the relation between globalization and health, posed the following additional questions: What is the relation between globalization and health? How can specific diseases be directly related to globalization? Why are some diseases included and not others? The response must necessarily link specific diseases to the core of globalization processes. In summary, the opportunities and threats posed by globalization and global economic policies demand strong and democratic states, such as policies, structures, and legislation that promote social justice, health equity, and well-being for citizens.

Because multidimensional factors are involved in the effective implementation of strategies aimed at reducing social and health inequities, it is important to reflect and act in accordance with this complexity. One question that demands is a response concerns the role of the health sector in the expected transformation processes. Again, at this point, the scope and operative meaning of the primary healthcare (PHC), HP, and health in all policies (HiAP) strategies in this construction should be questioned. The next section will address these issues.

Neoliberal Economic Policies: Impact on Health

The link between health and socioeconomic status has been documented; there is also evidence linking geographic areas, gender, and ethnic group to health conditions. Globalization is a widespread exchange of goods and services without physical boundaries, but only countries with adequate capacity have reaped benefits in terms of dealing with health-related challenges. These are the countries that have the resources and infrastructure needed to compete. Globalization strengthens policies that produce, maintain, and increase social and health inequities and leads to problematic situations in national health systems that should respond promptly and efficiently to emerging crises without the needed resources; therefore, globalization could reinforce and accentuate inequality.

The implementation of neoliberal reforms in Latin America brought with it the dismantling of the welfare state and its social benefits (Daulaire 2003). The putting into place neoliberal accumulation mode, according to Galafassi (2014:83), "produces a separation again, perhaps no longer between the worker and his original means of production, but between the worker and his improved living conditions thanks to the conquest of common social goods." The neoliberal structural adjustment model is one of the identified forms of capitalism, to remain, to reinvent itself, and to intensify its coercive actions, of containment and impoverishment of millions of people, over time. Busso (2010) analyzed poverty and social vulnerability in Argentina through a recount of the origin, permanence, and expansionist character of the capitalist system. In this sense, he found in Argentina a replicable model similar to that in most countries of the American continent:

> Two situations can be evidenced in the history of what Argentina and South America are today, which show evidence throughout half a millennium: the impressive social transformation in the countries of the region. On the one hand, the pre-Columbian communities possessed an economic, social, environmental, and demographic dynamic that was totally altered by the arrival of the Spaniards, carriers and enablers of the capitalist system in Latin America. On the other hand, and at the current point of arrival, at the end of the twentieth century the expansion of capitalist production relations to (almost) all territories and communities that conform it is complete.…Five moments or phases can be mentioned: the process of consolidation of the nation-state of a capitalist type (1810–1880), the agro-export model (1880–1930), the model of industrialization by import substitution (1930–1975), and the neoliberal model of external opening (1976–2009). (2010:10)

The hegemonic neoliberal political project discarded the possibilities of social transformation from politics through this type of action. In the developing economies of Latin America, the implementation of neoliberal policies resulted in the economic contraction of labor demand, which brought greater possibilities to women and adults, characterized by low wages. As a result, the employment of young people and young adults was reduced. The actions of neoliberal economic policy sharpened social inequality, characterized by impoverishment.

Latin America presents a singularity: its countries share common features and also have unique features, unlike Asia and Africa, for example. In the contemporary world, with regard to the world system, Latin America is in a peripheral situation, as a metropolis under center-periphery logic. De Sousa Santos (2010) has described the consequences of neoliberal policies (chaotic and agreed adjustments):

> After the crisis of the model of structural adjustment and neoliberal policies, political change is happening in many Latin American countries. A claim to the state arises in a regulatory role vis-à-vis transnational corporations and traditional material powers to recover old diminished social rights as well as new social and collective rights (water, food security, quality of life), including rights of nature, which reflect new conceptions of rights and aspirations for good living, from diverse cultural traditions. (2010:13)

Latin American countries have presented systematic fiscal deficits, which have been faced through the fiscal policy—as an appendix of the economic policy. In this way, the state budget, the public expenditures, and regulatory taxes have been subject to changes in order to preserve economic stability, but negatively influencing population well-being.

> Although the redistributive power of fiscal policy in Latin America is considerably greater when evaluating the effect of public social expenditure on education and health, compared to the effect of public cash transfers and direct taxes alone, the final impact of fiscal policy on reducing inequality is still limited in the region, especially when compared to that of the OECD (Organization for Economic Cooperation and Development) countries.…The results of this study suggest that one of the greatest challenges faced by the region is to improve the redistributive power of fiscal policy, both through taxes and expenditures, in order to promote greater equality in the distribution of available income and greater reduction of poverty levels. (ECLAC 2015:115)

The serious problem of Latin American countries lies in the difficulty of overcoming this situation. Thus, the countries must incur economic debts, which involve greater and prolonged external indebtedness, due to the corresponding increases in the interests. This policy requires a fiscal adjustment, which should encourage investments that sustain growth:

> Latin America's public debt has increased gradually and heterogeneously, going from 33.2% of GDP in 2014 to an average of 34.7% of GDP in 2015. Although this level remains low in many countries, the accumulation has been due to the financing needs in front of a deceleration scenario, at a relatively low cost. Today, the vulnerability of the region to external shocks is very different. In 1990, external public debt amounted to 90% of total debt, and by 2015 this ratio had fallen to 48%. Likewise, the expansion of public indebtedness has been greater than the growth rate in several Latin American countries, implying greater management challenges for the coming years. By subregions, the public debt has presented a dissimilar characteristic. In Central American countries, debt levels grew up to 2013 at a faster rate than in South America. The weight of public debt remains higher in the Central America subregion, where it reached an average increase of 8 percentage points of GDP between 2008 and 2015. In South American countries, this increase was of 4.4 percentage points of GDP. (ECLAC 2016:10–11)

The Fiscal Panorama of Latin America and the Caribbean (2015) document, published annually by ECLAC, compares the behavior of different regions of the world and observes that Latin American governments spend on health services, as a percentage of GDP, less than their peers in North America, Europe, Central Asia, or the Organization for Economic Cooperation and Development (OECD) countries, but more than in Africa, the Middle East, and South Asia.

> However, if per capita expenditure in health (both public and private) is assessed, the differences between regions are very large. On the one hand, the countries of North America, the OECD, and Europe and the Central Asia region spend per capita US $8,200, US$4,400, and US$2,300, respectively, in purchasing power parity. On the other hand, in sub-Saharan

> Africa and South Asia regions, the per capita expenditure barely reaches US$155 and US$124 (PPA), respectively. The countries of Latin America and the Caribbean are in an intermediate position, since they have average health expenditures (including public and private sectors) of around US$872 per capita (ECLAC 2015:84).

The disappointing current economic situation in Latin American countries, a widespread concern throughout the world, affects the performance of the development sectors, slows its progress as it reduces the scope for public investment in key areas such as health, education and housing:

> Governments of the region have been forced to make large, non-discretionary expenses on wages, salaries and interest payments on the debt, reducing the scope for public investment in key areas such as infrastructure, health and human capital improvement. In 2015, the index worsened by 1,9 percentage points, indicating a deterioration of flexibility, despite the improvement in fiscal balances (ECLAC 2016:32–33).

The 2016 Latin America and the Caribbean document ”Will the Current Cold Front Be Prolonged?” lists the factors that influence the current situation, the low potential growth, and the economic prospects of the South American countries. The previous document and the article “Latin America and the Caribbean: Managing Transitions” (2016) examine the current situation in several countries on this side of the world, where moderate economic growth is observed, some very slowly and others below their historical average, together with the fiscal policies and the capacity to adapt to the current transition situation:

> The current adjustment to persistently low commodity prices, despite its recent slow recovery, and idiosyncratic domestic developments continue to define growth performance and the economic perspective for South America. The economies of this region as a whole are expected to contract for the second consecutive year in 2016, before growth recovers to 1.1 per cent in 2017. However, policy perspective and priorities vary considerably within the region. (IMF 2016:13)
>
> To maintain economic development in the region, policies will be required to facilitate the transition to lower commodity prices, while reducing poverty and inequality and addressing the bottlenecks that have long held back investment and productivity in the region, without derailing the significant gains made in macroeconomic stability that have been so beneficial to the region (Werner 2016; IMF 2016).

In the projection for South America, a growth in real GDP in its percentage variation (0.8), after the contraction of 2016 (−2.0), is observed. The projection is positive in Latin American countries like Argentina, Colombia, Mexico, Peru, and Chile, versus negative projections in Venezuela and uncertain forecasts in Brazil.

The Concept

Various authors have provided definitions of *territory*. According to Rodríguez-Páez et al. (2012) territory is understood as

> Geographic space constitutive of the state, where natural and social subsystems coexist, where multiple social groups are organized with diverse cultures and habits that modify the physical and social environment, which participate in the construction of a cultural structure

> that varies according to the institutional participation and the degree of economic development. (2012:82)
>
> Geographic space socially organized, corresponding to a social space, real and objective, crossed by the cultural values and the meanings of the subjectivity. It has no definite limits, since it is characterized by its symbolic dimensions, and is not identified with administrative territorial criteria. (Santos 1988 in Junges 2003:4, cited by Fuenzalida Díaz et al. 2013:93)

A territory, understood as a unit of analysis and action, requires the construction of social networks characterized by cohesion, which can benefit the renewal of local responses. In that sense, the strengthening of the territory is the way to generate social cohesion. The territory can be understood in two ways: vertical and horizontal. The first refers to the ability to capture information, knowledge, and resources; the second refers to solidarity, recognition, and cooperation between the different actors. The interaction between these two forms is due to the possibility of redefining social problems and the responses to them through horizontal networks, which use vertical networks to capture resources that help strengthen responses. The interaction of these two forms promotes and benefits political and technical-political decision making, stimulating responsibility, identity, solidarity, and social integration. Territory's potential was recognized by the World Health Organization (WHO) (2016), which states that a healthy cities strategy engages local governments in health development through a process of political commitment, institutional change, capacity building, partnership-based planning, and innovative projects.

The Requirements

The close association between territory, population, and health requires the allocation of resources, initiatives, and a territorial approach to health actions. According to Fuenzalida Díaz et al. (2013:101), "The adoption of territory as a unit of analysis becomes essential to understand the behavior of any phenomenon related to inequity environments and their health outcomes." A systematic vision is necessary to establish the types of development related to health–disease processes to improve the capacity for intervention. The development of a territorial plan for action in health implies, from health authorities (there may be other actors wishing to achieve the same goal), the design of a prospective scenario within a given territory identifying the variables that influence or could influence the situation currently or in the future. Variables such as political, economic, social or cultural, technological, ecological, and demographic must be taken into consideration (Torres Andrade 2009).

Gradually, public health professionals and epidemiologists have begun to understand territory as a fundamental component of analysis that is not static, but dynamic, so its complexity is not strictly physical. The anticipatory capacity to visualize the intersectorality and the territorial dimension requires the planning of collective health in a territory. Systematically thinking about a problematic situation, defined by different actors (municipal authorities, community representatives, and civil society

organizations), demands the observation of the whole and of the parts and how they interact in a specific context, under what logic and influence, internal and external.

The foregoing definitions reflect an increasing interest in reinforcing the permanent work between sectors related to health and population welfare, within the framework of political and social processes. These political processes of change must be systematic, reflexive, anticipatory, and, to some extent, reactive owing to the emergence of contextual situations as well as factors that have an impact on a population's vulnerability. It is in the territory as a unit of analysis where the social determinants of health find their maximum expression.

It should be noted, for example, that researchers from several countries have reported that areas of residence are associated with health, beyond individual risk factors (Diez-Roux et al. 2000; Jones and Duncan 1995; Kaplan 1996; Kawachi and Berkman 2003; Macintyre et al. 1993; Pickett and Pearl 2001, cited in Bernard et al. 2007). This involves the idea of the influence that the social determinants of health have on the territorial context, where each individual's actions and collective actions have a direct or indirect impact on the health status of the population (Fuenzalida Díaz et al. 2013:93).

A territory requires development strategies for its advancement and competitiveness, within the framework of world capitalism:

> Territorial development is considered to retain the broadest meaning of development since it alludes to the natural territory, the equipped or "intervened" territory (which contains transport systems, equipment) and organized territory (characterized by activities of greater complexity, human settlement systems, transport networks, etc.). (Boisier 1999:8)

Sustainable territorial development emerged as a complementary concept or subconcept, after the emergence of the concept of sustainable development (in the mid-1980s), designed as an essential anchorage to a place or territory in which to govern it, with everything it needs. This concept is essentially associated with sustainable management implemented and developed by municipal administrations.

Rural territorial development has been defined by Schejtman and Berdegué (2003:13) as a process of productive and institutional transformation in a given rural area, whose aim is to reduce rural poverty.…Institutional development aims at stimulating and facilitating the interaction and coordination of local actors among themselves and between them and relevant external agents and increasing the opportunities for the poor to participate in the process and its benefits. It has the advantage of connecting issues of rural poverty with contemporary elements of public action, such as local economic development, levels of competitiveness, decentralization, and the environment.

According to Dallabrida (2008), the idea of human development is closely linked to the dynamics of territorial development:

> Referred to the set of actions related to the development process, carried out by actors, agents, organizations and institutions of a society historically and territorially identified. Its use supports the hypothesis that development has a direct relationship with the dynamics (social, economic, environmental, cultural and political) of the different territories. Depending on the type of action, passive or active territorial actors in the defense of their interests, before the process of globalization, territories assume development options that

promote or hinder, at different intensities, becoming submissive territories/losers or winners of an innovative type. This global-local dialectic process, reaction-action, whose intentions are designed by total size, but occurring in the territory, territorial inequalities or differentiations. (2008:6).

Sustainable development, according to Novo (2006), retains in its conception the following guidelines: a systematic approach, ecological viability, equity, global vision, endogeneity, and development processes. It may be added that the social and institutional viability (identification of strengths and opportunities) of a set of interrelated areas of development (scientific and technological, economic, capacities, political, societal, community, cultural, population, institutional, and human, among others) is inseparable from the notion of well-being. All of the aformentioned categories are structured on the basis of the purpose of integral development, which requires a systematic approach (relational, circular, procedural) by institutions, managers, and actors, who guide, mobilize, and act, according to the proposed social change actions, from the social capital built on the basis of past actions.

Educational institutions, workplaces, cities, and universities are sites serving as the main locus where actions in HP have taken place and where intersectoral action has begun. In line with this logic is the approach of Grueso-Hinestroza et al. (2013), who point out in their study on organizational health the actions required to generate the integral well-being of workers. The actions of organizational health refer to the set of activities that the organization can take, with a preventive approach, to generate greater well-being for its workers (Grueso-Hinestroza et al. 2013:67). Among the different definitions and recommendations set out in The Declaration of Alma Ata (1978), the need was pointed out—within the framework of HP—for greater development and growth of occupational health, for example. In the field of organizational health, promotion actions have a significant impact on cultural values and the adoption of organizational practices, as noted by Grueso-Hinestroza et al. (2013).

Some authors warn that the promotion of health in organizational environments is a challenge that must be faced since it is still adopted in a limited way in formal work environments with specific, sometimes fragmented, actions (Grueso-Hinestroza et al. 2013:65). The development of actions to promote health in organizational contexts is a hot topic, so it is necessary to carry out an investigation to identify the implications that this has in terms of the organization itself and in terms of the well-being of workers. Grueso-Hinestroza et al. (2013:65–66).

Authors from different locations and disciplines refer to intersectoral and transdisciplinary action in various studies and systematic reviews, where they reinforce the need for active actions to address social issues associated with the health conditions that various social groups experience in specific territories. Vargas Porras et al. (2010), Franco-Giraldo (2012), García Cachau et al. (2013), Duarte-Cuervo (2015), Díaz-Mosquera et al. (2015), and Santiago Declaration (2016) are among the researchers investigating this topic; however, this identification is insufficient (it is not enough to know what is necessary); it is also necessary to create conditions that facilitate the implementation of processes supported by political, legislative, technical, cultural, and regulatory changes aimed at ensuring the viability and sustainability of these interventions as well as generating concrete actions for structural transformation.

Intersectoral Management

The study "Inequity(ies) in health care in greater Buenos Aires. A view from local management" by Chiara et al. (2009) analyzed the processes of decentralization, relative autonomy, and relationships between subnational governments (provinces and municipalities), important governmental actors (characterized by unequal levels of power) versus the central government, and its supralocal authority (regional, national, and international). Of course, each municipality has defined its local socio-territorial configuration based on the characteristics of its population, its welfare levels, the availability of resources, and the local political fabric, among other factors (Chiara et al. 2009). This study reviews the different impacts, particularly those of political dynamics, on health care in the effective exercise of the right to health:

The development of the "relative autonomy" potential of the local level in the formulation of health policy has been informed by these historically shaped tensions and by the crises that marked the functioning of state institutions and structurally modified the conditions of reproduction of the life of the population in recent decades. (Chiara et al. 2009:107)

In Colombia, the 2012 "Plan Decenal de Salud Pública" document mentions the different interactions between actors and specific actions that each subnational government should lead, based on the purpose of reducing inequities in health, based on the social determinants of health:

> It brings together the actions that must lead the territory, appealing to the different sectors, institutions, and community, to develop them through projects aimed at the construction or generation of conditions, capacities, and means necessary for individuals, families, and society as a whole to intervene and modify the social determinants of health in that territory and, thus, the conditions conducive to quality of life, consolidating a healthy culture based on values, beliefs, attitudes, and relationships that allow individual and collective autonomy that enables identifying and making positive choices in health in all aspects of their lives, with respect to the cultural differences of our peoples. This line includes the following actions: formulation of public policies, social mobilization, generation of healthy environments, generation of social and individual capacities, citizen participation, and health education. (2012:41)

To address local problems, it is necessary that the different actors and sectors participate in the processes of diagnosis, programming, implementation, and evaluation of actions. Therefore, networking is a tool to solve community problems since it promotes participation and interdisciplinary and intersectoral articulation (Dabas et al. 2006, cited by; García Cachau et al. 2013:171).

The identification of common factors affecting each country and the type of work carried out up to now by and between the different sectors and actors involved serve as a basis for establishing comparisons between countries in order to analyze the procedures established by the experiences (successful or not) that through adaptations can be replicated in similar territories. The expected results correspond in many nations of the region to country goals with limited time horizons, which do not present the continuity or foresight needed to focus all the short-, medium-, and long-term efforts on progress from the gradual reduction toward the end of the problems of social inequity and health.

The solutions proposed are not structural and correspond to temporary actions. This challenge to address the reduction of health inequities requires the revision and incorporation of renewed governance ideas, new foresight capabilities, and exercises in planning systems that overcome short-term thinking and strengthen the construction and vision of the future in the medium and long terms.

A strategic plan for territorial development that is comprehensive and sustainable (municipal and regional) requires the ability to think strategically and involve different perspectives (spatial, territorial, regional, and local), as well as the development of a diagnosis, identification of vocations in the territory, strategic objectives, and a local development strategy, which must present a comprehensive vision that incorporates demographic central aspects related to the basic needs of the population (infrastructure and communications services, housing, health, education, and culture). This strategic plan requires citizen organizations involved in planning processes (local bodies, consensus building, participatory budgeting) to expand decision alternatives. At the municipal level, a strategic plan for territorial development requires the autonomy of local governments. Initiatives at the local level facilitate the active participation of the population in the planning of complementary community actions and in the development of programs and projects that affect the reduction of health inequities.

Governance and Balance of Power Relationships Among Key Actors

Globalization has different effects and scopes, which require the review of some forms or initiatives to overcome them. In this sense, Daulaire (2003) points to "a new era in international relations. While the world has outgrown traditional mechanisms for addressing global issues, it has not yet developed new forms of effective governance. This temporary void poses threats and enormous opportunities." Regarding the direct and indirect effects on human health, which involves some aspects of economic globalization, Kay and Williams (2009) point out the following:

> Works on global health governance regularly footnote the centrality of economic globalization, including how such factors as increased volumes of international trade, investment and finance are having direct and indirect effects on human health, not least in the more rapid transmission of infectious diseases resulting from trade flows and spatial compression. (2009)

Daulaire (2003) underlined the concern about the apparent lack of adequate governance in the context of globalization. This situation is giving rise to a series of threats to public health, especially in regions marked by economic instability:

> Some critics fear that globalization has shot beyond its traditional bounds and is now a runaway chain reaction that cannot be managed. Such concerns are fueled by the apparent lack of appropriate governance. Existing transnational governance structures were created when the world was dominated by the spirit of national sovereignty. (2003)

Buss (2014) referred to the results of a report on global governance for health prepared by *The Lancet*/Oslo University Commission, published by the English journal (Lancet 2014:683, cited by Buss 2014). This document lists the failed aspects of the

global governance system that affect the health protection of the poorest, most vulnerable, and most marginalized population. This report attributes to the five dysfunctions of the global governance system the adverse effects of global political determinants of health: (a) democratic deficit, (b) weak accountability mechanisms, (c) institutional immobility, (d) inadequate political space for health, and (e) nonexistent or even embryonic institutions. In this regard, the commission proposes three main initiatives:

> (1) Creation of a multistakeholder health governance platform—including global civil society, the UN, entrepreneurs, and NGOs—to function as a forum for policy discussion and agenda formulation and evaluation and its impact on health and equity in health, as well as proposing adequate solutions and overcoming barriers to its implementation; (2) creation of an independent scientific monitoring panel on the influence of global governance processes on health equity, through mandatory impact analysis on levels of health equity in international organizations; (3) use of human rights mechanisms for health, such as special inspectors, as well as stronger sanctions against a broad spectrum of violations committed by nonstate actors through the international legal system. (Buss 2014:683)

Different experiences have happened in Latin America regarding collaborative work between different actors and institutions, as well as efforts to include health issues in working agendas. In Brazil, according to Puerto (2009:78), "one of the social responses to social and environmental conflicts was the creation in 2001 of the Brazilian Network of Environmental Justice, which includes social movements, affected populations, environmentalists and academic groups."

> In Latin America, it was not until the 1990s that the relationship between the environment, health, human rights and justice became part of the political agenda of some countries with the adoption of the concept of environmental justice. Generally, in Latin America, situations of environmental injustice, in addition to other factors such as high social inequality and ethnic discrimination, emerge more intensely depending on their insertion in the international economy from the intensive and simultaneous exploitation of natural resources and hand of work, that is, for its role in the export of rural and mining products. (Puerto 2009:80).

Several authors have stated that this process of processes imposed a new developmental model that justified initiatives associated with the reduction of social inequities and health strategies. According to Feo Istúriz (2013:888), it "imposed a model of thinking" that is known as neoliberal and constitutes the economic paradigm of our time.…This model of development hinders the redistribution of wealth, concentrates capital, produces poverty and unemployment, and has a profound impact on life, the environment, and health." Many countries on several continents have suffered systematically from the precarious and unequal conditions (prior and new) imposed by globalization. Contributing to the perpetuation of the unfair accumulation of social inequalities and inequities and of health (challenge of the public health), as Cornia (2001) says,

> Globalization could impact inequalities through factors associated with economic growth and development, such as the loss of diverse natural habitats, the risk of pollution, and the vulnerability of single-crop economies to infestation or disease. Within many countries, including the UK, the USA, the Netherlands, and India, there is a wealth of evidence documenting the continued existence of health inequalities (Acheson 1998; DH 2005; Dorling 2006; Groffen et al. 2008; Lantz et al. 2001; ONS 2004; Subramanian et al. 2006 are cited of Naidoo and Wills 2010:83).

Over the last three decades, three health-related areas have attracted increasing interest: the social determinants of health, HiAP, and governance. Thus, the importance of the collective effort to integrate the social determinants of health and HiAP concepts has been gradually understood, which helps to explain the role of governance in health as a decision-making system based on the complex aspect of relations of power. Like many health concepts with multiple meanings, governance is an evolving practice. For McQueen et al. (2012), governance, with respect to SDH and HiAP, constitutes

> the most relevant concept of the three, which is imposed on the other two. However, many of the published explanations of the concept of governance were passive or structural rather than active, that is, they generally described which government agencies or bodies were making governance decisions, rather than explaining how agencies were making those decisions. (2012:4)

The foregoing statement, underlined by McQueen et al. (2012), is critical because of the guidance it offers regarding the nature of the contents of the available documents on the actions taken with respect to governance. The contents of the reports differ in their intentionality; most describe the agents and institutions responsible for the different decisions, while few analyze the internal processes that guided decision making. According to McQueen (2012), governance is the main element acting on social elements, and the achievement of HiAP is essentially based on two dimensions:

> (1) the structures that unite the actors and (2) the actions that emerge from their commitment and their mutual deliberations (e.g., the agreement by which policies are articulated in a concrete way, the decision to adopt some policies, the use of concrete policy instruments to implement their implementation). (2012:12)

Government agencies, through their governance, are responsible for managing tools such as regulation, law, and legislation. These instances must act in a process of permanent interaction between participants that are inside and outside the formal structures of government. McQueen (2012:14) points out that cross-sector governance structures (intersectoral relations, joint budgeting, and citizen participation, among others), understood as an analytical category, facilitate collaboration among different ministries, departments, and sectors. These structures facilitate actions that aim to align other governance policies with health objectives through evidentiary support, goal setting, coordination, advocacy, monitoring and evaluation, policy guidance, financial support provisions, legal mandate, implementation, management, and intersectoral governance structures. According to McQueen (2012:14): "An intersectoral governance structure is effective to the extent that it contributes to the integration of health into other policies." This is linked to the purpose of the final outcome of intersectoral actions: changes in other policies (structural issues) that make it impossible to achieve better results.

Governance is the system of decision making in which the guidelines are marked, legislative authority is exercised, and events are controlled and managed. Governments that recognize the complexity of social and economic factors will govern through collaboration with the market and civil society actors for the implementation and development of policies. Governance can include action that goes far beyond government, through the delegation of policy formulation and implementation

of policies or parts of them to interested parties or organizations. In essence, governance is based on power relations. (2012:14)

McQueen (2012:6) states that "In more advanced economies, governance by definition has an important role in all sectors of society. The government, whether central, regional, or local, takes responsibility for various aspects of society, from the mundane (sewerage, transportation, housing, energy, commerce) to the human (education, art, sports). The question is whether LMICs are aware of the policies, plans, structures, funding, and mandates that are necessary for a successful implementation of the strategies to which they have committed themselves. What is required to increase territorial governance?"

Social Structures and Health Systems

The strategies outlined earlier (PHC, HP, and HiAP) have evolved according to new conceptions of health and ways of creating and maintaining it; however, this development has not taken into account the constraints on LMICs' ability to implement them. On the contrary, what has been done is to add new responsibilities and complexity, which, although necessary, demand changes in the political and social systems, policies, and regulatory frameworks that support them. This statement is not new, and the WHO referred to HP as a philosophy that conceives of health as a human right, which responds to political and social determinants to obtain improvements in health equity for which it must develop "inclusive policies that are dynamic, transparent, and supported by legislative and financial commitments."

Health promotion practice responds to diverse complexities, structures, and scenarios, as well as to specific problems and priorities, so the emphasis of its practice reflects the intention to solve a specific problem. Understood in this way, the problems could be utilized as entry points or conjunctures conducive to scaling up and widening the scope of interventions addressing not only a specific problem but also more structural actions aimed at reducing social and health inequities. In this way, HP could also act as a mediator and materializer of intersectoral action, framed in social and political processes. Unfortunately, this role is not reflected in the reports; on the contrary, it has been pointed out that those aspects that transcend the provision of health services, under the radar of the health sector, are not reported in most cases, according to studies carried out by De Salazar (2012) and Díaz Mosquera et al. (2015). The reasons for this situation are considered central in this publication, so the exploration and understanding of the challenges, potentialities, and limitations will be the object of investigation in the following sections.

> It is clear that the imbalances generated by the globalization process and increased health risks exceed by far the established capacities of various national health systems, even though many of them have undertaken substantial reforms in recent years. It is this limitation that makes it urgent to build a new international institutionality that succeeds in successfully confronting the risk aspects of globalization in health matters. It is clear that the

> paradigms that guided the isolated action of national health systems are rapidly being overcome, as is the case with traditional approaches to safety, which tended to reduce it to dimension. (León 2006:152)

Previous decisions are not the initiative of an actor or sector but rather the result of political agreements rooted in models of development and social management. This is why there has not been substantial progress in the transition from instrumental to structural actions. The question that arises is whether the health sector can be the standard bearer to take this step. Experience has shown us that it is very unlikely. Does the scope of actions to address the determinants of social and health inequities need to be rethought in the light of what the sector is able to do? Or should the health sector necessarily act within the political and strategic framework of territorial development plans?

> Essentially what the critics are arguing is that health promotion programmes and interventions need to be assessed in relation to the social and structural influences that determine health. They therefore need to adopt an approach to evaluation that implicitly acknowledges the need for outcome data but explicitly concentrates on process or illuminative data that helps us understand the nature of that relationship. This approach to evaluative research that recognises 'people variables' and natural settings within the community has been applied to some interesting and testing case studies (Allison and Rootman 1996; Costongs and Springett 1997 are cited of Macdonald and Davies 1998:9)

These types of questions must be solved in the light of our reality, linking endogenous actions of the health sector with exogenous actions, in order to avoid tensions that arise when there are no complementarity and integration, frustrations and contradictions; on the contrary:

> An interesting example was the "Rescue" or "Health Systems Development in Central America, with an Emphasis on Efforts Developed by Civil Society" (2001)—developed after the signing of the peace agreements in Guatemala, a little against the course of the health sector reform at the time. The objective was to study the development of health systems from the perspective of civil society, based on the principles of primary health care (PHC), Health for All. Research with universities in Nicaragua and El Salvador, involving civil society organizations and decision makers in these countries and Guatemala, immediately after the armed conflict, became an important collective learning process. (Barten 2012:348)

Barten (2012) points out the close relationship between health systems and health inequities and in turn identifies the need to reorient and strengthen the formative foundations of health professionals in the face of the complexity of social determinants of health:

> Health systems deepen inequities, and therefore vertical coordination or intrasectorality demands the same attention as horizontal coordination or intersectorality. I agree with

> Mario Rovere that the current situation calls for a deep reorientation in the education of health professionals, in addressing social determinants, the social determination of health inequity. (2012:349–350)

Health systems have multiple objectives, including to improve health and exercise by the most efficient use of available resources. Barten (2012) underlines the difficulty of research in health systems in Central America, which provides multiple lessons in integrating different actors.

Two cases are reported in South America, one is the Colombian case. Rodríguez Villamil et al. (2013:36) point out the existence of several studies that confirm the unfavorable state of the Colombian health system, which makes difficult the implementation of the HP strategy:

> The current Colombian health system, as evidenced by various studies and especially the daily experience of citizens, is an adverse context for the development and practice of HP and for the guarantee of the right to health. (2013:36)

The second case took place in Chile. the Universal Access Plan with Explicit Guarantees (AUGE) was implemented in 2005 as a new reform of the Chilean health system, motivated by the need to "address social inequities in access and use of the Chilean health system to respond to the epidemiological changes that have occurred in recent years, which are among the first in Latin America…." (Espinoza and Cabieses 2014:46). The objective of this plan lies in "…ensuring equity in the population's access to health, regardless of people's ability to pay…" (Biblioteca Nacional de Chile 2002, in Espinoza and Cabieses 2014).

In general, it is necessary to reflect on the feasibility of a country or system to apply principles that allow for the application of the previously mentioned strategies in the face of sociopolitical changes and new health demands, as a result of the epidemiological transition and phenomena such as globalization, industrialization, and urbanization and their effects on health and equity. According to López Pardo (2007:2), equity principles should be applied at two levels: in the decision-making process and in the evaluation of outcomes as a result of the decisions taken. The author recommended undertaking a comprehensive analysis of both levels, given that equitable procedures do not necessarily guarantee equitable outcomes and vice versa López Pardo (2007:2). Therefore, continual reflection on the dynamic changes to operational definitions of these strategies is required, and national and international meetings promoted by countries and cooperation agencies represent an excellent opportunity for this. To engage in such reflections, these meetings should encourage the effective participation of all countries, not only those able to finance their participation but those facing complex challenges. It is necessary to expand the scope of these knowledge exchange scenarios from being merely informative to being prepositional and political scenarios in response to old and new challenges, according to differences between countries and regions. Hence, these meetings should transcend the moment of the conference to enter into politics and develop strategic plans that constitute work agendas financed by the countries and supported by the regional financing and cooperation agencies.

Key Issues of Practice and Questions to Consider

1. Research, monitoring and evaluation (M&E), knowledge sharing, and permanent advocacy are necessary to understand, interpret, and transform complex realities imposed by the multidimensional nature of strategies and a poor capacity to intervene. Often the definitions of terms such as *participation*, *empowerment*, and *capacity building* are applied loosely, so the requirements and resources to implement, evaluate, and appraise their success or failure are not clearly defined.
2. Strengthening of social and community participation in the process of formulating public health policies (OPS 2016:4). The question that arises here is the type and scope of participation, conditions under which participation takes place, and for what?
3. Imbalance between theory and practice: theoretical developments are not compatible with implementation achievements and expected results.
4. The relevance, feasibility, sustainability, and adequacy of structures for the appropriate implementation of strategies are not fully analyzed.
5. The political will to modify structures of power (institutions, groups, and social organizations, among others) is very limited. How can they be strengthened?
6. New strategies could serve as an entry point to strengthen previous ones; moreover, new strategies represent a valuable opportunity to integrate all strategies as well as to make more efficient use of available resources and scale up.
7. Knowledge development should be treated as a process, which is produced not only from the sciences but the permanent observation of the studied realities.
8. The responses to the following questions would help in the analysis of strategies to reduce health inequities and improve population health conditions.
9. Are unsatisfactory results mostly due to a lack of knowledge, capacity to produce the expected changes, to a lack of political will, or all of the above? What are the priorities?
10. Do the international and domestic agendas include actions to overcome previous challenges?
11. The means to improve people's health and exercise greater control over it: Several questions arise from this intentionality: Who is responsible for providing these means in a sustainable manner and without expiration effects? What kinds of state policies guarantee the adequacy, timeliness, and quality of the means to exercise control over health? Have the results of alliances between countries and cooperation agencies influenced regional and global policies and agendas? Do political wills generate social and economic conditions to balance power relationships between territorial actors? Could HiAP be an entry point to respond to previous gaps? How? Could it allow for the integration of PHC and HP strategies, addressing political and social dimensions neglected in the past? Do actors in the territory use a crosscutting approach to the formulation and analysis of health policies?

Thus, the agendas of the cooperation agencies could be informed by such considerations [or issues], reflecting not only their interests, but also those of the countries. This would place the countries in a position to negotiate the nature and scope of cooperation. It is also necessary to have forums for informing, reflecting, and proposing regional agendas whose interpretation and actions respond to the complex social, geographical, and political realities of the regions/countries. This requires the permanent and participative construction of mechanisms for critical thinking—to raise awareness about the complexity of the determinants of health inequities—as social facts, external to individuals, which correspond to complex long-term structural processes. In summary, it is imperative to rethink whether the strategies being implemented to reduce health inequities are in fact the ones those we are carrying out, considering our political systems, as well as the scope of our practice and institutional capacity to generate expected changes.

Do the current strategies aimed at reducing health inequities include actions to intervene in the direct or indirect social determinants of health, which are responsible for health inequities?

Do the intersectoral actions start by recognizing the links and interactions between economic, educational, employment, opportunities, and health, or are they based on circumstantial encounters between sectors?

Appendix

Tables 3.1, 3.2 and 3.3

Table 3.1 Main globalized processes and strategies

Dimension	Processes and strategies
Economic	Origin of large economic and political blocs in the world
	Privatization of economy and minimization of the role of governments and nation-states
	Deregulation and expansion of transnational market economy
	Free movement of capital
	Fall of protectionist trade barriers
	Foreign investment conditioned by low potential of national industrial development
	Transnationalization of mega companies (transnational corporations)
	Labor flexibility

(continued)

Table 3.1 (continued)

Dimension	Processes and strategies
Polític	Origin of large economic and political blocs around the world
	Loss of state sovereignty
	Pauperization and marginalization of states
Social	Dismantling and crisis of welfare state
	Privatization of public services
	Globalization of positive and democratic localisms, rights, freedoms, and solidarity
	Weakening of trade unionism

Table 3.2 Effects of globalization on health in Latin America

Description	Source
With globalization, transnational activities involving actors with different interests and degrees of power, such as states, transnational corporations, and civil society, have increased. When there are conflicts of interest or major inequities in power, these transnational activities can be inequitable and have negative health effects, whether intentionally or unintentionally. In these cases, the fight against inequity in health is both a global and a political challenge. Fulfilling this challenge requires actions that go beyond the health sector or the nation-state and require an improvement of global governance in all sectors	Ottersen et al. (2014:5–6)
New health threats emerge that overlap with traditional diseases, driven, at least in part, by the forces of globalization, which are generating epidemiological diversity and complexity. Three examples, discussed in what follows, are emerging: infectious diseases, environmental hazards, and social and behavioral disorders	Chen and Berlinguer (2002)
The impact of globalization on health and safety at work in Latin American countries shows many critical elements	Luna (2009)
Similar studies:	
Hiba (1999) *Impacto de la globalización en la salud de los trabajadores*	
Betancourt (2003) *Globalización y salud de los trabajadores*	
Feo (2003) *Reflexiones sobre la globalización y su impacto sobre la salud de los trabajadores y el ambiente*	
Rodríguez (2003) *Desigualdades en salud y seguridad en el trabajo que son inequidades: causas y consecuencias*	
Neffa (2004) *El impacto de la desocupación y la precarización del empleo sobre las condiciones y medio ambiente de trabajo (CYMAT)*	
Smoking and obesity are the best examples of emerging risks linked to globalization, which is imposing a double burden on health systems around the world, further complicating health inequities	Frenk y Gómez-Dantés (2007:158)
Globalization has not reduced poverty; on the contrary, the gaps between rich and poor have widened. One-fifth of the world's population lives on less than a dollar a day, a situation that threatens the achievement of the millennium development goals (MDGs) to eradicate extreme poverty and hunger by 2015	

(continued)

Table 3.2 (continued)

Description	Source
Globalization, from an economic point of view, resulted in the consolidation of supranational institutions that imposed as a consequence a restriction of power in the states since these surpassed the national authority to make decisions that affect the citizenship of each country. But even though there is a restriction on the economic and political maneuverability of national entities, it should be noted that the very strength of the state since the end of World War II has allowed globalization to strengthen	
Neoliberal globalization and the geostrategic recomposition of the world impose a predatory and harmful order on the life and health of peoples and drives processes that put at risk the viability of the planet (global climate change, wars for renewable and nonrenewable resources). Crises related to renewable energy and, more recently, food supply and the global financial system have emerged	López Arellano et al. (2008:327–28)
The effects of trade liberalization are manifested in economic inequality and insecurity, the conditionalities of international financial institutions and privatization policies on access to social services, deregulation in occupational health and the environment (15, 18), and the massive financial fraud committed against the lives of billions of people (31)	
In the area of health, the budget allocated to this area has suffered major cuts in developing countries, leading to the reemergence or permanence of diseases of poverty, such as certain infectious diseases like tuberculosis, malaria, and AIDS, as well as others like malnutrition	Villa-Caballero (2004:104)
If left unattended, the forces of globalization could significantly aggravate health inequities....It is unlikely that liberalized or poorly regulated private markets, which only obey commercial interests, will favor equity. Because only small groups have access to the benefits of globalization, many could be left behind, which will increase health inequities. Some trends in the 1990s underline these concerns about equity in health: the world's worst health indicators are those of countries plagued by conflict; the decline in mortality has been reversed in regions affected by the AIDS pandemic, especially in sub-Saharan Africa, and life expectancy has declined sharply in Russia during its political and economic transition	Chen and Berlinguer (2002)
States have less power and lose the ability to guarantee social rights, including the right to health. However, they must guarantee rights to health services and do their utmost for disease prevention and HP (conception of common goods)	Franco-Giraldo (2006: 11)
Countries that are not prepared to compete in trade and technology have lagged behind in multilateral treaties and have suffered the consequences, thereby widening the gap between North and South, that is, the gap between rich and poor countries. This is why the process of globalization has been characterized as a means to overwhelm or overpower and as a sign of economic neo-Darwinism	Villa-Caballero (2004:103–4)

(continued)

Table 3.2 (continued)

Description	Source
Globalization generates poverty, exclusion, and poor health conditions. The poor are also living in worse environmental, social, and health conditions and have the worst access to public policies of any order. Health is a condition and, at the same time, a result of these political processes: health as law and health as a situation. In both cases, we turn to the political determinants of health	Franco-Giraldo (2006:14)
Globalization has emerged as an aggravating or detonating factor of a governance crisis. In general, it is limited by the fragility of institutions, the consequence of an exclusive economic model such as that of Latin America, where inequality and social marginalization are at the forefront of social and cultural trends. There is no doubt about the need to seek alternatives that favor social inclusion and the reduction of inequalities, in a world under the sway of economic globalism and its wake of inequities	Franco-Giraldo (2006:6)
The massive globalization of capital and its ferocious impact on workers' strikes, the progressive weakening of states, and the general relation of labor value are gradually hampering social cohesion at all latitudes. Even in the United States obvious signs of these realities are emerging, including their impact on the salaries of workers, as reported by Lester Thurow, director of the Sloan School of Business Management at the Massachusetts Institute of Technology, who claimed that 80% of the labor force in that country saw its wages decline in the 1990s while GDP has risen by a third. Thurow comments: "Probably no country has ever had such large movements in the distribution of wages without having gone through a revolution or without having lost a war...."	Pazos Beceiro (2002:28)
The main strategies of globalization—indiscriminate privatization, exportable agriculture, rapid economic growth, deregulation, and the gradual diminution of state power in the economic affairs of nations—have had a negative impact on all the determinants of health conditions: budgets, development programs, nutrition, health status, and many others. These effects are reflected in the most important health indicators, in addition to the anguished general situation of poverty in which those are framed. Some pain was undoubtedly necessary, but in my view, the development suffered by developing countries in the process of globalization and development guided by the IMF and international economic organizations was far greater than necessary. The reaction against globalization derives its strength not only from the damages caused to developing countries by policies guided by ideology but also from the inequalities of the global trading system	Pazos Beceiro (2002:33) Stiglitz (2002:17)

(continued)

Table 3.2 (continued)

Description	Source
Critics of globalization accuse Western countries of hypocrisy, who force the poor to eliminate trade barriers but retain their own, preventing underdeveloped countries from exporting agricultural products and depriving them of desperately needed income via exports....Even when the West was not being hypocritical, it set the globalization agenda and made sure to monopolize a disproportionate share of profits at the expense of the underdeveloped world. It was not only that the industrialized countries refused to open their markets to the goods of developing countries—for example, they maintained their quotas against a multitude of goods, from textiles to sugar—although they insisted that they open their own to the goods of affluent nations; it was not only that the industrialized countries continued to subsidize agriculture and hinder the competition of poor countries, insisting that they suppress the subsidies for their industrial goods. Globalization had negative effects not only on trade liberalization but on all its aspects, even despite apparently good intentions. When Western-recommended agricultural or infrastructure projects, designed with advice from Western advisers and funded by the World Bank, fail, poor people in the underdeveloped world must repay loans equally, unless some form of debt forgiveness is applied. If the benefits of globalization have too often turned out to fall short of what their defenders promised, the price paid has been higher because the environment was destroyed, corrupt political processes were allowed to become entrenched, and the rapid pace of change left countries insufficient time for cultural adaptation	Stiglitz (2002:31–33)
The consequences for the health policies of economic globalization affected the following thematic areas. (1) Globalization under current conditions favors policies of pharmaceutical multinationals (the top ten companies control 35% of the world market). These companies restrict, guide, and regulate the market according to demand, not the needs of the social majorities. They guide research from unique economic profitability criteria and, through patents, control the production of raw materials and their use in the production of generic drugs. (2) Globalization, through the application of adjustment policies, decapitalizes government social programs, favoring insufficient resource use of all kinds in healthcare networks of character and public ownership. Therefore, they abound in the prestige and inability to solve health problems of the same, in addition. Do it in their own professional dissatisfaction and lack of motivation. (3) The application of neoliberal macroeconomic policies leads to social marginalization and an increase in poverty among already impoverished sectors of the population. This is the main risk factor for human health. (4) Advances in diagnostic and treatment technologies can be observed around the world. However, such advances are cost-prohibitive for the poor, increasing the lack of equity in universal access to health benefits	

Some studies identified regarding their direct and indirect health effects in the short, medium, and long terms

Table 3.3 Opportunities for health improvements in globalization

Description	Source
In a positive light, globalization can be seen as an extraordinary opportunity to reduce inequalities and inequities between and within countries, so that among human populations around the world, the exercising of human rights, solidarity, equality of opportunity, and protection of our planet allow for an alternative perspective from which to view globalization as a movement that seeks global social justice	
Not only was health introduced as a citizen's right and state obligation in Brazil's 1988 national constitution, which marked the end of the military regime in the country, but also the effective organization of a national and public health system was guaranteed. This system was launched in the early 1990s	Elías et al. (2006:148)
Information technology, one of the driving forces behind globalization, has enabled the acceleration of the "transmission of knowledge" in real time. Thus, now, through the Internet, we have immediate access to new technology in health and therapies to combat diseases that afflict humanity	
For globalization to have a positive impact on health, it is necessary to radically change the current approach to economic issues, both nationally and internationally. At the national level, policies must be designed with the explicit aim of increasing the population's well-being, rather than assuming that it will be achieved automatically through policies geared to economic growth, complemented by other elements such as safety nets and safeguarding health and education expenditures	Woodward et al. (2002:37)
Foreign aid, another aspect of the globalized world, despite its many drawbacks, has nevertheless benefited millions of people, often in ways that have not been reported: when the guerrillas in the Philippines turned in their guns, they were given jobs thanks to projects financed by the World Bank; irrigation projects more than doubled the incomes of farmers who thereby gained access to water; educational projects expanded literacy to rural areas; in a handful of countries, AIDS projects have contained the spread of this lethal disease. Those who vilify globalization often forget its advantages, but its supporters have been even more biased; for them globalization (when it is typically associated with the acceptance of triumphant American-style capitalism) represents "progress." Developing countries must accept it if they want to grow and fight poverty effectively. However, for many people in the underdeveloped world, globalization has not delivered on its promises of economic benefits	Stiglitz (2002:29)
A successful example of well-exploited globalization opportunities is the effort to immunize children in the world's poorest countries. This efforts has been funded by the Global Alliance for Vaccines and Immunization (GAVI), an alliance established between the World Bank, WHO, the United Nations Children's Fund, developed donor countries, private foundations (such as the Bill and Melinda Gates Foundation), and other partners. GAVI established a vaccine fund that supports basic immunization (DTP + polio) as well as for hepatitis B and HiB in 70 countries with GDP per capita below US$1000. More than six million children have been immunized with basic vaccinations	
There is no single recipe for transforming the equation of globalization/poverty and exclusion/worsening of health conditions into an equation of globalization/equity and inclusion/health. Certainly, global solutions must be formulated under the aegis of specific national and local initiatives to effect the concrete expression of globalization, poverty, and the health–disease situation at these levels	

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Part II
Latin American Experiences

Chapter 4
REDLACPROMSA: Latin American and Caribbean Network of Health Promotion Managers

Rita M. Ferrelli

Background and Justification

Health is widely recognized as a human right, a public good, and a social justice issue. The health status of a population is determined mainly by political systems, economic, environmental, and social policies that extend beyond the direct influence of the health sector and shape the conditions of daily life, from birth to growth, work, and aging (Whitehead 1990; Organización Mundial de la Salud 2011; The Lancet–University of Oslo Commission on Global Governance for Health 2014). Thus, public policies and decisions made in all sectors and at different levels of government have a significant impact not only on population health but also on health equity (Solar et Irwin 2010). Health in All Policies (HiAP) is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity (WHO 2013).

In recent decades, Latin American countries have responded to the social and health protection needs of their populations and made sustained progress in addressing the determinants of health and improving the health of its population. However, health inequities persist along a social gradient and a worse health status for people in a lower socioeconomic position (PAHO 2012). Latin American countries have committed themselves to fighting health inequities and to strengthening intersectoral coordination to address socio-environmental determinants of health, as stated in the Pan American Health Organization (PAHO) Strategic Plan 2014–2019, “Championing Health: Sustainable Development and Equity” (PAHO 2014). The first of the nine impact goals set by the plan outlines health and well-being improvements that occur with equity. However, additional efforts are needed to strengthen

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L. Malagón de Salazar, R.C. Luján Villar (eds.), *Globalization and Health Inequities in Latin America*, https://doi.org/10.1007/978-3-319-67292-2_4

and develop national policies, plans, and strategies that will allow progress toward health equity. Moreover, health and social protection programs in Latin America are mainly focused on an individual risk behavior approach that does not take appropriate account of the role of structural determinants of health or intersectoral action.

In light of the preceding discussion, there is an urgent need for countries to strengthen their health systems from the perspective of health promotion and action on the socio-environmental determinants of health. On December 5, 2015, in Lima, Peru, the Latin American Network of Latin American and Caribbean health Promotion Managers (*Red Latinoamericana y del Caribe de Gestores de Promoción de la Salud*—REDLACPROMSA) was established as an instance of cooperation, exchange, advocacy, and mutual support among health managers of ministries or departments of health promotion (REDLACPROMSA 2015; REDLACPROMSA 2016). The REDLACPROMSA is open to all ministries and public institutions involved in health promotion at all levels of government: national, regional, and local. It is currently composed of eight ministries of health (Chile, Cuba, Peru, Ecuador, Colombia, Mexico, Venezuela, and Paraguay), one ministry of social development (Chile), and five institutions related to health promotion in Latin America and the Caribbean (Facultad Latinoamericana de Ciencias Sociales—FLACSO, Argentina; Centro para el Desarrollo y Evaluación de Políticas y Tecnologías en Salud Pública, CEDETES, Universidad Del Valle, Colombia; Fundación para el Desarrollo de la Salud Pública, FUNDESALUD, Colombia; Escuela Nacional de Salud Pública, Cuba; Consejo de Ministros de Salud de Centroamérica y República Dominicana, COMISCA; Centro de Educación Ambiental de Guarulhos—CEAG, Brazil; Red de Municipios y Comunidades Saludables de Lima Metropolitana, Perú). Moreover, REDLACPROMSA relies on the technical and financial support of the Pan American Health Organization (PAHO).

Network Aims and Objectives

REDLACPROMSA aims to make health promotion a key element of public policies by means of technical and political cooperation among Latin American and Caribbean countries in order to achieve equity, welfare, and social development.

Moreover, it aims to strengthen the stewardship function of ministries of health to act intra- and intersectorally and to make health promotion a core issue on the agendas of policymakers.

The general objective of REDLACPROMSA is to strengthen cooperation among ministries of health at all levels of government (national, regional, and local) with a view to political incidence (by meaning for "incidence" the action oriented at changing the legislative, fiscal, physical and social environments that affect peoples' health and equity), and to the management of health promotion policies that uphold the right to health.

Specific objectives include:

1. Strengthen capabilities and institutional skills of advocacy to act intra- and intersectorally in the management of public policies for health promotion at national and international levels.
2. Produce, share, and diffuse knowledge, experiences, achievements, and research results about public policies and health promotion.
3. Establish monitoring and evaluation mechanisms of health promotion policies and their impact on welfare and health equity.
4. Promote strategies, methodologies, and tools for implementing health promotion at the local level.
5. Exchange and boost mechanisms of participation, surveillance, and social control on public policy management.
6. Strengthen joint mechanisms that make it possible to approach socio-environmental determinants of health at the different levels of government in each country.

Method of Work

The achievement of these objectives requires a commitment to implementing the WHO strategy "Health in All Policies" as well as the strategic line 4 ("Strengthening Intersectoral Coordination to Address Social Determinants Of health") of PAHO Resolution 53/5, "Strategy for Universal Health Access and Coverage," of September 2014.

The methodological principles informing REDLACPROMSA recognize the value of local experiences and social participation as a basis to achieve sustainable regional development, acknowledge the need to advance regional strategies of political incidence in order to put on government agendas a public policy approach based on equity and socio-environmental determinants of health, retain horizontal cooperation as a new collaboration learning model, and use participatory methods and action–reflection processes to plan, implement, and evaluate public policies aimed at reducing health inequities.

REDLACPROMSA's strategy is structured around the following objectives:

1. Establish a theoretical, methodological, and practical framework for health promotion that can facilitate the definition of intra- and intersectoral management patterns for the design, implementation, and evaluation of public policies with a focus on socio-environmental determinants, according to the context of Latin America and the Caribbean.
2. Set up mechanisms for transferring technologies, experiences, and sectoral and intersectoral strategies of health promotion, facilitating the achievement of health equity and health in all policies in the Latin American context.
3. Strengthen institutional competence in the knowledge of social health determinants and in the advocacy of local management for health equity.
4. Facilitate public participatory management, surveillance, and social control.
5. Support the monitoring, evaluation, and regulation of public policies at different levels of government.

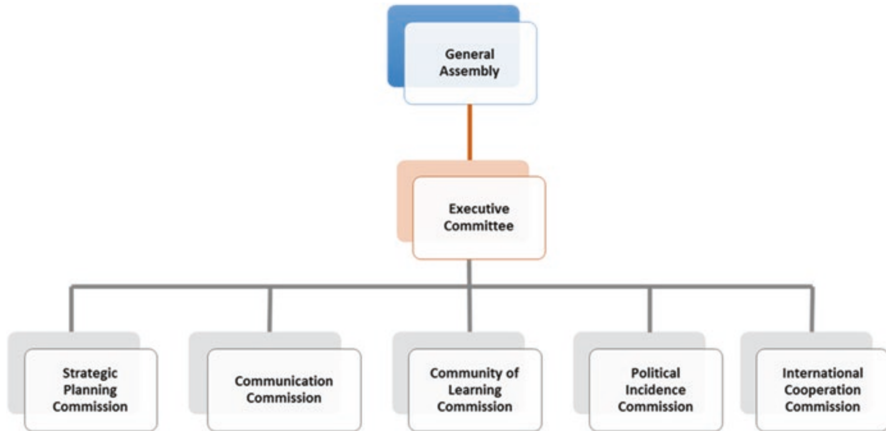

Fig. 4.1 REDLACPROMSA organizational chart (2016)

Organization of the Network

REDLACPROMSA bodies are represented by the general assembly, the executive committee, and five working commissions: strategic planning, community of learning, political incidence, communication, and international cooperation (Fig. 4.1).

The general assembly is composed of all network members and meets twice yearly.

The executive committee is composed of the president, vice-president, and secretary. In November 2016, the Department of Health Promotion and Citizen Participation of the Ministry of Health of Chile took over the presidency of REDLACPROMSA, the General Direction of Health Promotion of the Ministry of Health of Cuba took over the vice-presidency, and the General Direction of Health Promotion of the Ministry of Health of Peru took over the secretariat functions in the person of the respective general directors. The committee is in charge of executing the decisions taken by the general assembly.

The five working commissions are in charge of developing knowledge and ensuring the interchange of knowledge and practices among the member states in relation to public policies, determinants of health, and health promotion in the Latin American context. Each working commission is coordinated by a director of the health promotion unit of the ministries of health (or health secretariats) of the member states. Also, a cooperation entity that participated in the constitution of the network is allowed to coordinate a commission. Each commission is supposed to present a 12-month plan of action that must be approved by the executive committee for its implementation.

REDLACPROMSA counts with a dedicated space for virtual meetings that are hosted by PAHO by means of a WebEx platform. Moreover, it is present in social networks, with Facebook and Twitter accounts, while a WhatsApp group has been formed to ensure quick communication among members of the network.

Activities Carried Out

During its first year of life, REDLACPROMSA met twice, and each working commission produced a strategic and operational plan.

REDLACPROMSA was present at the 22nd IUHPE World Conference on Health Promotion of the International Union for Health Promotion and Education (IUHPE) and signed the Curitiba Statement for Health Promotion and Equity (Appendix A).

The REDLACPROMSA "Working Commission of Community of Learning" is collaborating with PAHO in identifying "Successful Practices in Health Promotion in Latin America" in relation to schools and municipal contexts.

The REDLACPROMSA "Working Commission of Political Incidence" is carrying out a survey about advances in terms of intersectorality and the implementation of the PAHO/WHO strategy "Health in All Policies."

REDLACPROMSA was present with a dedicated space at the 9th Global Conference on Health Promotion: "Health Promotion in the Sustainable Development Goals," Shanghai, China, November 21–24, 2016.

In preparation for this event, REDLACPROMSA and PAHO organized a preforum for mayors in Santiago de Chile in July 2016, for the purpose of strengthening the PAHO/WHO strategy of Healthy Cities, Municipalities, and Communities. The preforum saw the signing of the Santiago declaration (Appendix B). Also, on October 20, the president of REDLACPROMSA participated in a side event of the HABITAT III Conference, in Quito, Ecuador, for the purpose of consolidating the strategy of Health Cities. The ministry of public health of Ecuador organized the event, which saw the participation of mayors, local authorities and health promoters, representatives of other sectors, and citizens.

Strengths and Weaknesses

The knowledge of people's relationships and the analysis of social networks in the field of public health are becoming increasingly important. Varieties of network include professional ("expertise") networks, project networks, policy networks (including policy "communities"), learning networks, and interest networks, which promote particular policy or interest groups. Many health systems now use networks as governance structures. Networks are believed to generate a "macroculture" that in turn generates practices and activities that can affect the community. A network's macroculture is the complex of values and assumptions through which network members coordinate network activities. Knowledge of how network macroculture develops is therefore of value for understanding how health networks operate, how health system reforms affect them, and how networks can be used as governance structures[11]. The strength of REDLACPROMSA, as a network, resides in the strong willingness of its members to foster health promotion and action on socio-environmental determinants of health to reduce health inequities. By being

embedded in the health promotion units of the ministries of health (or health secretariats) of the Latin America member states, REDLACPROMSA as a network is expected to have an impact on policy formulation for health promotion.

Another strength of REDLACPROMSA is reflected by the scientific, technical, and financial support offered by PAHO, which sees REDLACPROMSA as a strong ally for its 2014–2019 strategic plan, "Championing Health: Sustainable Development and Equity."

While claiming strengths for networks, the same mechanisms that create the macroculture can be responsible for network weaknesses since changes in networks' core practical activity are what stimulate changes in other aspects of network macroculture. As a matter of fact, the articulation of REDLACPROMSA working commissions, their outputs, and their impact on policy formulation will definitely be affected by the relationships among its members or institutions and by how they coordinate among themselves and in relation to all these issues. Special effort will be required to define pathways that can facilitate both the growth and presence of REDLACPROMSA as a network.

Two more issues need to be mentioned in relation to the weaknesses of REDLACPROMSA: governance and financing. While its institutional features allow for the sustainability of network activities, especially if they coincide with government options, at the same time a lack of autonomous resources may hinder network developments that do not coincide with the different national policies. For the same reason, governance may affect sustainability because of changes in the policy agenda, following political elections. Again, special attention will be needed to identify a stable sustainability mechanism.

Final Remarks

Action on the socio-environmental determinants of health recognize different levels of intervention for reducing inequities and ensuring the full enjoyment of the right to health as the maximum possible level of "good health." Structural determinants of health include social and policy contexts that create social stratification, assigning individuals to different social positions.

Social stratification acts as an intermediate determinant of health by engendering differential exposure and differential vulnerability to health-damaging conditions. It also determines the effects, i.e., differential consequences, of ill health for more- and less-advantaged groups. Norms, policies, and practices that arise globally from transnational interactions should also be understood as political determinants of health that cause and maintain health inequities, since power asymmetry and global social norms limit the range of choice and constrain action with respect to health inequity. These limitations are reinforced by systemic global governance dysfunctions and require vigilance across all policy arenas. Ensuring that transnational activity does not hinder people from achieving their full health potential is a global political responsibility. The international character of REDLACPROMSA is

promising for establishing a common ground for action at the regional level. However, given the complexity of the issue, the action at the local level can represent a good entry point for acting on socio-environmental determinants of health. Local governments can play a fundamental role in human health from the perspective of social determinants and intersectoral action, even from a life-course perspective, since local governments oversee the planning and delivery of services that profoundly affect socio-environmental determinants of health. Moreover, local governments can support citizens' participation, empowerment, and governance. The activities carried out so far by REDLACPROMSA underline the importance for health promotion of strengthening local capabilities and skills.

Another positive consideration stems from the favorable momentum for the development and reinforcement of health promotion. As an example, we mention the case of Costa Rica. The offices of the Republic of Costa Rica that are in charge of asserting autonomous oversight of the government (*Contraloría General de la República*) observed in 2014 that the ministry of health was not complying with its guiding role in the health sector. As a result, the ministry of health underlined the importance of shifting from the prevailing therapeutic focus of the health sector to a perspective of health promotion. A vice-ministry of health promotion was created in 2015, a unique initiative in the region, since no other country could claim such a relevance in the organization of their ministry of health. Most countries in the region have in their ministries of health a general direction of health promotion. However, only Costa Rica established a vice-ministry of health promotion, raising health promotion to the core of national health policy.

In conclusion, the institutional feature of REDLACPROMSA is an achievement both as a network and as a tool for implementing global policies aimed at implementing health promotion and reducing health inequities in the region.

Acknowledgments This paper reflects the contributions of the Network of Latin American and Caribbean Health Promotion Managers (REDLACPROMSA).[1]

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[1] The members of the REDLACPROMSA, listed in alphabetical order, include Eduardo Álvarez, Ministry of Public Health, Cuba; Maria Edith Baca, WHO, Perú; Grettel Balmaceda García, Ministry of Health, Costa Rica; Maria Elina Barrera, Ministry of Health, Chile; Irma Cáceres Orellana, Ministry of Health, Chile; Anselmo Cancino, Ministry of Health, Chile; Patricia Caro Jiménez, Ministry of Health and Social Protection, Colombia; Carolina Cobos, Ministry of Health, Chile; Alfonso Contreras, WHO, Washington, DC; Maria Sofia Cuba Fuentes, Ministry of Health, Peru; Ligia de Salazar, Fundación para el Desarrollo de la Salud Pública, FUNDESALUD Colombia; Eva Estrella, Ministry of Health, Peru; Rodrigo Faundez Vergara, Ministry of Health, Chile; Oscar Feo Istúriz, Carabobo University, Venezuela; Rita M. Ferrelli, Istituto Superiore di Sanità, Italia; Bibiana García, Ministry of Health, Argentina; Ivette Johanna Gómez, Ministry of Health and Social Protection, Colombia; Diego González, WHO, México; Sandra Katherine Gordillo Iñiguez, Ministry of Public Health, Ecuador; Cecilia Guzman, Seremi Salud Los Lagos, Chile; Nelson Guzmán, Comisca (Council of Ministers of Health of Central America and Dominican Republic); Eduardo Jaramillo, Secretaría de Salud, México; Jorge Laureano Eugenio, Secretaría de Salud Jalisco, México; Miguel Malo, WHO, Peru; María José Mendieta Jara, Ministry of Public Health, Ecuador; Raúl Mercer, FLACSO, Argentina; Virginia Murillo Murillo, Ministry of Health, Costa Rica; Rosaida Ochoa Soto, Ministry of Public Health, Cuba; Elkin De Jesus Osorio Saldarriaga, Ministry of Health and Social Protection, Colombia; Adriana Pavon,

Appendix A

22nd IUHPE World Conference on Health Promotion

May 22–26, 2016, Curitiba, Brazil

PROMOTING HEALTH AND EQUITY

CURITIBA STATEMENT ON HEALTH PROMOTION AND EQUITY

To assure Democracy and Human Rights
in all countries around the world

The Curitiba Declaration embodies a spirit of local and global commitment to democracy, equity, and justice. It promotes social rights and "health for all' in an inclusive and sustainable world.

This Declaration represents the voice of researchers, practitioners, social movement members and policymakers who participated in the 22nd IUHPE World Conference on Health Promotion, held in Curitiba, Brazil in May 2016. The Curitiba Declaration articulates the recommendations of conference participants and focuses on how strengthening health promotion and improving equity, can improve people's lives where ever they live, work, play and learn.

We want to send a reminder that equity has been recognized as a pre-requisite for health and a key objective of health promotion for at least the past three decades. As the process for creating the Sustainable Development Goals is completed, we must recognize that the achievement of health equity is not a separate goal. Equity is the goal; continuing inequity in gender, race and ethnicity is a sign of system failure.

Participants of the 22nd IUHPE World Conference on Health Promotion recognize their own role and that of global society in pursuing a common agenda and solidarity bonds that collectively advocate for the prioritization of democracy and human rights as essential conditions for the promotion of health and equity.

All players involved in the international, national and local arena must try to work together to produce common directions that take into consideration their respective roles.

We urge **International Organizations** to recognize that:

1. Austerity causes inequity: Health is a human right and should not be treated as a commodity.
2. A social and economic system that accelerates capital accumulation and results in extreme wealth concentration is inconsistent with achieving equity goals.
3. Many people live in a threatening and hostile environment; and there is a need to work towards the elimination of work practices of corporations that harm health, damage the environment, and compromise social cohesion.

Ministry of Public Health, Ecuador; Giselda Sanabria, Escuela Nacional de Salud Pública, Cuba; Oscar Sánchez, Ministry of Health, Salvador; Monica Simons, CEAG—GTI-PSE, Guarulhos, Brasil; Melisa Maricel Snead Bustto, Ministry of Public Health and Social Welfare, Paraguay; Adriana Stanford Camargo, Secretaría de Salud, México; Julio Valdés, COMISCA (Council of Ministers of Health of Central America and Dominican Republic); Xiomara Vidal, WHO, Venezuela.

4. They have a role in advocating countries implement and enforce progressive income tax to address health equity and strengthen the role of the State in promoting social policies.

We call for **Governments at all levels** to:

5. Implement policies that promote gender and racial/ethnic equity as a main aim and evaluation measure.
6. Recognize that citizen participation in health decisions is a right not a concession.
7. Use innovative strategies that strengthen and protect the universal right to health and the well-being of the people of the world at all times and especially during any financial crisis.
8. Enrich their understanding of the threats that affect vulnerable and marginalized populations.
9. Demonstrate better and more transparent use of politics and power.

We recognise that the **Health Sector** should:

10. Be ready to learn from, not simply to lecture to other sectors.
11. Design effective health promotion policies and invest more in the capacity of health promotion systems to implement them.
12. Advocate to other sectors to recognize the impact that their policies have on human health and well-being, affecting mainly vulnerable populations.

We advocate that **Citizens** should be invited to:

13. Engage in a critical reflection about their role as active participants in the exercise of citizenship.
14. Exert their great transformative potential in mobilizing and pressuring local authorities to put health equity in their agendas.

We encourage **Health Professionals and Researchers** to:

15. Adopt new processes to achieve effective social participation, inclusion, intersectoral action and interdisciplinary approaches.
16. Recognize that the practice of health promotion is influenced directly and indirectly by politics and ideologies
17. Use evidence as an instrument for positive social change. We need science with compassion and with an intercultural approach.
18. Play a key role, through the use of multiple interventions, in generating an enabling environment and conditions that ensure ownership and agency with the people with whom they work.

We further advocate that EVERYONE—International Partners, Governments, Health Sector, Health Professionals, Researchers and Citizens—should recognize:

19. Their influence in changing and eliminating all forms of discrimination and exclusion.
20. The potential and capacity of health promotion throughout the life course.
21. Health Promotion goals will only be fully achieved by incorporating these four basic principles: equity, human rights, peace and participation.

Appendix B

THE SANTIAGO DECLARATION

Mayors Preforum, Road to Shanghai
–Chile, July 25 and 26, 2016–

VISION, STRATEGIC DIRECTIONS, AND ACTION COMMITMENTS FOR THE HEALTHY MUNICIPALITIES NETWORKS IN THE AMERICAS

We, the mayors and senior political representatives of cities, municipalities, towns, and territories, gathered at the Mayors Preforum in Santiago, Chile, convinced of the increasing relevance and the significant contribution the Healthy Municipalities movement can make to the health and well-being of our citizens, confirm our commitment to action that will inspire and guide our work in the years to come.

This Declaration is meant to provide political impetus and legitimacy to strengthen the Healthy Municipalities movement in the Americas, building on our past investments and achievements and better tuning to and connecting with twenty-first century approaches to health, social development and sustainable development.

The Santiago Declaration outlines our rationale, the values and the principles, as well as the renewed strategic objectives and approaches of the Healthy Municipalities movement in our region in the light of emerging priorities, scientific evidence on solutions that work, lessons learnt from our work, and the work of the global Healthy Cities movement to date and the relevant regional and global strategies and plans.

The Declaration is structured around four main sections:

1. Health and sustainable development and the key role of local governments
2. Healthy Municipalities movement: values, principles, and approaches
3. A renewed, reinforced agenda and important themes for the Healthy Municipalities movement in the Americas
4. Declaration of Santiago, Chile (Political Statement for the Global Conference on Health Promotion, Shanghai, China, November 2016)

Health and Sustainable Development and the key role of local governments

We recognize that:

- Health is a fundamental human right and every human being is entitled to the enjoyment of the highest attainable standard of health.
- Health is a core value and goes hand in hand with the social, economic, human and sustainable development of our cities, municipalities and territories.
- The health status of our people and that of our communities is profoundly affected by the conditions in which individuals are born, live and work.
- The knowledge and experience of the social, environmental, urban, cultural, commercial and political determinants of health provide the basis for how we should understand and deal with health in our cities, municipalities and territories. The public health challenges of the twenty-first century to be addressed effectively require the full engagement of local (municipal) governments.
- Local (municipal) governments can provide effective leadership and capacity for intersectoral work for health and sustainable development and they can promote and enable community involvement and empowerment. Local authorities are in a better position than the health authorities to enlist the participation of a wide variety of social actors.
- Local governments generally have primary responsibility for planning and/or delivering services critical for influencing the social determinants of health (SDH) (e.g., education, transportation, housing, urban planning) and often they have responsibility for health service delivery and public health.
- Local (municipal) governments have a key and central role to play in the implementation of all the sustainable development goals (SDGs) and in particular address the strong links between SDG 3 (Good Health for All) and SDG 11 (Make Cities and Human Settlements Inclusive, Safe, Resilient and Sustainable).

Examples of Areas Where Action by Local Governments Can Make a Significant Difference
Creating the preconditions for community empowerment and inclusiveness in the face of poverty and social disadvantage; giving children a healthy start in life; preventing and managing chronic diseases at community level; promoting active living; tackling obesity; developing community resilience to deal with emergency situations; creating age-friendly environments and promoting healthy urban design.

- The well-being, health and happiness of our citizens depends on our willingness to give priority to the political choices that address equity and the determinants of health.
- Ultimately health is a political choice that should match our values and aspirations for protecting and constantly improving the health and well-being of all our citizens.
- This means creating supportive social and physical environments and conditions for enabling all people to reach their maximum health and well-being potential.
- In the complex world of multiple tiers of government, numerous sectors and both public and private stakeholders, local governments have the capacity to influence

the determinants of health and well-being and inequities. They are well positioned to have such influence through whole-of-local government and health in all policies, regulation, integrated strategies and plans and partnerships across society

Healthy Municipalities movement: values, principles and approaches

We are very conscious of the fact that:

- The aim of the Healthy Municipalities movement is to put health high on the social and political agenda of cities, municipalities and territories by promoting health, equity and sustainable development through innovation and change.
- The Healthy Municipalities movement was created on the recognition of the importance of action at the local and urban level and the key role of local governments.
- The Healthy Municipalities movement is a political, strategic, cross-cutting and intersectoral initiative. "Healthy Cities/Healthy Municipalities" is a strong global movement because of its local political connection.
- Healthy Municipalities represents "a real-world laboratory" to generate good practices, evidence and knowledge, methods and expertise that can be used to promote health in all cities, municipalities and territories in the region of the Americas.
- Healthy Municipalities is a value-based initiative which offers the opportunity to whole-city governments and societies to promote health and well-being for all, using the very best evidence available and innovative ideas at any time.
- It represents a channel of connecting with the urban public health conditions on the ground across the region of the Americas.

Healthy Municipalities' Influence on Health, Well-Being and Equity
Regulation. Cities are well positioned to influence land use, building standards and water and sanitation systems and enact and enforce restrictions on tobacco use and occupational health and safety regulations

- *Integration. Local governments have the capability of developing and implementing integrated strategies for health promotion.*
- *Intersectoral partnerships. Cities' democratic mandate conveys authority and sanctions their power to convene partnerships and encourage contributions from many sectors.*
- *Citizen engagement. Local governments have everyday contact with citizens and are closest to their concerns and priorities. They present unique opportunities for partnering with the private and not-for-profit sectors, civic society and citizens' groups.*
- *Equity focus. Local governments have the capacity to mobilize local resources and to deploy them to create more opportunities for poor and vulnerable population groups and to protect and promote the rights of all urban residents.*

The values, principles and approaches of the Healthy Municipalities movement are deeply rooted in the Constitution and key strategies and resolutions of the Pan American Health Organization (PAHO), the World Health Organization (WHO) headquarters, and other agencies as well as in the best available evidence and experience from practices from our Region and beyond.

In this context, we acknowledge the importance and relevance of the:

- Regional Plan of Action on Health in All Policies
- Rio Political Declaration on Social Determinants of Health (2011) and Resolution WHA65.8 (2012) of the World Health Assembly "Outcome of the World Conference on Social Determinants of Health"
- Health Promotion documents: Cuenca Declaration (1978), Ottawa Charter (1986), Declaration of Santa Fé de Bogotá (1992)
- The Curitiba Declaration and the La Granja Declaration
- Political Declaration of the United Nations High-level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases (2011)
- The Zagreb (2008) and Athens (2014) Healthy Cities Declarations of the European Healthy Cities movement
- The framework of the Sustainable Development Goals of the 2030 Agenda for Sustainable Development

We stress that:

Healthy Municipalities is a dynamic concept which should be continuously enriched with new developments and emerging priorities and scientific evidence. This is essential for Healthy Municipalities to maintain its relevance and credibility. The agenda, themes and goals of each phase of the Healthy Municipalities movement in the Americas should therefore reflect global and regional priorities and strategies and issues emerging from the urban (health, social, environmental) conditions in our Region.

We declare our constant commitment:

- To the promotion of action to put health high on the social and political agenda of our cities, municipalities, towns and territories
- To the fundamental values of the Healthy Cities-Healthy Municipalities movement since its inception, namely the right to health and well-being, equity and social justice, gender equality, solidarity and social inclusion, universal coverage and sustainable development
- To the following principles and approaches that should underpin all Healthy Cities-Healthy Municipalities policies, strategies and plans: addressing the determinants of health and root causes of ill-health and inequalities; promoting intersectoral action and partnership-based approaches; promoting health and equity in all local policies; supporting community participation, empowerment and democratic governance; and using the life-course approach.

Community participation is essential for the success of the Healthy Municipalities movement

The Ottawa Charter (1986) defined health promotion as “the process of enabling people to increase control over, and to improve, their health.” Giving a voice to individuals and communities and creating the pre-conditions for empowerment and meaningful engagement are at the core of the Healthy Municipalities approach. More than ever before and in the face of the fast changing social landscapes of cities and towns there is a need to create inclusiveness and social cohesion. Empowered communities will have the knowledge, the skills and the means to participate in decisions that affect their health and well-being and also navigate and access resources that can improve their health and quality of life. There is increasing evidence that socially inclusive and cohesive communities are healthier and happier.

We declare our commitment to the following critical issues:

- To investing in our cities, municipalities, and territories and our people striving to create cities for all our citizens.
- To fully using and integrating in our health development work, twenty-first century evidence-based public health and health promotion approaches and solutions that work.
- To ensuring that our policies and plans are comprehensive, systematic and strategic aiming at delivering best outcomes and maximum impact.
- To integrating health and sustainable development considerations in how we plan, design, maintain, improve and manage our cities, municipalities and territories and neighborhoods and use new technologies.
- To valuing social diversity and investing in building trust and cohesion amongst our communities.
- To employing whole-of-local government and whole-of-society and Health in All policies approaches in our efforts to reaching out to different partners (public and corporate) and civil society.
- To focusing in engaging with other sectors on what they can do for health and what health can do for them identifying win-win, synergistic and co-beneficial outcomes.
- To promoting policy coherence, synergies and better coordination as well as systems enabling joint planning and accountability.
- To investing in creating adequate capacity for steering, managing, and implementing our Healthy Municipalities initiatives and programs.
- To putting in place the resources and mechanisms for systematically assessing the health and the conditions that affect health in our cities, municipalities and territories as well as for monitoring our Health in All policies and reducing health inequality efforts.
- To publishing regularly a city health profile as a basis of identifying priorities and accountability for health in our cities, municipalities and territories.
- To increasing our investments in disease prevention and health promotion applying the social determinants of health (SDH), equity and economic lens and aiming at creating social and physical environments that are conducive to health and well-being as well as increasing health literacy.

- To promoting awareness about individual responsibility and social responsibility for health through SDH and equity perspective.
- To developing strategies and plans that are framed on population-based and life-course approaches.
- To developing an intersectoral integrated strategic framework and plan for health development in the city with commonly agreed goals.
- To making sure that local Healthy Municipalities plans and activities are aligned and connected with the main city development strategies.
- To developing local and national platforms, networks and fora that promote social dialogue and broad civic engagement.

A renewed, reinforced agenda and important themes for the Healthy Municipalities movement in the Americas

The Health Municipalities approach provides an adaptable and practical framework for delivering Health for All at the local level. It provides an exceptional platform for joint learning and sharing of expertise and experience between cities, municipalities and territories within and between our national networks in the Region.

We endorse the fact that:

- Every city is unique and distinctive and within the frame of the overarching goals and themes of Healthy Municipalities approach, cities, municipalities and territories have the flexibility to identify and give weight to areas that are of particular relevance to local realities.
- A big strength of the Healthy Cities/Healthy Municipalities movement is its diversity.
- Our commitment to Healthy Municipalities will not be wholehearted and comprehensive without being true in our actions to its fundamental values and principles.
- The transformative potential of a Healthy Municipalities strategy for local health promotion/development can only be made alive through joint efforts by the different stakeholders in our cities, municipalities, towns and territories.
- The future prosperity of urban populations depends on our willingness and ability to seize new opportunities to enhance the health and well-being of present and future generations.

We are fully convinced that the time is right to reinforce and expand our Healthy Municipalities movement in the Americas and commit to initiate a new phase of Healthy Municipalities in the Americas.

This phase should be shaped on the basis of six strategic priorities:

1. To strengthen the political, strategic and operational capacity of our national networks
2. To revisit, update and expand the goals, commitments and action agenda of Healthy Municipalities in our Region

3. To agree on a minimum number of common goals that will be shared and pursued by all national networks and member cities, municipalities, towns and territories
4. To introduce five-year cycles (phases) in the development of the Healthy Municipalities program in the Americas that will provide the opportunity to regularly renew its action agenda and evaluate the outcomes and lessons learned from each phase
5. To establish the International Healthy Municipalities Network of the Americas comprised of our national and local networks, and develop a common strategy with principles, priorities, and standards
6. To actively seek to connect with the global Healthy Cities movement and key international networks of cities and municipalities that are concerned with aspects of urban development

Investing in Establishing New and Strengthening Existing National Healthy Municipalities Networks
National networks have a key strategic role in promoting the Healthy Municipalities principles and ideas, supporting their member cities, municipalities, towns and territories, organizing training and learning events as well as working with different ministries and participating in national programs

We recognize that:

- Strengthening leadership and governance for health and well-being is fundamentally crucial, and for this reason we will join our efforts to promote better awareness and dialogue about the principles and added value of Healthy Municipalities; the political determinants and capacity required for change and innovation; and methods for reaching out to other sectors and engaging civil society

We declare our commitment to a comprehensive Healthy Municipalities framework that covers six action domains:

- Promoting local leadership and intersectoral governance for health/*working together for the health of our city*
- Addressing the needs of people of all ages and vulnerable groups/*caring for our people and community and promoting equity*
- Creating supportive physical and social environments for healthy living/*making the healthy choices, the easy choices and healthy settings*
- Promoting healthy physical and built environments/*making the city clean, safe, attractive and sustainable*
- Strengthening community resilience and health literacy/*engaging and empowering our people with knowledge and skills for health and well-being*

- Strengthening public health services and community care services/*making high-quality services accessible to and for all*

Local Leadership for Health and Sustainable Development
Local leadership for health and sustainable development means: having a vision and an understanding of the importance of health in social, economic and sustainable development; becoming an advocate and active implementer of the SDG agenda; having the commitment and conviction to forge new partnerships and alliances; promoting accountability for health and sustainability by statutory and non-statutory local actors; aligning local action with national policies; anticipating and planning for change; and ultimately acting as a guardian, facilitator, catalyst, advocate and defender of the right to the highest level of health for all residents. Effective leadership for health and well-being requires strong political commitment, a vision and strategic approach, supportive institutional arrangements and networking and connecting with others who are working towards similar goals.

We declare our commitment to including in our strategies a minimum set of seven common goals:

- To ensure that the HiAPs and SDG agendas are explicitly and fully integrated in our vision and plans
- To give high priority to community participation and empowerment and community resilience
- To measure and systematically and comprehensively address health inequalities
- To give all our children a healthy start in life with the active involvement of different sectors (such as health, social services, education, housing and planning), families and communities
- To create conditions for healthy and active living for all with emphasis on physical activity, healthy and sustainable nutrition, reduction of obesity and mental stress, controlling the use of alcohol and creating smoke- and drug-free cities.
- To increase health literacy among individuals, communities and institutions
- To invest in healthy environments and healthy urban planning and design, creating safe and clean neighborhoods with access to green areas and space for social interaction and good facilities for all and creating age- and child-friendly settings

The Critical Importance of the Life-Course Approach
Supporting good health and its social determinants throughout the life course leads to increased healthy life expectancy as well as enhanced well-being and enjoyment of life, all of which can yield important economic, societal and individual benefits. Interventions to tackle health inequities and their social determinants can be derived at key stages of the life course: maternal and child health; children and adolescents; healthy adults; and healthy older people.

The Importance of a Good Start in Life for Children
A good start in life establishes the basis for healthy life. Cities investing in high-quality early-year childcare and parenting support services can compensate for the negative effects of social disadvantage on early child development. Promoting physical, cognitive, social and emotional development is crucial for all children from the earliest years. Children born into disadvantaged home and family circumstances have a higher risk of poor growth and development.

We finally declare our commitment to:

- Increasing our capacity for effective leadership and intersectoral action through whole-of-government, whole-of-society and HiAP approaches
- Working together as city leaders and as national networks promoting solidarity, sharing experiences and shaping our future visions and strategies
- Generating policy and practice expertise, good evidence, knowledge and methods that can be used to promote health in all cities, municipalities, towns and territories in the Americas Region
- Establishing working links between cities, municipalities and territories and networks of local authorities in the Americas and partnerships with agencies concerned with urban issues
- Increasing the accessibility of the Healthy Municipalities movement in the Americas to all member states in the Region

Declaration of Santiago, Chile
<u>This is our moment!</u>
We, the mayors and city managers of Chile, Ecuador, Peru, Guatemala, Cuba, Brazil, Argentina, Mexico, Haiti, Colombia, Guyana, and Paraguay, present at the Mayors Preforum of the Americas, Road to Shanghai 2016, held July 25–26, 2016, in Santiago, Chile, hereby declare that:

The Global Conference on Health Promotion, to be held in Shanghai, China, in November 2016, offers a unique opportunity to strengthen political commitment to health promotion and the Healthy Cities, Municipalities, Towns, and Territories Movement worldwide.

This is our moment to promote policies and action to address health determinants, human rights, and inequities through health in all policies and intersectoral approaches, within the framework of Sustainable Development Goals.

As local leaders, we are convinced that we have the power to make a real difference in the health and quality of life of the citizens of our territories.

(continued)

We are determined to improve the development and performance of local and national healthy cities networks.

We are convinced that national policies must recognize the importance of the role of municipalities in health development and actively promote healthy cities networks.

It is our conviction that working together, we can create synergies and platforms for sharing our local experiences and innovations. We have therefore decided to create an International Network of the Americas and develop a common strategy with principles, priorities, and standards.

We call on the international community and international agencies, such as the Pan American Health Organization (PAHO/WHO), to join us in this effort and assume this commitment.

In witness whereof, we, the participating mayors and city managers of the Americas, sign the Declaration of Santiago in La Granja Municipality, Santiago, Chile, on 26 July 2016.

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Chapter 5
Denaturalizing "Long-Lasting Endemic Diseases": Social Mobilization in the Context of Arboviral Diseases in Brazil

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L. Malagón de Salazar, R.C. Luján Villar (eds.), *Globalization and Health Inequities in Latin America*, https://doi.org/10.1007/978-3-319-67292-2_5

Context

Since the 1980s, the Brazilian population has been facing successive dengue epidemics. The disease is caused by a virus transmitted by the *Aedes aegypti* mosquito, a vector that disseminates other infections that have appeared in recent years in the national context, such as zika, chikungunya, and urban yellow fever (the latter reemerging in the country). Aggravating the situation, epidemiological studies have shown an association between zika virus infection and congenital malformation causing microcephaly in newborns.

In 2015, this scenario led the World Health Organization (WHO) to declare a Public Health Emergency of International Concern (PHEIC) owing to the dispersion of the zika virus and its consequences with autochthonous transmission in 24 countries. In Brazil, this epidemic has the potential to lead to tragedy, given the socio-environmental and sanitary conditions favorable to the dissemination of the disease in regions where there is the predominance of extreme social inequity and precarious living conditions.

It is important to stress that the alarming number of cases of arboviral diseases are concentrated in the same regions where dengue has been occurring for 30 years. Considering this panorama, two issues should be discussed: first, current strategies adopted by different governmental spheres to tackle arboviral diseases may fail; second, the origins of the problem are not merely in the vector's dispersion also associated with the social determinants of health.

In the Brazilian context, in recent history, the health sector has been marked by the organization of an assistential and clinic-centered model, resulting in the expansion of a globalized health industry complex dominated by large corporations. This model has not effectively responded to the population's health problems in countries with demographic, epidemiological, and sanitation characteristics like those of Brazil, marked by inequities in social and healthcare access (Gondim 2011).

Therefore, it is necessary to create a health surveillance system to counteract the medical-assistential and sanitarian-campaigning model, one that will include health, disease, and care as manifestations resulting from historical and cultural processes (MENDES 1993). This article draws on the perspective that health surveillance should be territorially and community based, simultaneously incorporating the social determination of the health–disease process of epidemics and the promotion of health as a guiding axis of processes and interventions.

The Territory as Locus of Social Mobilization

We are living in a historic period of profound transformation in people's lifestyles and in society, resulting from the process of economic globalization with the expansion and massive incorporation of technical processes in networks of finance and productive chains around the planet, with the appropriation of local resources and intensification of circulation flows and exchange of information, material resources, and people (Gondim et al. 2008).

The space-time speed of events produces local changes with consequences in the environment, social life, culture, and politics requiring immediate responses from governmental sectors—like health—to be vigilant, prevent problems, and give assistance to the populations in cities, rural areas, and forests. In this process, as a counterpoint to globalization (Santos 1999), the issue of the local and the lived territory emerges. These areas should be seen not only as loci of dwelling but also as sites of production, symbolic exchanges, and coexistence between people.

The central characteristic of the globalization process is the transposition of any forms of physical or symbolic boundaries in the individual and collective sphere. All sorts of problems circumscribe complex and multidimensional challenges. Economic globalization and the intensity of flows homogenize resources and exchanges, subtracting from territories their particularities and singularities and allowing rapid and significant changes in the propagation of diseases and pathogens (viruses and bacteria) throughout the planet.

In contrast, health surveillance—the idea proposed and disseminated in Brazil since the 1980s—rests on the idea of the *territory*, understood as the place where social life is produced and where health potentialities, necessities, and problems are highlighted. The understanding of the specific and local reality enables technical structuring of interventions to improve the life and health conditions of the population. In this sense, the territory is the central category for the operationalization of different forms of intervention with the aim of tackling multiple and singular health situations. In Brazil, the proposal of territory-based health surveillance (Teixeira et al. 1998; Mendes 1993; Monken and Barcellos 2005) emerges as a technological model for the organization of work process and health care based on the observation and contextualization of social determinants of health and on the concreteness of social processes occurring in the territory, which help to organize sanitary practices by means of social participation and intersectorality.

To understand each socio-sanitary context, territory-based health surveillance makes use of various areas of knowledge—epidemiological, geographic, sociological, educational—that are essential for strategic action. Furthermore, by micro-territorializing problem situations, this perspective materializes and highlights the populations' needs and, counting on community participation for problem solution, seeks to ensure access to health services and actions in an integral, effective, and fair way (Mendes 1993).

Territory and Social Participation in Facing Health Problems

Territory is a concept that helps to describe and understand ways of living on the planet. It enables social analysis of populations in general, particular, and singular realms (Castellanos 1990; Monken and Barcellos 2005; GONDIM 2011) contributing to the knowledge of people's and groups' lifestyles: their culture and traditions, traditional knowledge, ideas, sentiments, projects, and various interests that are materialized in the appropriation of and control over spaces. The territory also

expresses various dimensions of human existence (physical, political, economic, social, environmental, epidemiological, sanitarian, subjective) that may serve as the structural base for social mobilization and intersectoral intervention to tackle arboviral diseases and other health problems.

Getting to know a territory contributes to an understanding of the health–disease–care process and to identifying forms of use that may potentiate the operational capacity of the local health system in order to organize actions and services to tackle a population's problems and needs. Analyzing the territory makes it possible to identify spatial singularities and social, economic, and political dynamics and to decode the multitude forms of knowledge (popular, technical, technological) that confer meaning and significance to them. It also enables health professionals to understand the social production of health, thereby contributing to the implementation of effective health care practices with respect to the various population groups (Monken and Gondim 2016).

Power is the key concept to understand the meaning of territory. It expresses the possibility to exert command, domination, or imposition of will or a particular project on other people, groups, or institutions. It has been practiced, beyond its contribution in the definition of the state, as a singular characteristic of all social players who use and dispute ideas, intentions, and desires in a collective or private space. Populations, firms, public power, social groups, and the various social, cultural, religious, and other organizations have power and exert it according to their plans and projects and based on their capability to have those plans and projects materialized. Community networks also exert power in the appropriation of territory. They are structured in daily life, strengthening neighborhood processes, community relationships, and relationships of diverse coexistence among people and groups.

These relationships build social support processes by means of local players who serve in traditional roles such as herbal medicine practitioners, midwives, healers, and informal caretakers of elderly and children, among others. It is traditional knowledge that strengthens links, bonds, and territorial identities in tackling problems and seeking fulfillment of local needs and it is crucial for a population's mobilization. This dynamic is strongly present on the local level, in territories with low-income populations, where there is extreme social exclusion and where an active search for support networks as a survival strategy can be observed (Monken and Gondim 2016).

When producing and appropriating territory, society creates rules of use and power. Those power relations dictate social rules or specific laws, which may be created by the state (formal) or by society (informal). Formal laws are written, not all people know them, but all must submit to them. Informal laws are not written; everyone recognizes and follows them if they are collectively agreed upon. Rules, laws, and lifestyles are codes, values, and meanings that permeate daily life and affect people's conduct, creating behavioral cultures. Recognizing these rules is essential for the organization of whatever kind of social mobilization is used to tackle local problems.

Territorial dynamics create different territorialities that express power relations, which in turn affect singular spatial delimitations. Thus, territorialities are strategies that social players, individuals or collectives, public or private, use to influence or

control people, resources, phenomena, and relations, delimiting and making effective the control over an area, community, district, municipality, state, and even a country (Sack 1986).

Currently, there is intensification in the production of multiple territorialities because of an increasing diversity of players in various projects, engendering a constant transformation process. This means there is an overlap of several intentions of use and control over territories by different players at the same time. Each territory may contain various forms of use that delimit distinct objectives. These include residents living in the area, firms that use the territory to produce and commercialize their goods, or associations of all sorts that operate locally. There are also social groups that operate illegally, such as gangs and criminal bands that impose their rules by appropriating the territory. Public authority also creates territorialities when performing in a specific way. This is the case, for example, with health and education services, with their specific work processes structured according to the characteristics of each local context. This movement of many interests under dispute in the same territory engenders conflicts that should be identified, understood, and resolved. Recognizing those processes and their multiple players will contribute to the mobilization of populations (Haesbaert 2004).

To understand multiterritoriality, one can compare this process to what happens in a "multisport court." There are delimitations on the court—the territory—for different sports to be played: football, basketball, volleyball, and handball, among others. Each modality has its own rules. Similarly, multiterritoriality translates different ways of appropriating and using a territory by individuals and groups that occur simultaneously and overlap, some with more and others with less potency (Moreira 1987; Monken and Gondim 2016).

We live daily in a permanent process of territorialization, i.e., seeking to be fixed to territories—places that enable the construction of identity, rules, and bonds. However, especially in capitalism, we also suffer or are submitted to processes of loss of territory, referred to as deterritorialization. It is characterized by social dynamics whereby population groups are denied access to a territory in the most basic and material sense of existence, as are the landless, *quilombolas* (descendants of runaway African slaves in Brazil, living in isolated communities), peasant fishermen, indigenous groups, and those socially excluded from the benefits of material progress (Haesbaert 2004).

Economic systems based on income concentration promote not only deterritorialization but also precariousness of the population's living conditions. Vulnerable territories are characterized by irregular delivery of essential services such as sewage system, clean water supply, rainwater drainage, and garbage collection, which potentiates the occurrence of certain groups of diseases, like arboviral diseases, whose social determination is associated with low levels of environmental sanitation and hygienic living conditions. Such places suffer recurring problems connected with urban mobility, food security, and, in most cases, fragile social cohesion and community strength, whose participation in mobilization processes becomes another challenge for disease control.

There are many exclusion and exception territories within cities. Often with high demographic density, they are sites with strong neighborhood impacts (e.g., violence, traffic, pollution) and peculiar geography owing to the proximity/agglomeration of the territory's objects—public ways, rivers, dwellings, production facilities (small industry and commerce). Furthermore, access to people and goods is precarious and occurs via narrow streets, alleys and pathways, with the intensification of flows, contacts, and interrelations with the environment (Monken and Gondim 2016). These socially excluded and deterritorialized groups are simultaneously potential victims of arboviral diseases and crucial players in tackling the problem.

Social Identity and Territory: Structuring Elements in Social Mobilization

Territories differ, presenting great spatial heterogeneity and great internal homogeneity. They are shaped by the interests of people, groups, and institutions that produce them to fulfill specific objectives and purposes according to their own projects. Some territories present singular profiles, such as those of fishermen communities, family agriculture, industrial workers, and those where abundance and wealth predominate. The identity that a population superimposes on a territory is often a result of long-term processes of social relations marked in space-time, connecting issues of people's belongingness and bonds to places of life. These are processes that incorporate cultural practices, habits, and behaviors entangled in social relations. These are, therefore, territory-structuring factors and are fundamental for actions of community mobilization and organization.

The social, cultural, environmental, and sanitary characteristics involving territorial identities and representations conferred by the population, turning them into reality, affect the health practices in the territory, especially those that incorporate the population in health actions. Community participation in health practices is vital to broaden action and bring community near to health teams and services in the control and surveillance of health problems, thus enabling the construction of communication and participation pacts.

Mobilizing a population as a central player in actions related to care with the population's territory of life means bringing people together to act; this requires the creation of a structure to establish cooperative relations and the use of resources to achieve the goals of mobilization. In this sense, territory-based health surveillance grounded on an information–decision–action strategic practice may bring greater efficiency and sustainability to social mobilization structured by situational strategic planning (STP) (Teixeira et al. 1998; Mendes 1993).

The situational strategic approach originally proposed by Carlos Matus (1993) indicates a possibility of subsidizing concrete practices in any dimension of social and historical reality, simultaneously contemplating the formulation of health

policies, planning, and programs. Founded on the social production theory, it sees reality as indivisible and understands that all that exists in society is created by humans (Teixeira et al. 1998; Mendes 1993). It is thus an indispensable tool for the support of health surveillance actions that presuppose health promotion and intersectorality.

To understand the effectiveness of territory-based health surveillance practices incorporating social mobilization at tackling health problems, one should know the various territorial dimensions (political, economic, environmental, sanitary, cultural, and others) since they exert a direct influence on people's life story and determine ways of perceiving, experiencing, and living with health and disease. The political dimension is also vital to any form of social mobilization in a territory. The recognition of social players, their capabilities and power for local action, and their resources are essential for the effectiveness of the process. The identification of the projects of each social player in a territory and the material and symbolic resources that can be put into action locally for the implementation of interventions will indicate which of them are essential for the effective mobilization of the population.

The cultural dimension also stands out because through it people become organized and legitimate their group in society, producing elements for their social, political, and economic organization. It includes knowledge, beliefs, art, morality, laws, and habits that people acquire and develop in places and social contexts throughout life, influencing behaviors, perceptions, emotions, language, religion, rituals, family structure, diet, clothing, body image, time and space concepts, and attitudes in the face of disease, pain, and other types of misfortune (Dias and Dias 2010).

Social mobilization processes should incorporate theoretical and practical elements of territorial politics and culture, recognizing them as devices for their effectiveness/potentiation. The knowledge of rules, norms, and laws that give structure to local power are often materialized in the local culture, allowing for the understanding of health problems and needs, both individual and collective, besides imprinting specific meanings on social life that favor community mobilization, emancipation, and empowerment.

The set of devices identified in a territory opens up possibilities for cooperative encounters between people, strengthened by the identity vector to build various forms of mobilization, potentiating the local capability to collectively promote improvements in living conditions and health situation and perform specific actions in accordance with the local identity.

Health Territorialization for Social Mobilization

To intervene in a specific health situation having social mobilization as the intervention strategy, it is essential to analyze the living conditions in the territory, identifying players, resources, and social rules of coexistence that translate into, in the

dynamics of local daily life, and determine, to a greater or lesser extent, the population's health conditions and quality of life. The process of health territorialization enables the analysis of the health conditions of a given population; thus, population groups and public agents, in particular health agents, may recognize the local health situation and make the key decisions and formulate the appropriate strategies. The recognition of the territory for public health interventions (health territorialization) is achieved by the identification of social players, local potentialities, threats to health, vulnerabilities, public facilities, leadership, and recovery of the territory's occupation history, its traditions, and cultural manifestations.

This process is made viable when carrying out systematic field observations, with primary and secondary data collection, achieved by a health team working together with the population, associating objects identified on the site with actions promoted by each social player (individual or collective, public or private) in the context of life. The aim is to identify territorialities structured by local players and their distinct sociocultural characteristics. It also presupposes the analysis of local contexts based on social production theory, which spearheads the development of investigation strategies and the elaboration of data collection tools for the achievement of diagnosis, planning, and sanitary interventions aimed at the improvement of the population's life and health conditions (Monken 2008).

Qualitative and quantitative methods are used in the process of territorialization to identity, acquire knowledge of, analyze, and intervene on health problems and needs. Innumerable tools can be used, and some are indispensable (Monken et al. 2016):

Primary data fall into the following categories: (a) recognition and mapping of a territory: data collection on risks, vulnerabilities (e.g., pollution, solid waste, openly discharged untreated sewage, violence), diseases, and injuries; families, social groups, and institutions (e.g., social support networks, churches, temples, schools, health services); means of communication (neighborhood newspapers, community radio, social networks); physical-spatial boundaries; physical geography and built objects (e.g., buildings, roads, schools, commerce, streets, bridges, public facilities); (b) interview: listening to territorial players to learn about the history of the occupation of the territory; the perceived problems and needs and potentialities that can be set in motion for problem solving; identifying organizations and their action capabilities—public administration, especially the health sector, civic entities (NGOs, churches, associations, and informal care networks); social movements (pop music groups, homeless people, drug users, women) and community leaderships; (c) field observations: notes and photographs for the recognition of local singularities, such as popular meeting places and communicative actions (e.g., squares, churches, residents' associations, sports areas, football fields, bars).

Secondary data fall into the following categories: (a) demographic: absolute population, age groups, gender, education level and literacy rates among adults); (b) geomorphological: climate, temperature, relief, hydrography; (c) sanitary and productive structures: distribution of water, sewage, garbage collection and disposal; housing; services for health, transportation, security, finances, communications; public and private education facilities; production facilities (industries, commerce, and services).

The analysis of groupings and associations between primary and secondary data will serve as a basis for the production of a diagnosis of living conditions and health situations in territories, in order to reach a consensual agreement between health teams and community leaders, thus enabling processes of social mobilization between the population and public agents (of health, sanitation, social assistance, urban and rural development, for example) aiming at the organization of cooperative and participative interventions. In the case of arboviral diseases, the dynamic territorialization/recognition/learning/mobilization/intervention may simultaneously constitute collective learning about living conditions and health situations in territories and a mechanism for social integration and mobilization in search of solutions to tackle health problems.

In this sense, community insertion in the process of health territorialization is strategic for social mobilization. The central axis of this pedagogic method of knowledge and recognition of the territory consists of structuring commitments and solidarity between community and local public agents, especially of the health sector, with the capacity to build the basis for cooperation and co-responsibility for the planning, definition, and development of appropriate sanitary practices and for tackling health problems.

Communication for Social Mobilization

Regarding social mobilization around arboviral diseases (and other health problems), the strategies used during the last three decades by different spheres of the Brazilian government have been mainly related to communication actions. Since the early dengue epidemics in the 1980s, publicity campaigns have occurred based on material and speeches mostly centrally produced (in general by publicity agencies hired by the Ministry of Health) reflecting the traditional communication concept of "information transfer" (Araújo and Miranda 2007).

The speeches publicized, with slogans like "Dengue, Zika and Chikungunya: If You Act We Can Avoid[1]" or "Combating Dengue Is in Your Hands," tend to make citizens responsible for overcoming epidemics.[2] Radio and TV spots, pamphlets, and posters make strong appeals for people to participate by eliminating mosquito-breeding places inside their homes, which, though crucial, is not sufficient, considering that the social determinants of arboviral diseases are beyond the individual habits of every citizen. For instance, it will be totally inefficacious to make a continuous effort to eliminate mosquito-breeding places in a residence situated in a neighborhood without sanitation and garbage collection.

Anyway, the aggravation of the sanitation situation suggests that those communication strategies have been inefficacious even regarding social mobilization.

[1] Campaign developed by the Brazilian Ministry of Health in 2017.

[2] Campaign developed by the Brazilian Ministry of Health in 2015.

When considering the results of the adopted model it is possible to question the idea of a causal relation between a "good communication" and a "behavioral change." In an article published in 2009, Miranda and Lerner oppose this concept and as an alternative they defend communication actions that take into consideration the different contexts (local, existential, and situational) in which are inserted people and groups with whom one intends to dialogue (instead of "those to be informed"). The point is not talk about dengue, zika, and chikungunya but rather talk about dengue, zika, and chikungunya in the community.

Taking as a reference the document "Social Mobilization: A Way to Build Democracy and Participation" ("*Mobilização social: um modo de construir a democracia e participação*") by José Toro and Nísia Werneck, social mobilization occurs when a group of people, a community or a society, "decides and acts with a common goal, daily seeking results that are decided and desired by everyone" (1999). This collective construction presupposes exchange, production, dispute, and the agency of ideas and meanings, a process that materializes precisely by means of social communication in the sphere of each specific space-time. Therefore, communication that makes community mobilization feasible is that which is processed in the context of a territory. In the words of Orozco (1993), it is understood as a process that is multimediational, multidimensional, and multidirectional where everyone talks, although notably from distinct places of speech and levels of empowerment.

Mobilization, thus, cannot be mistaken for propaganda or publicity; it requires a process of sharing speeches, visions, and information. It presupposes including the other in decision making rather than vertically transmitting what must be done, especially when referring to social determinants (proximal or distal) of health, which equally require tackling sanitation problems.

Social Mobilization and Vulnerable Territories in Contexts of Zika and Other Diseases: Experience Reports

In 2015, Gonçalves and collaborators published an article on an integrative review of works on the knowledge, attitudes, and practices of the Brazilian population concerning dengue. In the articles analyzed, the authors observed that a gap remains to be filled regarding the empowerment of people as active participants in the process, rather than being mere spectators of official policy decisions. They highlight the need to carry out work in the community, taking into consideration the territory's particularities. They stress the importance of the development of the sense of responsibility and nonculpability of citizens and the promotion of dialogue between science and common sense. In this perspective, the approaches taken can contribute to strengthening the population's engagement with the prevention and control of *Aedes aegypti*. Experiences carried out in the cities of Belo Horizonte and Rio de Janeiro that may indicate the way are described next.

Community Surveillance to Strengthen Social Mobilization to Tackle the Triple Epidemics of Dengue, Zika, and Chikungunya: An Ongoing Proposal in the State of Minas Gerais

The proposal described here stems from an action of the René Rachou Research Center (*Centro de Pesquisa René Rachou*), a unity of the Oswaldo Cruz Foundation (Fiocruz), in the state of Minas Gerais. The activities were initiated and will be organized along three axes: (1) creation of community committees; (2) definition of social technologies based on solidarity networks aimed at women of fertile age, pregnant women diagnosed with zika virus infection, and babies with microcephaly or disorders of the central nervous system related to the zika virus; and (3) elaboration of proposals for public policies.

The community committees are in place in schools of the Public State Network (*Rede Pública Estadual*—RPE) and will carry out community surveillance in the territory. They will be spaces for action and reflection. The RPE of Minas Gerais has 47 Regional Education Superintendencies (*Superintendências Regionais de Ensino*—SRE) comprising 3665 schools throughout the state. The idea is that the committees are composed of students, parents, teachers, other residents, and members of the school community. Together with the local population, each committee shall define and implement participative strategies for the recognition, analysis, and discussion of the territory, aiming for the elaboration of a diagnosis of the health situation and living conditions in the locality, so as to be able to plan social mobilization proposals to form environments that are conducive to health.

The work is conceived as a form of community education, and all activities will be developed by means of research action techniques. For the implementation of the proposal, an intersectoral network was created that is composed of professionals from the Oswaldo Cruz Foundation (Unities of Rio de Janeiro and Minas Gerais), from the State Secretariat of Education, State Secretariat of Health, Public Health School of Minas Gerais, and Association of Parents and Friends of People with Disabilities (*Associação de Pais e Amigos dos Excepcionais*—APAE). The committees are being gradually phased in, and by February 2017 16 SREs, from the total of 46, had been invited to join.

Each school that agreed to take part selected a representative to coordinate the work in the territory in which the school is located. The capacity building of the committee members has the support of an online platform with the intermediation of tutors. The themes studied include the disease, the vector and favorable conditions for its proliferation, the concepts of territory and territorialization, the method for establishing a local diagnosis, community participation, and communication processes.

In February 2017, the coordinators of the 214 schools that had agreed to participate in the process were already in contact with the tutors via the digital platform and were preparing to create committees and start their members' capacity building.

Following the capacity building, and with the tutors' support, the committees will organize workshops in their communities and carry out the local diagnosis and planning of actions in each territory. The project includes the development of communication strategies to broaden the debate on the social determination of epidemics. Communication processes and tools will also be used to resolve local problems and perform risk assessment. The creation of solidarity networks to give support to mothers and babies victimized by the sequelae of the zika virus (such as microcephaly) is under discussion, and a pilot proposal is in progress.

The entire proposal will be assessed by an evaluation study that will analyze the implementation of the proposal by studying the relations between the intervention and its context during implementation. For this purpose, case studies will be develop to deepen the analysis of the implementation of the methodology in each local organization context. Indicators will be elaborated to evaluate adhesion to the proposal, adequacy of the online platform, tutors' work, conditions conducive to the vector's proliferation, and solidarity networks. Data collection will be carried out through questionnaires, interviews, focus groups, and surveys. This is an innovative proposal that may contribute to social mobilization and the empowerment of population groups to tackle arboviral diseases (Fig. 5.1).

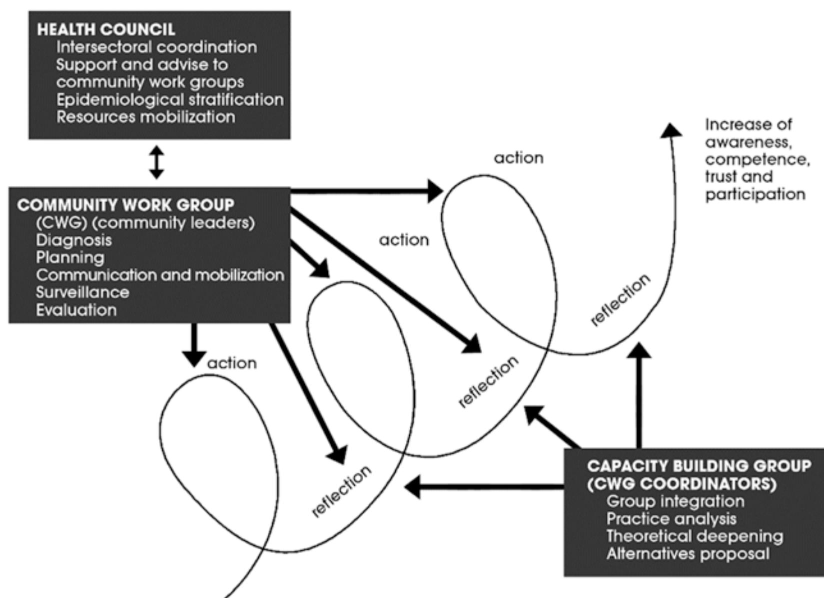

Fig. 5.1 Network for the control of *Aedes aegypti*. Illustration/logic model 1—Capacity building model for tutors and community committees for social mobilization to tackle arboviral diseases in Brazil—experience reported by René Rachou Research Center/Fiocruz—MG/based on article by Sanchéz et al. (p. 64) cited in consulted works

Manguinhos is a district that has a century-long occupation history. It is situated in the Northern region of the city of Rio de Janeiro and its spatial boundaries go beyond the limits officially established by the municipal administration. Its occupation presents a mosaic of distinct socio-historical movements, with the characteristics of having been the target of various unconcluded urban projects.

The name *Manguinhos* originates from the word “mangue,” the Portuguese word for swamp, and this is because before human intervention, it actually was swampland. The rivers that intersect the region had their course altered and receive most of the untreated sewage from the 10,000 dwellings currently in the district. On rainy days many of these rivers overflow in a setting of self-built housing, with no formal/legal regulations regarding either land use (ownership regularity) or construction process (e.g., unapproved height, mixed materials, improvised sewage systems).

Despite having a history that adds clientelist and paternalistic policies carried out by state representatives to the limitations (often violent) imposed by the police and by drug-trafficking gangs, that history has also known several movements and insurgencies in favor of the rights and life of its population on issues such as housing, health, sanitation, peace, and security, among others.

Located in Manguinhos district, the main campus of the Oswaldo Cruz Foundation keeps a historical relationship with the surrounding population, especially with the delivery of health services since 1967, with the inauguration of the currently named Health Center School Germano Sinval Faria (*Centro de Saúde Escola Germano Sinval Faria*). More recently, the relationship between Fiocruz and the populations that live in Manguinhos are based on the logic of “cooperation” with the local collectives and organizations, which is a concept present in the modern perspective of Health Promotion.

It is in this context that the Network for the Control of *Aedes aegypti* emerged in Manguinhos. In the face of divergent announcements on possible outbreaks of epidemics of dengue, zika, or chikungunya, all of them transmitted by the mosquito *Aedes aegypti*, the office of the president of Social Cooperation of Fiocruz received notification on the concerns of various local social activists. The entire Fiocruz scientific community was then convened for a meeting with representatives of the Local Residents Associations (*Associações de Moradores Locais*), the Community Council of Manguinhos (*Conselho Comunitário de Manguinhos*), and the Intersectoral Management Council of TEIAS (*Conselho Gestor Intersetorial do Teias Escola Manguinhos*—CGI-TEIAS)[3] to formulate action strategies.

The meeting took place in December 2015. Many proposals were put forth, and previous experiences with dengue control in Manguinhos were reported. At this meeting, an appointment was made for January 2016, and a plan was prepared for a *mutirão* (an action carried out simultaneously by many people and covering a large area) to inspect houses in the community, with the participation of community health

[3] CGI-TEIAS is a health council composed of representatives of users, health workers, and management workers. It has a deliberative character and has user representatives from various segments of the public health system (e.g., afro-descendants, women, youth).

workers, epidemic control personnel, Fiocruz workers, social activists, and representatives of the municipal administration.

This first *mutirão* raised various questions, taking into account the memory of events that had taken place in previous years in various contexts. These reflections gave origin to the “Plan for the Control of Territorial Aedes” (“*Plano de Controle ao Aedes Territorial*”) that was structured based on the following premises: (a) comprehensive understanding of Manguinhos territory, (b) presence of total territorial coverage of Family Health Strategy (*Estratégia de Saúde da Família*—ESF), (c) community participation in decision making in all stages of plan, (d) vector control drawing on ecosystemic approach and adoption of integrated management, and (e) use of various technologies validated by Fiocruz researchers for the control of *Aedes aegypti.*

Besides these premises, four axes of action were defined: (1) *Mutirões*: appoint public agents and organize civic society in the territory for education actions on health, collection, and destination of large unserviceable objects and home visits; (2) training: of health and environment community workers; youth in the community may be contacted and trained for permanent monitoring of possible mosquito breeding sites; (3) community communication and health: use local newspapers and other alternative media present in the territory of Manguinhos; (4) monitoring: establish a nucleus to centralize data resulting from the actions.

The second and fourth axes did not advance owing to a lack of funding. On the communication front, the newspaper *Fala Manguinhos* (“Speak Manguinhos”) is worth highlighting; it was printed and was published on Facebook by community residents, who approached the issue of confronting the epidemics in a sustained way. The *mutirões* were carried out with great energy until the end of the first half of 2016, guaranteeing that actions would be taken in each sublocality in Manguinhos.

The experience of the *mutirões* highlighted the precarious and inefficacious nature of garbage collection in the territory and the scarce clean water supply furnished by the state administration. Regarding health services, it was verified that the actions performed by community health workers and epidemics control assistants were not governed by the same territorial delimitation and so did not enable the planning of an effective home visit. This aspect motivated the collective to seek a meeting with the Municipal Secretariat of Health, which did not happen.

Another obstacle was the amount of hours the epidemic control assistants were allowed to work; until the end of 2016 they were not permitted by the central management of the municipality to work on Saturdays, Sundays, and holidays, which are precisely the best days to make home visits in the territory (on weekdays during work hours, most residences are closed because the dwellers are at work).

Final Considerations

The experiences reported and the reflections on the outlook on arboviral diseases in Brazil point to a series of obstacles that hinder the process of social mobilization necessary to tackle not only arboviral diseases but health problems in general. Table 5.1 shows a synthesis of the challenges:

Table 5.1 Obstacles in facing arboviral diseases

Obstacles
Absence of a plan to confront social determinants in health in vulnerable territories
Centralization of government interventions with low integration of states and municipalities
Vertical communication model, centralized and based on citizen culpability
Absence of territorialization and social mobilization, in which coping with "long-lasting" endemic diseases/epidemics results from the permanent triplet "action–reflection–reflective action"

To overcome such obstacles, our reflection suggests the creation of information networks for decision making, horizontally constituted and incorporating the democratic engagement of different social players in each territory. These networks may enable the development of alternative ways to tackle health problems. Drawing on minimal combined methodological elements, both distance and presential, it is possible to facilitate exchanges and interchange of local and regional responses, extending/replicating them, whenever possible, to other vulnerable territories with similar socio-environmental characteristics.

It is crucial to "move in the direction" of vulnerable territories, getting to know their realities "from the inside." This assessment serves as a starting point for the postulated social mobilization process. To begin with, it is vital to work from the premises of empowerment, equity, and sustainability, taking into account locally based diagnosis made by health teams and community, taking into consideration categories such as gender, ethnicity, race, culture, and the traditional knowledge that emerges from each social group in the mobilization process.

Therefore, it is also important to bring to the table reflections on the proposed social mobilization in which the people affected by the sanitary crisis should be actors. The participation in decision making for the development of public policies, the inclusion of community health surveillance actions, capacity building, and popularization of science, combined with the maintenance of research and assistance, potentiate other types of responses to arboviral diseases and other health problems.

People can be invited to participate in mobilization, but ultimately it is an individual decision whether or not to participate. The decision depends on people's perceptions about being part of the entire process and, above all, as being capable of enacting changes; this presupposes "a collective belief in relevance, a public sense of what suits everyone" (Toro and Werneck 1999).

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Chapter 6
Health Promoting Schools: Implementation Challenges, Barriers, and Lessons from a Case Study

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Introduction

The "Saúde na Escola" (SEP) program, established in Brazil on December 5, 2007, incorporates a set of initiatives developed in recent decades that focus on health care, organizational support, and parental involvement. Incorporating the international debate on health promotion and the premise publicized by the Pan American Health Organization through the initiative of Health Promoting Schools (WHO Regional Office for Europe 1996), the Brazilian program highlighted important lessons learned from experiences developed in different municipalities (Figueiredo et al. 2010; Silva and Pantoja 2009). The SEP has as its main objective an organizational change process that involves student engagement, intersectoral action, negotiated planning, and a health promotion approach to support the pedagogical project in each school. Partnerships and networking are recognized as crucial for sustainability. In this perspective, health services would be expected to share commitments

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L. Malagón de Salazar, R.C. Luján Villar (eds.), *Globalization and Health Inequities in Latin America*, https://doi.org/10.1007/978-3-319-67292-2_6

to whole-school development. Thus, the SEP tends to potentiate the consolidation of the Family Health Strategy (FHS) (Villardi and Cyrino 2012), considered as a priority strategy of primary care and crucial component of the universalization of public health coverage in Brazil.

The family health teams, composed of physicians, nurses, oral health professionals, and community health workers, are responsible for monitoring children's health through nutritional evaluation actions, early detection of hypertension and diabetes, hearing health, oral health, and psychological support in each defined geographic area. In addition, the FHS helps to ensure close collaboration between professionals and local communities.

Between 2008 and 2009, SEP created institutional routines, implementation guidelines, and political commitments involving the health and education sectors. School and Child Care Health Centers (SCCHC) in Rio de Janeiro were organized in accordance with their respective municipality programmatic areas, incorporating the social assistance, education, and health sectors. During the program's implementation, federal resources and financial support from the Municipal Secretariat of Education supported recognized needs and actions that could help to maintain the clinical, psychosocial, nutritional, and oral health of the most vulnerable students. However, these resources were also used to hire nongovernmental organizations (NGOs) to manage teams of doctors, psychologists, dentists, and nurses. The reason alleged by the managers was the low coverage of the FHS strategy. In Manguinhos, such a group created parallel and overlapping actions, threatening the integration of health promotion initiatives in schools.

Initially, the SHP in the city of Rio de Janeiro defined as a target the so-called Schools of Tomorrow, a set of 152 schools located in socially vulnerable regions and known for their high levels of drug-related violence, and 8 Spaces of Infant Development (SIDs) involving approximately 136,000 students. In the region of Manguinhos, a context of chronic poverty and social exclusion, in 2011 this strategy prioritized only 2 of the 152 local schools: the Maria de Cerqueira e Silva Municipal School and the Juscelino Kubitschek Integrated Center for Public Education. Although the SHP official design emphasized the role of FHS teams in child care and in the development of more comprehensive practices involving environmental, social, and cultural aspects of health promotion, these professionals' actions were kept in "mobile teams" hired by the NGOs from 2011 to 2014.

Methodological Approach

In accordance with Patton (Patton 2008), *"The evaluation of implementation processes is incremental, descriptive, continuous, flexible and inductive"* (Villardi and Cyrino 2012). From this perspective, it is important to highlight institutional routines, resistance, diversity of views, and conflicts between stakeholders in each local context. Frequently, there are discrepancies between what was laid down in the original program design and the actions undertaken during the implementation

process. Thus, it is necessary to explore the relationship between causal models, activities, contexts, and results (Weiss 1998), reinforcing the perspective that programs are "theories" and, once implemented, are immersed in open social systems that need to be interpreted based on permanent interactions with local networks (Chen 1990; Potvin et al. 2005; Salazar 2011).

The theories that guide actions and programs are not necessarily correct. On the contrary, they can reveal ambiguities, contradictions, limits, and vague goals. Furthermore, different stakeholders have different views, assumptions, and expectations. But the theories of programs configure the logical model of the program or the set of assumptions that articulate resources, activities, and results. Analyzing the theory that structures interventions we can understand the complex process of translating goals into activities in local context and feed back the information for decision-making and implementation processes. The analysis of program theory and implementation process reveals the goal of change and helps to specify how a program works and whether it is doing what it is supposed to do.

Based on this conceptual framework, a qualitative case study was undertaken to describe and analyze the implementation process. Evaluative questions were prepared to guide the program theory analysis and assess the implementation process in a local context. Such evaluative questions were arranged in a matrix (Appendix A). The evaluative questions guided the documentary analysis, and nine in depth-interviews were conducted with managers and health and educational workers. Moreover, one focus group with teachers and one focus group with students' parents were conducted during the course of the fieldwork between April and September 2014.

Results

Process Evaluation

The analysis of official documents revealed the endorsement of the principles of decentralization, regionalization, and universalization of healthcare present in the Brazilian Unified Health System (UHS). Aiming to contribute to a comprehensive approach to the public education system, program theory provides a rationale for clinical follow-up associated with participatory and intersectoral strategies. Interviews with federal managers showed the core principle of intersectorality:

> The program works by three principles: intersectorality, integrality, and territoriality. (Federal Manager of Health)

> The program's innovation is its application of intersectoral management. (Federal Manager of Health)

However, despite the intersectoral design, the difficulties present in the linkage between the federal entities affected the mechanisms of cooperation and, paradoxi-

cally, many times sectoralization. Furthermore, although a single information system has been established to be used by health and education professionals in a shared form, distinct databases were created for each sector. The monitoring of results was also hampered by the use of instruments closed and inflexible use of methods of data gathering.

> A system of health monitoring that is official does not exist; it is not being implemented in the municipality, and we cannot follow the implementation of component I (clinical and epidemiological surveillance). (Municipal Manager)

> The Information System of the Ministry of Education (ISME) was never enforced. (Local Manager of Health)

> Coordination of Programmatic Areas (CAP) submits reports and data, but there is nowhere for us to register … we do not want more information because we can't analyze it. (Federal Manager of Health)

Several problems related to management capacity and partnerships weakened the linkage between SHP and FHS. The absence of professionals in the education sector and low level of local health services combined to weaken the links between interventions. On the other hand, even if provided under program theory, the recruitment of health professionals through NGOs generated parallelism, a lack of transparency, and a waste of resources. There was little synergy between clinical activities, community engagement, and intersectoral strategies. In this scenario, program effectiveness was unclear.

The Challenge of Information Collection and Interpretation

Stakeholders' interviews and narrative descriptions of objectives, activities, outputs, and desired effects revealed heated controversies. Some respondents agreed that school should be monitored in accordance with clinical demands. However, teachers identified the priority of educational and participative components of health promoting schools beyond healthcare.

As for the municipal management of the program, the main focus of the SHP was supposed to be the connection between comprehensive, clinical, and health promoting actions. In this perspective, the implementation and monitoring of all actions should be reflected in the schools' political-pedagogical aims. Teachers and professionals of the FHS also believed in the necessary integration between a clinical schedule of SHP and intersectoral initiatives. However, there were disagreements over the allocation of responsibilities and the scope of actions. For some of the interviewed professionals, the SEP was intended only for Schools of Tomorrow that were covered by NGOs, so some nurses were specially assigned to child care and support of "mobile teams." These contradictory perspectives were, in part, due to the lack of transparency about the implementation process and the amount of public funds allocated for the program.

In accordance with the federal managers, the Ministry of Health (MH) was responsible for the basic healthcare grant and the Ministry of Education (ME) was

to guarantee material support. The uncertainty around these grants hampered local planning:

> Here in the city of Rio, it is a mystery, we receive a financial incentive from the MH for primary health care, but the material of the ME never came. (Municipal Manager)

> There is not a specific resource for school programs … this resource could motivate goal achievement. (Local Manager of Health)

The FHS team's routine included lectures, activities around oral health, anthropometric assessment, epidemiological surveillance, and health promotion practices, and although they could not be described as interventions related to SEP, they somehow met the program objectives. The boundaries between these practices and the SEP were, therefore, ambivalent, and the absence of systematized data on the scope of these practices was associated with low consensus about common responsibilities:

> It is confusing for the school and it is confusing for us. (Local Health Manager)

> For me the SEP works only for the application of fluoride … nothing else. (Teacher)

> The SEP that works is a health agent within the school. (Teacher)

> It is necessary to have a nursing technician in the school, for the anthropometry, for small bandages … this is not a teacher's work. (Teacher)

In addition to the controversies about the program's goals and each strategy adopted at the local level, the issue of healthcare was often associated with the precariousness of health services and the local environment surrounding the school:

> There is nowhere for me to refer my students with neurological problems and even with a medical prescription … there are no health services available. (Teacher)

> Healthcare is not a priority. (Teacher)

> I provided a referral form to a mother and she came back without healthcare. (Teacher)

> Sometimes the children have an injury for over a month … we ask the parents to bring them to the health service but they return alleging that there are no openings. (Teacher)

> I've had several emergencies, and when we arrived at the nearest hospital, they did not attend to the children's needs. (Teacher)

In Manguinhos no agreement was reached about the number of FHS teams and schools to be covered by SEP. In this scenario, the expansion of the program was driven basically by contract rules between the NGOs and the municipality. The "mobile team" linked to NGOs and the professionals of the FHS acted in parallel and with overlapping activities, compromising the program's efficiency and effectiveness:

> There were many conflicts. The FHS offered a thousand kits for oral health, as did the mobile team. How do you deliver 2,000 kits for 1,000 students? (Community Health Worker of FHS)

> While FHS professionals were acting in a school, the SEP staff arrives at the same school to do the same work. (Local Manager of Education)

> The program is expanding very fast, and it is necessary to monitor actions related to intersectoral management and training in local contexts. (Federal Manager)

Besides the fragility of decision-making arenas, the poor dynamism of community participation in Manguinhos hampered program monitoring.

Different Expectations

Between 2012 and 2014 little progress was made in the implementation process, and in accordance with the professionals of education only oral healthcare serves were developed continuously and systematically. Even so, the lack of permanent, ongoing dialogue among stakeholders compromised the articulation effort in Manguinhos:

> Sometimes the health team comes to develop an action for tooth decay prevention and application of fluoride in December when the kids are on vacation. (Teacher)

With regard to the mobile teams, the challenge remains the sharing of information and experiences. In general, for teachers the strategy adopted in the "Schools of Tomorrow" was effective and responded to the main demands of everyday life: completion of exams, emergency care performed by nurses when accidents occurred at school, and referral to more complicated health services. Considering the difficulties in accessing public health services, parents also approved the presence of health professionals in schools.

> The nursing technician has worked the whole day in the school … he administered fluoride, examined children's health state, and gave them a referral to health services. (Student's Mother)

However, because only "Schools of Tomorrow" had nursing technicians and supported mobile teams, it was difficult for the local managers, teachers, community health agents, and residents to determine which actions were associated with SEP and which with FHS. Furthermore, despite the principle of universalization of health actions in schools, the existence of professionals working in just a few schools without having a connection with primary healthcare services in Manguinhos was problematic. In addition, debate about the schools' pedagogical projects and the dynamization of local association was postponed.

Interdisciplinarity: Rhetoric or Real Strategy?

During fieldwork, there was a noticeable absence of strategies to encourage debate on health promoting organizational change processes. Health workers showed no interest in the demands of other sectors, thereby creating barriers to exchanging experiences and improving collaboration. Likewise, teachers were reluctant to modify their routines.

> The teachers' work, the pedagogical mission is completely different from healthcare. (Teacher)

> A teacher is not enabled as a health worker to prevent dengue or administer a vaccination … The government has handed over its duties to schools, which are outside their areas of competence. (Teacher)

> The math teacher is able to teach mathematical expressions … the Portuguese teacher is able to teach grammar classes … A teacher is not able to talk to students about their father's alcoholism, the domestic violence that affects their mother …. (Teacher)

> Schools do not have to deal with social exclusion … A teacher is not a social worker. (Teacher)

Despite treating interdisciplinarity as a strategic component of the program, it is not reasonable to expect a shared view or consensus between stakeholders in the implementation process. The construction of bonds of trust and strategies for reducing conflicts between sectors that traditionally compete for resources and recognition requires specialized skills and permanent, ongoing dialogue about the limits and possibilities of intervention in a local context. With no incentives to promote this integration and cooperation between social workers, teachers, and health professionals, SEP will not lead to effective changes.

Discussion

In Brazil, SEP requires heavy investment in primary healthcare and intersectoral coordination. Traditionally, the health and education sectors have had a hard time developing cooperative actions and reconciling their different interests in decision-making processes. In this scenario, SEP needs to engage in continual efforts to ensure interdisciplinary dialogue and motivate stakeholders. Without shared values among staff and a collaborative culture, health promotion programs and the whole school context involving the environment and community participation face enormous challenges. At the same time, targeting strategies must be constantly evaluated and reviewed. In Manguinhos, the focus on a reduced number of schools and the recruitment of health professionals without the necessary integration with the Family Health Strategy led to overlapping actions and weak engagement with the program's goals and objectives.

Disarticulated, outdated databases led to a limited scope of intervention. The information systems organized by sector nurtured a duality between educational and health actions. Despite the intersectoral nature of health practices, many programs and initiatives faced obstacles in producing multidisciplinary results. In this sense, concerning the experiences of health promoting schools, the health sector must value what the education sector considers as relevant evidence, and vice versa. Thus, resistance to collaboration, hierarchical conflicts, and parallelism can be reduced.

Conclusions

One of the greatest methodological challenges for the evaluation of complex interventions in the health promotion field is how to extend the lessons learned in one specific context to other realities, in other words, how to translate and use evidence based on contextualized practices to other settings without compromising their meaning. To deal with this challenge, evaluative tools and strategies must seek to reconstruct the process of implementing change theories and discover the extent of adaptation and conformity to the original design in each context. It is also important to recognize which program components tend to reveal greater dependence on the local implementation context. This is not a trivial task. Apart from the communities themselves and interest groups, institutions and decision-making arenas that are apparently "stable" can be remade or can react to specific circumstances in an unpredictable way.

Thus, the evaluation of possible discrepancies between an intervention's original design and their effects on each context can guide decisions about the expansion or continuity of programs, especially in health promotion. But to progress along this path, it is necessary to confront the mechanisms that link causal models to the impacts expected on the theoretical plane with the standards of interaction between institutions, resources, and actors in the daily life of programs and interventions. Health promoting schools involve vertical and horizontal collaboration. Close relationships between state and private institutions can favor a virtuous circle capable of mobilizing and coordinating—in a polycentric perspective, where power is distributed among multiple forms of organization—a network of resources, practices, and knowledge, in which participation and spaces for agreement are essential. Frequently, before the intervention advances with defined routines, responsibilities, and roles, conflicts emerge around resource allocation or information flows, and this may complicate the strengthening of the bonds of trust necessary for executing a common agenda. In intersectoral programs, it is reasonable to suppose that disagreements and controversies will tend to grow in the same proportion as the complexity of the required partnerships and alliances (Potvin et al. 2005).

Negotiation the possible alternatives to adopt in the implementation process must be permanently valued. It is important to explore how potential hierarchical superpositions remain or not, how the relations between actors are shaped, and in what way previous learning and experience influence perceptions about intersectoral actions. For example, the question of healthy eating in schools can strategically involve joint actions between local commerce, teachers, families, and health agents and thus expand their long-term effects. However, this will require ensuring an affinity between managers, professionals, and community. In Manguinhos, networking, collaborative partnerships, and exchange of knowledge are crucial for the program's success.

With regard to the methodological approach adopted in the survey, we believe that the use of a matrix with evaluative questions has contributed to understanding the program's design and implementation process. This instrument has fostered reflection on how and why multistrategy and intersectoral initiatives work and tend to achieve the desired effects in different local contexts. At the same time, the meth-

odological tool was useful in terms of supporting the analysis of adaptations and changes during the course of action.

Acknowledgments PDTSP-VPPLR/VDPT.

Ethical Considerations The research presented here was guided by a respect for privacy and the right to interaction free of constraints. In addition to direct contact with participants, individual e-mails and phone calls were used. All participants in the study signed an informed consent form. The research was approved by the Ethics Committee of the National School of Public Health and ethics committee of the Municipal Secretariat of Education.

Appendix A

Table 6.1 Evaluation matrix

Evaluative Matrix	Validity of program theory (I)	Implementation Process (II)	Linkages between program theory, implementation process and changes (III)
	Program theory model, mechanisms and desired outcomes and changes	Routines, adaptations, organizational practices, management strategies, partial results, conflicts and controversies	Obstacles, barriers, effects and changes, degrees of fidelity and adaptation of the program in the context validity of the theory and implementation strategies in the context lessons learned
	Evaluative Questions 1-What are the goals, resources and capabilities required in the program? 2-What problem does the program seek to solve? 3-What staff competences, monitoring system and intervention practices are expected? 3- What are the results expected at short, medium and long term? Considering the nature of the problem and the local context, is the theory of the program consistent? 4- What are the main controversies around the program design?	Evaluative Questions 1- How implementation agents interpret goals and program objectives? 2- What alternatives have been adopted? 3- How and in what way does the flow of information contribute to improve program implementation in local context? 4-Have new partnerships been established or have new agents been incorporated? 5- What were the contextual aspects and institutional contingencies that affect the implementation? Hpw does communities and families participated in implementation process?	Evaluative Questions 1-What were the changes related to the original design of the program? What were the effects of those changes? 2-What were the main obstacles? 3-Do program address the social context, local opportunities and challenges? 4- What worked, for whom and in what circumstances? What are the lessons learned? 5- How can the theory and the implementation process be improved?

Quantitative and qualitative data choices: documentary analysis, semistructured interviews, focus groups, direct observation

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Chapter 7
Health in School Program: Practicing Intersectorality on a Territorial Basis for the Future of Health in All Policies

Rita Andrade, Myrian Mitzuko, Cristina Passeri, Claudia Segantini, and Monica O. Simons

Introduction

> "… the centrality of Pathos,
> the recovery of Eros and the re-invention
> of the heart's logic are fundamental …" (Boff 1999:119)

Among other successful experiences developed in Brazil, this chapter intends to answer some of the guiding questions proposed in the monograph, inserting the description of the Health in School program, developed in the municipality of Guarulhos in the state of São Paulo in the southeast region of Brazil, as part of a federal program being developed in most of the national territory.

To contribute in a way that meets the proposed standard, justifying this contribution, this chapter was developed following a suggested script and tries to answer the posed questions.

As an introduction, we can start by affirming that many advances have been made in recent decades on theoretical concepts linked to health promotion. It is common to speak of social determinants or, more recently, socio-environmental determinants, under the shadow of the Sustainable Development Objectives with

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© Springer International Publishing AG, part of Springer Nature 2018

L. Malagón de Salazar, R.C. Luján Villar (eds.), *Globalization and Health Inequities in Latin America*, https://doi.org/10.1007/978-3-319-67292-2_7

their international agenda predicted by 2030, but there is still a great deal of distance between the theoretical construction and the desirable and necessary "praxis," so that we can actually talk about "health promotion" with results that really promote quality of life for all, thus going far beyond medical assistance to only avoid diseases.

To talk about health, it is necessary to speak of territory, and in doing so, one cannot be restricted to only describing a certain geographical space but must refer mainly to the people who occupy that space and the enormous complexity of social relations. Environmental and economic conditions that are established, with stories of struggles, dreams, victories and defeats, ventures and misfortunes, and how this whole universe is necessarily reflected in the health conditions of the communities, must be given due attention.

Thus, when one aims to understand and practice "health promotion," one must know and consider the complexity of the social and environmental determinants that affect each particular community, especially when the goal is the development of public policies that will bring about results on a large scale and of a long-lasting and truly transformative character; that is, it is important to take into account that health can only be promoted within particular localities on a daily basis!

As in other areas of social organization, health has historically been seen and constituted as the structuring of current economic models, generally not emerging from the Latin American reality but reaching it from culturally different and historically dominant countries, arriving at the level of the clear dynamics of "commodification of life," which in fact has been happening also with education.

The SUS—Brazilian Unified Health System (Law 8080 of 9/19/1990), emanated from the political process of retaking democracy in the country in the 1970s and 1980s, with the basic premise of decentralization of power at various levels of government organization, has taken considerable deviations, producing results that often fall short of expectations owing to the different conceptions in the SUS imaginary, such as

> …democratic, idealized by the set of proposals of the health reform movement; the formal, expressed in the constitutional text; the real, hostage of financial constraints, a result of readjustments and macrostructural reforms of the economy…; of poor people, impelled by the conception of the international organisms of focalization, and not of universalization, in social policies. (In PAIM, Jairnilson 2006, apud Cadernos da Regionalização COSEMS-SP 2007:7).

Despite this condition, however, over time significant advances have been made in the quality of national public health, having as its main tool the decentralization of management and a greater allocation of public health budget resources, enabling an "…increase of the organization of local health systems, improving the standard of service provision and actions"(COSEMS-SP 2007:8–9).

Finally, by Ordinance 687 of March 30, 2006, the National Health Promotion Policy was approved considering the principles of SUS, in the context of the Pact for Health with its components Pact for Life, Pact in Defense of SUS, and SUS Management Pact.

Today, in the international context, especially in Latin America, we are talking about the need to consider health in all policies (HiAP), and it is significant and emblematic that already in 2006 Brazil asserted in its National Policy for Health Promotion that

> …the promotion of health narrows its relationship with health surveillance, articulating the need for an integrative movement to build consensus and synergies and the implementation of governmental agendas, so that public policies are increasingly favorable to health and life and stimulate and strengthen the protagonism of citizens in their elaboration and implementation, ratifying the constitutional precepts of social participation. (MS 2006:11)

In the same way, in this same document, one reads: "It is understood, therefore, that health promotion is a cross-cutting strategy in which visibility is given to the factors that put the health of the population at risk…, aiming at the creation of mechanisms that reduce situations of vulnerability, radically defend equity, and incorporate participation and social control in the management of public policies" (MS 2006:11).

It is in this scenario, then, that Brazil has been looking for innovative results in its approach to promoting health, and it is evident that, although much remains to correct, significant advances have been made that can bring answers to key questions to qualify more and more what is understood by a real praxis in health promotion.

Contextualizing (Fig. 7.1)

Guarulhos: 1.221.979 Inhabitants/Surface: 342 km^2/30% still with green areas preserved/50% of waste water treated/housing problems (invasion areas), final destination of residues, environmental education, employment, use of drugs, violence, early pregnancy, insufficient water resources

Fig. 7.1 Guarulhos—Metropolitan region of São Paulo

Guarulhos is one of the 39 municipalities that comprise Greater São Paulo, Brazil's most economically important region, which also houses the largest airport in Latin America. With almost 1,300,000 inhabitants, according to the latest census of 2010 by IBGEI Brazilian Institute of Geography and Statistics, it is the 2nd largest city by population in the state of São Paulo, the 12th most populous in the country, and the 8th richest city in Brazil, with output representing more than 1% of gross domestic product (GDP). In recent decades, the city has undergone a significant verticalization and disorderly growth, attracting population groups from diverse regions and states who arrive in search of employment and housing opportunities.

This unplanned in-migration has led to the consolidation of an environment marked by strong imbalances and impacts, making the consideration of socio-environmental determinants a fundamental condition for thinking about health promotion, which necessarily implies public policies that can incorporate health into all policy decisions, as well as the guarantee of democratic instruments and social participation.

The management of this whole complex is governed by 21 secretariats, in addition to different coordination and other instances of the prefecture. Thus, the municipality has secretaries of, among others, the environment, public services, urban development, health, and education (Fig. 7.2).

The Municipal Health Secretariat manages more than 100 health facilities, including hospitals, Basic Health Units, 24-hour emergency services, specialty outpatient clinics, psychosocial care centers, dental specialties centers, Reference in Elderly Health, Health And a Public Health Laboratory, a human milk bank, sanitary transport service, Municipal Emergency Service (SAMU), street doctor's office, and a modern Zoonosis Control Center.

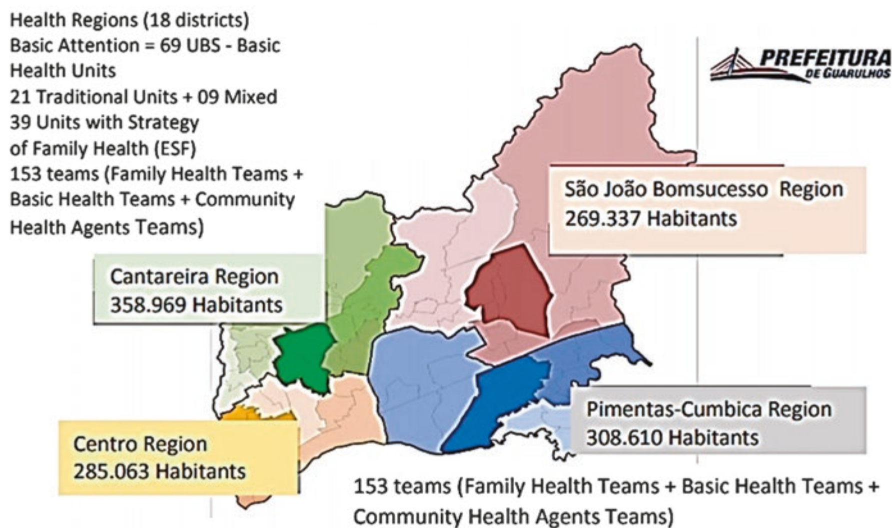

Fig. 7.2 The Municipal Health Department divided the territory of Guarulhos into four health regions

It offers integral assistance for individual and collective health to improve the quality of citizens' life. To this end, it carries out, among other activities, health promotion actions taking into consideration the multiplicity of socio-environmental determinants, as well as the protection and recovery of the population's health, reducing diseases, controlling endemic and parasitic diseases, and improving health surveillance. It counts on popular participation and social control acting as a democratic instrument for the construction of public policies for the sector.

The Municipal Secretary of Education runs 140 schools attended by more than 116,000 students and employs about 5000 teachers. Counting indirect employees, the Secretary of Education has approximately 8000 employees. Also part of the municipal network are the Municipal Centers of Education (CEUs) and Incentive Centers for Reading. It also has 55 schools serving 9400 children aged 0 to 5 years. Its education policy is based on participatory management processes both at the central level and at the teaching units.

The state schools of the municipality, under the management of the Regional Teaching Offices, constitute a universe of 87 schools in Guarulhos North and 88 schools in Guarulhos South serving a total of 174,000 students. It is in this context, very briefly presented, that the PSE—Health Program in the School, forms the center of this contribution to the Monography written and organized by Dr. Ligia Salazar, counting on other collaborators, besides the authors of this article.

PSE: School Health Program

As can be seen on the website of the Ministry of Health, the Health in School Program (PSE) was launched in 2007 by Presidential Decree 6286 as an intersectoral policy between Health and Education, focusing on children, adolescents, young people, and adults in Brazil's public education system that was implemented in an integrated way in an effort to promote health and integral education.

The school is considered a privileged locus where, insofar as one can work on the construction of values and ways of knowing and relating to the world, one can also develop critical and political thinking and thus contribute directly to the social production of health through the defense of the quality of life.

Based on the fact that the PSE's actions should form part of a school's political-pedagogical project, the program takes into account "respect for the political-executive competence of the states and municipalities, the socio-cultural diversity of the different regions of the country and the autonomy of educators and pedagogical teams. " Therefore, both health professionals and educators motivate the adherence of schools to the program and work to strengthen the basic principles of health promotion among students, teachers, and school staff, always counting on the support of area managers in education and health in the establishment of agreements and goals for each school year with the backing of the ministry, in terms of both technical support and the transfer of funds.

Based on the fact that the actions of the PSE must respect the reality of each school, the work of health promotion with students, and with teachers and employees, always has as its main starting point the knowledge and previous potential of the collective school to expose them to practices and attitudes that promote health and improve the quality of life of communities in and out of school.

The program is coordinated through intersectoral working groups (GTIs) based on shared management, in which both planning and execution of actions are carried out collectively to meet local needs and demands. That is, the work in the GTI presupposes an exchange of knowledge and a participative and shared management between health and education professionals, as well as between students, community, and other social networks and partners.

The organizational structure includes the Federal intersectoral Working Group (GTIF) and the State Intersectoral Working Group (GTIE), together with the Intersectoral Commission on Education and Health at the Ciese School. Thus, the municipal GTIs are composed of representatives of the health and education secretariats and, whenever possible, other local partners, and representatives of social policies and movements (youth groups, culture, leisure, sports, transportation, urban planning, civil society, nongovernmental sector, and private sector, among others).

In this way, schools participating in the program include health in the political-pedagogical school project, meeting the expectations of teachers and, especially, students, so that the themes to be explored within the scope of the PSE are debated in the classroom by teachers, guided by health professionals or directly by the health professionals themselves characterizing shared and joint actions respecting the specificity and competencies of the sector.

The program guidelines are as follows:

1. Decentralization and respect for federal autonomy.
2. Integration and articulation of public health and education networks, by linking actions of the Unified Health System (SUS) to the actions of public education networks, in order to broaden the scope and impact of students and their families, optimizing the use of spaces, equipment, and available resources.
3. Territoriality, respecting the realities and the diversity existing in the space under shared responsibility.
4. Interdisciplinarity and intersectorality, allowing the progressive expansion of the exchange of knowledge between different professions and the intersectoral articulation of actions carried out by the health and education systems, with a view to paying integral attention to the health of children and adolescents.
5. Integrality, treating integral health and education as part of comprehensive training for citizenship and full enjoyment of human rights, strengthening the confrontation of vulnerabilities in the field of health that might jeopardize the full development of the school.
6. Care over time, acting effectively on the shared monitoring of student development, carried out by educators in partnership with health professionals, providing for the reorientation of health services beyond their technical aspects in clinical care, which involves promoting health and a culture of peace; promote

the prevention of diseases; evaluate signs and symptoms of change; provide basic and integral attention to learners and the community.

7. Social control: promote the articulation of knowledge, the participation of students, parents, school community and society in general in the construction and social control of public policies of Health and Education.
8. Ongoing monitoring and evaluation: promote communication, interaction, and resolution between schools and health units, ensuring care and attention to the health condition of the students and informing actions taken in the monitoring systems. Evaluate the impact of the actions with the students participating in the PSE.

Program components:

1. Assessment of health conditions: anthropometric and nutritional assessment, evaluation of oral, ocular, and auditory health, verification of vaccination status, identification of possible signs related to neglected diseases and elimination.
2. Health promotion and prevention of injuries: food safety actions and promotion of healthy eating; promotion of physical practices and physical activity; prevention of use of alcohol, tobacco, and other drugs; promotion of culture of peace and human rights; prevention of accidents; sex education, reproductive health, and STD/AIDS prevention; environmental health promotion; promotion of mental health.
3. Training: formation of the Intersectoral Working Group; training of young workers using the methodology of peer education; training of health and education professionals in PSE-related issues at school and distance education (EaD) courses.

Each year, the municipalities participating in the program sign a Term of Commitment with an agreement on goals, with the Ministry of Health of the federal government, for the purpose of combining efforts aimed at the prevention of diseases, promotion of and attention to the health of students by the health program in school, articulated intersectorally between health and education networks. As already pointed out, this is a strategy to integrate public policies as a way to address vulnerabilities that jeopardize the full development of children and young people in Brazil's public education networks.

In turn, at the beginning of each school year, the managers of the participating schools and health units also sign a compromise agreement, agreeing on their goals, as well as the Health Regionals, taking responsibility for the goals that the municipality has agreed to with the Ministry of Health.

All data are fed in a unified information systems based on spreadsheets to be filled virtually on the Ministry website with a specific password for each municipality. Based on these data and the goals achieved, the federal government transfers financial resources to the Health Secretariat of the qualifying participating municipality.

Regarding the financial resources that the federal government transfers to each municipality:

Calculation of financial incentive ceiling:

- Amount of US$960.00 or R$3000.00 (three thousand reais), for up to 599 prospective students;
- From 600 (six hundred) students, each additional 1–199 students add US$320.00 or R $ 1000.00 (one thousand reais) to the maximum annual amount to be received by the municipality.

Criteria for transfer:

- At the moment the Municipality signs the participation term, the municipality receives 20% of the total resources allocated by the Ministry of Health, to the program, according to the number of students who will be benefited each year;
- When 50% of agreed goals is reached, the municipality begins to receive the value proportional to the reach obtained;
- The transfer of resources may occur up to 3 times, occur after an action, and be verified in the information system at 6 months and 12 months.

Information Systems and Monitoring:

At the ministry: monitoring is carried out through the following systems: E-SUS (Virtual Electronic Health Single System) and SIMEC (Integrated System for Monitoring, Execution and Control).

At the local level: The municipality has spreadsheets for each essential action of evaluation carried out by the teams; the data of each health region are later consolidated, and finally the municipality passes on the information to the ministerial level.

Health Program in School in Guarulhos

The municipality has always developed health promotion actions in schools, initially under a program called "Health Promoting Schools Program," carrying out actions with a more restricted focus. In 2010, the municipality adhered to the "Health in School Program" with the Ministry of Health, which had a systematic vision based on socio-environmental determinants and developed in an intersectoral way, aimed at strengthening the territories and developing through the following lines of action:

(a) Integration of public policies when establishing partnerships between the UBS and the schools;
(b) Development of program components;
(c) Regular courses, seminars, and thematic workshops for in-service training of health professionals and educators;
(d) Implementation of projects by teaching units;
(e) Diversification of educational resources suitable for all types of audiences and age groups;
(f) Performing a successful experiences exhibition biennially, with awards for the best experiences;
(g) Search for partners to enhance the development of actions.

Results

Because of the results it obtained since the program's implementation, Guarulhos was considered by the Ministry of Health, under the management of Dr. Alexandre Padilha, as the national reference point for the program.

The process of implementing the program has become more qualitative over time, having gone through several phases of adequacy. One of the most difficult issues to overcome was the practice of integrated and intersectoral work, both internally within each secretariat and between secretariats.

From the outset we faced significant resistance in schools to the entrance of health professionals, and health professionals also had difficulties in adapting to the complexity and specificity of the dynamics of schools.

These impasses were gradually overcome through an exhaustive and regular work of evaluation and monitoring, accompanied by several moments of dialogue in integration workshops with all the professionals involved regionally, always being careful to contextualize the actions according to local realities.

Another change that needed to be made was to get health professionals involved in regularly inputting information to the systems, regularly inputting information to the systems that was added to the new imposed by the Ministry of Health, demanded a concerted effort by everyone involved.

Faced with this scenario of joint growth and gradual correction of deviations, the municipality has presented a performance of increasing quality in several aspects that complement each other, namely:

- Increasing the number of schools in the public school system that are approved by the health teams and joining the program;
- Increasing the numbers of learners involved;
- Increasing the quality of integration achieved among health and education professionals;
- Increasing the number of partners from different segments of the social organization;
- Increasing the quality of the work done by schools, with schools awarded by PAHO in the third Ibero-

American Competition for Good Health Practices 2011, with the Environmental Seal of the Environment Commission of the Guarulhos City Council and in the Health Promotion Forums of the State of São Paulo.

Over time several results have been achieved:

- Early detection of signs of obesity, overweight, and malnutrition;
- Possibility of a better evaluation by the health and education teams on the need to intensify actions to improve results (actions of Component II, for example: evaluation of the quality of the food supply in cooperation with families);
- Better identification of Educandos in need of oral care, with activities of direct and indirect supervised brushing and delivery of toothbrushes and toothpaste, teaching the importance of correct brushing of teeth;

- Identification of students scheduled in a Basic Health Unit of reference for treatment;
- Implementation of new model of Pupil of the Eyes program, aiming at detecting, preventing, and providing visual health to students, contributing to school success, as well as raising awareness among parents and educators about the need to prevent and recognize signs, symptoms of difficulty or visual impairment, and visual changes, as well as the importance of early treatment. This program has guaranteed access to ophthalmological consultation, as well as provision of corrective lenses when prescribed;
- 100% vaccination coverage;
- Higher consumption of vegetables and fruits observed by teachers at meal times at school;
- Reduction in food waste;
- Decreased consumption of foods rich in sugar and fats;
- Adoption of sustainable practices for the consumption of natural resources such as water;
- Awareness of the environment, with respect to plants and green areas, proper waste disposal, and practices of selective collection of waste, combating the Aedes aegypti mosquito and caring for domestic animals;
- Evident multiplication of what has been learned by children with their families.

Immunological evaluation, anthropometric and nutritional assessment, oral evaluation.

Some Results (Fig. 7.3)

Component I (Tables 7.1 and 7.2)

Ocular health—total of students who received an ophthalmological consultation following visual acuity screening. Monitoring prescription glasses only from 2014, when we hire a Mobile Ophthalmology Assistance Unit, which performs the consultations in Polo schools, predetermined by the group conducting the Eyes of a Girl program (Table 7.3).

In the implementation of the program several types of evaluation tools are used, and different segments of the public are involved throughout the year.

The Health Department performs monitoring, but schools do as well by developing their projects mainly within the diversity of axes that are part of Component II of the program.

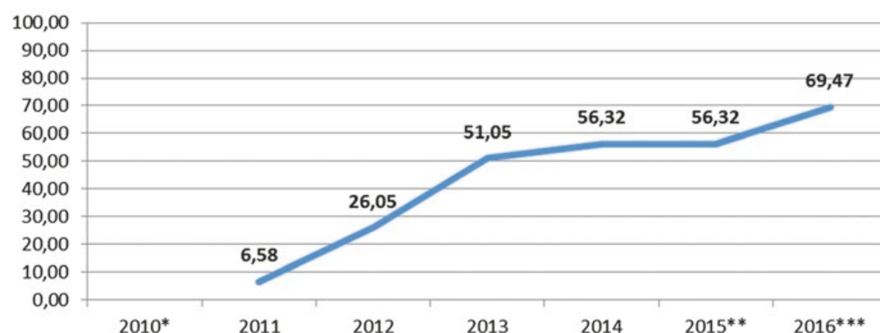

Fig. 7.3 PSE coverage indicator: number of schools approved in relation to total number of schools in public school system. (Source: Nucleus of Information Management—DARAS—Secretary of Health)

Table 7.1 Nutritional assessment—historical series. Source: DARAS—Secretary of Health 2015

YEAR	GOAL PSE COMP. I	Total Nutritional Evaluation	%	Total malnourished	%	Total over weight	%	total obese	%	Total with mal nutrition	% dist. Nutri
2013	113 707	88691	78	5485	6	12026	14	9398	11	26909	30
2014	114929	98711	86	4729	5	12182	12	9423	10	26334	27
2015	121191	92773	89	7515	8	13778	15	10437	11	31730	34
2016	149463	114200	76	5108	4	19451	17	16135	14	40694	36

Source: DARAS -Secretary of Health

Table 7.2 Evaluation of oral health—history. Source: DARAS—Secretary of Health 2015

YEAR	GOAL PSE COMP. I	Total evaluated in oral health -	% evaluated in oral health	Total with oral health needs -	% with oral health needs -
2013	113707	83844	74	30175	36
2014	114929	85530	74	35373	41
2015	121191	91153	75	38108	42
2016	149463	10496	67	40758	41

Source: DARAS - Secretary of Health

Table 7.3 Number of children benefiting from visual acuity program—Pupil of the Eyes. Source: DARAS—Health Secretary 2015

YEAR	Nº OF TESTS CARRIED UOT	Nº OF GLASSES INDICATED
Source: DARAS – Health Secretary 2015 Secretaria da Saúde 2015		
2010	1220	-------
2011	2291	-------
2012	3926	-------
2013	4400	-------
2014	5169	3074
2015	7299	4151

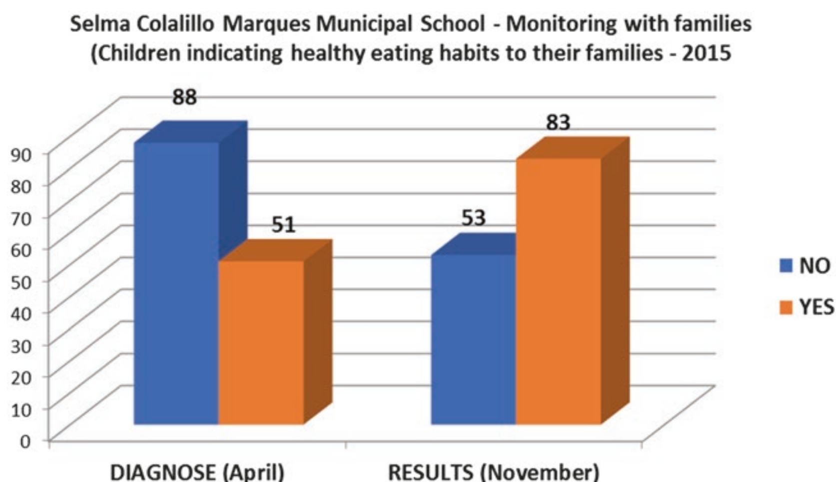

Fig. 7.4 Selma Colalillo Marques School—Monitoring with family members

Component II

For example, one indicator that is considered very important is the “Level of Learning Multiplication” by children, along with their families, since it is understood that health promotion begins with self-care by each family; this is one of the information tools used, in addition to sensitization (Fig. 7.4).

In this chart, blue columns refer to children's negative responses to talking about healthy habits in their families, and the orange columns refer to the child's affirmative responses. In the diagnostic evaluation in April, 88 children did not talk and 51 children did. In the evaluation of results in October, the situation is reversed, with only 53 who do not speak and 83 who do. In other words, the values of the columns are inverted, showing that the work done sensitized them, increased their knowledge, etc., mobilizing to play the role of multipliers with their families.

Component III: Formations, Seminars, Journeys, Successful Experiences, Contests

Historic Serie

2012

June 25: First PSE seminar, "Strengthening Partnerships," whose main objective was to establish a global and interconnected vision of the topics formulated with the Curricular Proposal of the Municipal Department of Education (Municipal Network Schools) and the Curricular Parameters (State Schools)

November 13: First exhibition of successful experiences of PSE, where 20 cases were presented and 8 awarded with cameras.

2013

January 23: Training in accident prevention and first aid

March 4: Opening of program with training in visual acuity screening with awareness of National Mobilization Week whose theme was Infant Obesity and Ocular Health;

April 4: First PSE conference (on adolescent health, child obesity, hypertension in childhood and adolescence, biology and control of dengue, attention deficit and hyperactivity syndrome, drugs in childhood and adolescence: aiming to qualify health promotion actions through intersectorality in the search for quality of life as potential results of the PSE),

May 28: PSE seminar on worker health and disease prevention.

June 26: Seminar on sexuality

August 13: Environmental education seminar on a way to promote health through school

October 29: PSE seminar: Taking care of one's body and healthy eating

2014

April 10: Mobilization Week: Culture of Peace seminar: "Corporal practices, physical activity, and leisure in a perspective of culture of peace and human rights"

August 15: "Meeting the Millennium Goals: Breastfeeding a victory for all life"

October 9: Adding forces in the fight against drugs: raising awareness, welcoming and preventing;

November 14: Second exhibition of successful experiences: "Promoting the exchange and sharing of experiences, strengthening and qualifying the participation

of all in the partnership." Health and education accounted for "18 experiences where 8 were awarded with a multipurpose speaker."

2015

March 9: Opening of the seminar program "Importance of Vaccination—Myths and Truths," focusing on the HPV vaccination campaign;

May 20: "Overcoming Homophobia: Challenges for Health and Education";

August 11: "Healthy Food and Food Safety: Practices to Promote the Quality Of Life";

November 12: Seminar: "Environmental Education—A Look at the City, Quality of Life and Health at School"

2016

February 25: Targets scorecard, with signature of regional compromise terms and Talk Wheel about the aedes mosquito;

April 12: Second PSE day, with the following themes: together in prevention: discussing gender and sexuality; nutrition in schools; restorative justice contributions to the culture of peace; dealing with the abuse of psychoactive substances in childhood and adolescence;

June 23: "Together against the Mosquito" contest. Awards for works in the following categories: drawing or painting, comics, slogans, and parody—12 award-winning schools;

November 18: PSE seminar: "Cultures and Practices of Inclusive Education from an Intersectoral Perspective"

Intersectorality and SETP—Health in All Policies

This is the core of the work that must be done when thinking about health promotion, and if we accept that to promote health we need to consider the diversity of socio-environmental determinants involved, we are necessarily talking about complexity and, therefore, of inter- and transdisciplinarity.

From this point of view it is practically unfeasible to imagine that health can be promoted by a particular secretariat. This statement strengthens the idea of the importance of being strategic by applying intersectorality.

The PSE in Guarulhos is placing increasing emphasis on this format, which is obviously still in process since it represents a relatively new approach. Throughout these almost 6 years of implementation of the program, we have noticed that there is a significant gap between theory and practice when it comes to intersectorality. In other words, the majority of professionals in the program affirm that it is an important and necessary strategy, but when intersectorality is applied in practice, sharp resistance is encountered; this resistance can arise in the form of, for example, definitions of identities and skills, difficulties in engaging in productive dialogue, and conflicts over the roles that the partners in each segment should assume.

In our experience, even though considerable improvements have been made, all these situations have taken place and are still happening, especially when new actors begin to

form part of the intersectoral network. Over time, those who have grown into the role of managers have learned to deal with these deviations, using different tools, namely:

- Promotion of evaluation workshops on a regular basis, providing spaces for discussion, always in the presence of the various actors involved, to promote an analysis of deviations;
- Provide conditions so that they are themselves involved in deviations, which are stimulated to propose solutions that are closer to the ideal of intersectoral work;
- To promote reliable information and communication about the characteristics and specificities of the dynamics of each of the segments involved, for the purpose of facilitating understanding of the different modi operandi and qualifying the entry of one actor into the field of the other, seeking to minimize the natural friction caused by modifications in the routines of work customary to each area;
- Permanently visit UBSs—Basic Health Units and the UEs—and teaching units to “feel” in loco, when intersectorality is actually happening in practice, or when there is are noises of miscommunication or a confusion over roles and elevations, creating obvious friction and tensions in interpersonal relationships;
- The creation of a regulation for the samples of successful experiences, in which a point of high evaluation of the projects is precisely the level of intersectorality achieved.
- To hold PSE seminars in three consecutive years as part of the official program of Education Week, which will necessarily end up strengthening the quality of intersectorality, increasing its scope.

We understand and know in practice that the role of managers is of fundamental importance. There are different levels of management in the program. Two people coordinate it from the municipal Secretary of Health and Education and two others from the two state Departments of North and South Education.

On the other hand, at the central level, an Intersectoral Working Group (IWG) was created, with representation from each sector involved (public sector, civil society, and private initiative) and representatives who have a voice and a vote in the management decisions of the program. Finally, in each territory, other intersectoral collectives are created, involving several actors as each reality or project is being developed, and the management in this case is the responsibility of the managers of the UBS of the surroundings of the schools and the vice-directors of the teaching units.

The role of the GTI has shown to be strategic in contributing to:

(a) The quality of the management of the program, since it is a space of representation of each of the sectors or partners involved, where it is not only possible to carry out joint agreements but also to analyze deviations with a lot of transparency and can trigger shared processes of correction of deviations and
(b) What is expected of the results of the program to achieve its objectives, as well as to qualify the level of intersectorality, since it is known that we can only strengthen the territory if in fact there is intersectorality in practice.

Challenges and anticipation of future advances in the program:

- Maintain the PSE with the guidelines implemented throughout this period (2012–2016);
- Extend coverage to 100% of schools in the public school system;
- Strengthen the action of nutritional evaluation, finalizing and presenting the line of care of nutritional disorders with training in anthropometric and nutritional assessment for the nursing teams of AB—Primary Care Network;
- Initiate hearing screening in schools;
- Maintain the Ophthalmologic Assistance Mobile Unit, expanding the assistance to the state network and providing corrective lenses when prescribed;
- Strengthen the partnership between health and education more and more, so that professionals in the schools and Basic Health Units work in a more integrated way and understand the PSE not as something extra to be worked on but as a transversal opportunity that allows them to optimally fulfill their roles in health promotion;
- Improve the dynamics and deadlines for feeding municipal and ministerial systems with the results of local actions.

Conclusion

Analyzing some of the questions and challenges proposed by Dr. Ligia, we believe that the experience just described may answer some of these questions.

The first finding is that, despite knowing the importance, historically there is still a significant distance between theory and practice regarding intersectoral work. As reported, this was one of the first impasses that had to be overcome in the work being carried out with the program in the municipality of Guarulhos. Therefore, in answering the first question, we understand that in speaking of intersectorality we are necessarily speaking of complexity, and therefore there are several aspects of each alternative of the presented definition that can be applied; however, we believe that to speak of it as "a public health practice to control the influence of the determinants of health inequities, articulating sectors that have traditionally been outside the management of health programs "(SALAZAR 2013:2) is close to what we mean by health promotion.

Therefore, we understand that the definition indicates intersectorality as a strategy that necessarily implies both a managerial and operational/technical action in a process, which in our case is still in progress, already with evident advances but still Intersectoriality significant potential for further development.

Regarding the second question, we believe that the presented case confirms that we are indeed working in an intersectoral way and have made significant progress in overcoming the initial impasses arising from the lack of tradition in working in this way.

This initiative emerged in 2011 in the face of the history of a program that involved public school students as part of a public education system that needed to

be expanded in the face of a very complex social and environmental reality involving various social and environmental determinants.

As already described, the program has already been in existence for 5 years, and we intend to continue on the basis of the results achieved and because we believe that the intersectoral work makes it possible to envision ever bolder goals. In the ongoing processes, information tools, mainly virtual ones (social networks—Health in the School Program: https://www.facebook.com/groups/1608466092737548/?fref=ts) were constructed, both in terms of cooperation and integration between partners, with shared coordination through the establishment of an IWG, which meets monthly to ensure good management of the program.

The partners primarily involve the entire structure of the health and education secretariat, as well as other municipal secretariats, as well as representatives of the third sector and a private initiative, according to the different projects that the schools develop.

Regarding the third and fourth questions: Already since the late 1970s at the Alma Ata conference, the social determinants have been highlighted, which necessarily implies intersectoral work. The Brazilian Ministry of Health has assumed this condition mainly since the consolidation of the SUS (Law 8080/90) and bodies such as the Brazilian Association of Public Health believe and invest in the discussion and training of professionals with this vision.

Thus, the factors that contribute are diverse: a global movement linked to Millenial Development Goals and now to the ODS, the complex reality of a municipality, which necessarily implies considering socio-environmental determinants and therefore demands intersectoral work. On the other hand, as has been pointed out, the main factor that hampers intersectoral work is a lack of culture with respect to this practice, which has necessitated an intense process of training and permanent dialogue between the actors and parties involved.

Faced with this reality, several adjustments were obviously necessary, such as, among others:

- Increasingly qualify the processes of evaluation and shared monitoring of the different lines of action of the program;
- Make greater investment in the training of both health professionals and educators, not only for the themes inherent in Components I and II of the program, but also the practice of intersectoral work in the face of the specificities of each reality;
- Encourage regional agreements to better serve the local reality;
- Provide seminars for the exchange and sharing of successful experiences on an intersectoral basis, so that as a reference, they stimulate the participation of teaching units not yet engaged;
- Define ways of rewarding the best works as a way of stimulating increased competition each year to attract more schools into the program.

Finally, in relation to evaluation processes, several strategies are used that may reflect the inherent complexity of the program itself:

(a) Quantitative evaluations that reflect the number of schools and children affected by the program, according to the targets set for each region and approved by the Ministry of Health;
(b) Each axis of Component I implies individual evaluations of each student reflecting their health status;
(c) In the same way, each axis of Component II implies differentiated assessments according to the specificities of each; the assessment should be both quantitative and qualitative, especially concerning behavioral aspects, such as the adoption of sustainable practices.

Final Words

We affirm that the experience of implementing the Health in School program in the city of Guarulhos has been shown to be an excellent path for health promotion, mainly owing to its absolutely intersectoral character.

Since the program was implemented in 2011, many adjustments have been made gradually, according to the various evaluations that indicated a need to correct deviations. Always the has been not only to comply with numerical goals approved by the Ministry of Health but mainly to be able to verify behavioral changes and, therefore, habits that encourage the self-care of the community, allowing conditions to act with criticality and protagonism or, in short, the development of people's ability to prevent the loss of their health

The main lessons learned from the work through "intersectorality" were as follows:

- Strengthening the identity and potential of the territory's action;
- Empowerment and autonomy of local actors and partners involved;
- Optimization of time, material, and financial resources, with the appreciation of people's efforts;
- Development of concrete actions to prevent and promote health;
- Increase, empower, and qualify the ability to network by establishing networks of strategic partnerships;
- Strengthen the role of schools within the territory as spaces that disseminate good health practices in the community.

In short, we seek to contribute to the guarantee of rights in all its aspects by linking them to an intersectoral design that converges with the empowerment of students and the entire school community, with a sense of autonomy and protagonism of all participants, given the complexity and diversity of the socio-environmental determinants that characterize each community, seeking to build new partnerships and new strategies that guarantee health promotion to its full potential.

There is still much to be learned and built, but there is certainly already a meaningful and consolidated experience that allows us to know the details about where we are and where we want to go.

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Chapter 8
Strategic Analysis of Health Care Practices for the Homeless in Rio de Janeiro, Brazil

Elyne Montenegro Engstrom, Gisela Cardoso, Alda Lacerda, Mirna Barros Teixeira, Pilar Belmonte, and Regina Bodstein

Beggar[1]
This cold slab of paving
is where I make my bed
where I rest my hungry head
each and every morning.
I hold out my hands,
and stare into nothing,
while secretly laughing
at their outrage for my wounds.
An open sore on the street,
draped in shredded rags
small change and shopping bags
and eyeing the shoes on your feet.
Don't pretend not to see me out prone
as your eyes shy away from my form
don't disapprove my lack of decorum
for I am what you might have become.
Mauro Gouvêa

[1] ***Mendigo*** *// O chão frio da calçada / é onde faço meu leito / e com fome me deito / toda madrugada. // Ponho-me de mãos estendidas / com os olhos no vazio / enquanto secretamente me rio / quando escandalizam minhas feridas. // Sou chaga aberta nas ruas / coberto de panos rasgados / recolhendo alguns trocados / cobiçando coisas tuas. // Não finjas que não me vês estendido / nem desvies os olhos de minha figura / não reproves minha falta de compostura / pois sou o que poderias ter sido. // Mauro Gouvêa.*

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L. Malagón de Salazar, R.C. Luján Villar (eds.), *Globalization and Health Inequities in Latin America*, https://doi.org/10.1007/978-3-319-67292-2_8

This chapter systematizes and analyzes a model for working with primary health-care (PHC) teams specifically for homeless people in the municipality of Rio de Janeiro, a major metropolis in southeast Brazil. The chapter is organized into an initial introduction, which reflects on the main theoretical references that underpin the workings of such teams—in Brazilian law called *Consultório na Rua*[2] (CnaR) and, in this chapter, the intervention under study. The specific context where these teams work in the municipal region is then outlined, so as to frame the problem that justifies such an intervention, as well as its expected outcomes. Next, the section "The case of the CnaR teams in Rio de Janeiro" presents unpublished primary data from an evaluation study by health personnel with the Rio CnaR teams in 2016. This mode of service forms a strategy directed at the homeless population, on the principle of guaranteeing access to basic services, especially health services, and promoting comprehensive care. The importance of this study is demonstrated by how recently these teams have been introduced in Brazil and in Rio de Janeiro (about 5 years ago), the complexity and relevance of their work, directed as it is at such extremely vulnerable groups, and the lack of evaluation studies of how the CnaR teams work in practice. The methodology used, strategic analysis, is directed toward mapping problems, modeling interventions, and identifying key outcomes and the partnerships established (Champagne et al. 2011a).

Introduction

In Brazil and in other countries of Latin America and Europe, there is evidence of significant growth in the numbers of people who live out their days on the streets as places of refuge and residence (Castel 1993), embedded in a context of poverty, violence, and extreme social vulnerability, dispossessed and deprived of their basic civil rights, and posing an enormous challenge to health promotion.

This population is more vulnerable to numerous health problems, to violence, and to socio-environmental hazards, in addition to being socially and economically deprived, placing it at the margin of the social protection system. These people's exclusion is evidenced in a stereotyped image of criminality and promiscuity in the eyes of society. Concentrated in specific areas of large cities and with characteristically migratory habits, constantly moving about from place to place, the homeless encounter great difficulty in accessing public health services, either because of stigma or lack of information, documentation, or a registered, fixed abode.

Living on the street brings with it a diversity of situations that can be temporary or permanent, long or short term, from choice or necessity, and a diversity of related reasons. There are those who spend the greater part of their time on the street but have a fixed address; they make that choice. Others really have nowhere to live; they have abandoned their family or have none, and there are whole families living on the

[2] Literally "Street clinic teams" or "homeless care teams; most of the care is provided at PHC facilities.

streets. This heterogeneous group may comprise immigrants, jobless, former prison or psychiatric hospital inmates, and so on. It is generally concentrated in large cities and has the street as its chief source of livelihood. It has in common poverty, weakened family ties, and a diversity of health conditions, such as drug abuse, sexually transmitted diseases, tuberculosis, skin diseases, mental disorders, and various forms of psychological distress (Brasil 2008a, b).

In Brazil, federal government demographic and census data estimate a total of 101,854 people in a "street situation" in 2015.[3] In the municipality of Rio de Janeiro, the census published by the Municipal Social Assistance Department in 2013 indicated 5580 street dwellers, a contingent that practically tripled ($n = 14{,}035$) in the 2 years following the municipal census (Natalino 2016).

To meet the challenges associated with such a large and diverse population of homeless people, and taking Brazil's health promotion policy guidelines as a frame of reference, there is a need to reduce the systematic inequities in the social determinants of health while considering disparities in access to public services and to social rights. Reducing those inequities poses the need to construct differential approaches for the various different social groups involved, bearing in mind their differing needs (Brasil 2013, 2014). It must be borne in mind that the vulnerability of the homeless manifests in numerous dimensions, expressed in everyday barriers to quality of life, as in access to drinking water, to appropriate settings for tending to personal hygiene and bodily functions, food security, shelter from cold and rain, protected sexual relations, and even equity in conditions of life (and death). These adversities are direct influences in the higher morbidity and mortality in this group.

Given the vast inequalities of Brazilian society, it is of fundamental importance to implement sustainable public policies for more vulnerable, priority groups, so as to foster social inclusion and reduce inequities. With that in mind, in 2014 the Brazilian government reformulated its National Health Promotion Policy (*Política Nacional de Promoção da Saúde*, PNPS), reiterating principles such as equity, autonomy, individual and collective empowerment, territoriality, intersector collaboration, and so on (Brasil 2014).

In Brazil and internationally, health promotion has been considered a strategy for expanding equity in health and has been inspiring public policies and measures designed to respond to complex social problems, while seeking sustainability for the intended social changes (Carvalho et al. 2004; Brasil 2014). Complex social groups, such as the homeless, call for greater approximation between health promotion policies and public health policies. What is involved is not solely the magnitude and complexity of the issues, but the fact that the social problems and health inequalities are inseparable.

Note that Brazil's National Health Promotion Policy is to be operationalized within the national Unified Health System (*Sistema Único de Saúde*, SUS). One of the largest public health systems in the world, it is grounded in the extended concept of health and was set up with the participation of government agencies and organized

[3] Brasil. Ministério do Desenvolvimento Social e Combate à Fome. Sistema Único da Assistência Social. http://www.mds.gov.br/suas/ Accessed on 23 March 2017.

civil society (Brasil 1988). Health actions in the SUS range from primary healthcare (PHC) through to technologically medium- and high-complexity procedures, and universal, comprehensive care is guaranteed free of charge to Brazil's entire population. The health system gateway should preferentially be PHC, and in Brazil there is specific legislation that considers the Family Health Strategy to be a model of inclusive, priority care, with essential features that guarantee its comprehensiveness. PHC is the level at which care is coordinated, making referrals to higher-complexity services to suit each specific situation (Brasil 2011; Giovanella and Mendonça 2012).

With a view to strengthening the SUS and promoting individual and collective health by improving conditions of life, the National Health Promotion Policy emphasizes the importance of adopting social and health practices centered on comprehensive care, equity, and reduced vulnerability and health hazards (Brasil 2014). On that logic, health equity promotion policies were put in place, which make special provision for the health of the homeless and will form "*a series of health actions and services prioritised by disease severity, and will help to meet, in an egalitarian and universal manner, the SUS's greatest challenge of guaranteeing timely, quality access to problem-solving health actions and services*" (Brasil 2013:6).

On that same logic of responding to the principle of universal access and equity in the SUS, the National Primary Health Care Policy (*Política Nacional de Atenção Básica*) formulated and implemented in Brazil calls for specific healthcare teams to be introduced to serve the homeless, with the goal of expanding their access to public health services and guaranteeing healthcare (Brasil 2011). These teams can include a diversity of health professionals (doctors, nurses, dentists, social assistants, psychologists, nursing technicians, and community health workers), all trained exclusively to care for this population and to work in partnership with the Family Health Strategy and with other existing health facilities in the catchment area, in line with federal government guidelines on the organization and functioning of CnaR teams (Brasil 2012a, b). These guidelines provide for three different modalities of a CnaR team, from which local health managers can choose among considering their feasibility in the realities of each individual municipality. Modality I comprises two graduate (nonmedical) professionals and two medium-level personnel; modality II has three graduate (nonmedical) professionals and three medium-level personnel, and modality III is modality II plus a doctor.

The magnitude of the contingent of homeless people living on the streets, their greater vulnerability, and the difficulty of assuring their basic civil and health rights were the arguments that prompted social mobilization and influence in favor of federal public policies to address these inequities (Brasil 2012a, b). The nationwide introduction of CnaR teams connected with PHC and the SUS that began in 2011 and 2012 can be considered a result of that process. Since then, the number of CnaR teams has been rising, and in 2017 there were 133, 112 of them formally accredited, entitling them to direct federal funding by the Ministry of Health. However, the challenge remains for these teams to constitute effective arrangements for delivering comprehensive care to the population of homeless people living on the streets.

What is expected under the guidelines is that the CnaR will operate effectively to promote and expand homeless people's access to basic rights, especially to health, as well as to comprehensive healthcare through the primary and broader healthcare

systems (Brasil 2010) and to intersector services (social assistance, employment, education, housing, and so on).

The teams are multiprofessional and itinerant, as they must be to respond to homeless people's specific demands and needs in the context of their lives. In that respect, one of the key characteristics of the work is that users are approached directly wherever they are to be found, which makes for a more comprehensive perception of their conditions of life and their most pressing needs.

It should be remembered that being on the street in a city like Rio de Janeiro means dealing, on a day-to-day basis, with violence, drug trafficking (in a system that criminalizes users and traffickers), and clashes with security forces—all situations that confront the general public, but especially the homeless (Engstrom and Teixeira 2016). Considering the contingent of homeless people with mental disorders and abuse of alcohol and drugs, the program "Health in Movement on the Street" (*Programa Saúde em Movimento nas Ruas*, POP-RUA) was launched in 2010. This is considered the first experience in healthcare for the city's population of homeless.

This, then, is the context of the study presented in what follows, a scenario in which the usual challenges are greater still. Note that the city has made considerable progress in organizing health service provision for the general population. From 2009 onward, a PHC reform movement brought major changes to the model of health management and healthcare in the municipal region (Soranz et al. 2016). The number of Family Health Strategy teams grew substantially—population coverage by the Family Health Strategy rose from 3.5 to 70.0% between 2008 and 2016—and the scope of their work widened with the construction of a number of Family Clinics (the name given to PHC facilities working on that model of care). Also important in that period was the growing number of teams providing care for homeless people (to a total of seven in 2016). Each of the city's CnaR teams is attached to a PHC facility, that is, with use of its physical premises and services, the same as are available to the public with fixed addresses.

Despite the advances, there is still heterogeneity in how these policies directed to healthcare practices are implemented, whether in the field of collective health, epidemiology, or clinical care. The municipality of Rio de Janeiro was chosen for this case study on the rationale that it is Brazil's second most important metropolis, is highly visible internationally, and has a growing homeless population, added to which a large part of its overall population lives in communities where social conditions are poor and social vulnerability high.

The Case of the CnaR Teams in Rio de Janeiro

Building on the frame of reference cited earlier, data from an evaluation study in which strategic analysis was used will now be presented in order to permit an initial understanding of the intervention. Systematization of those data can afford a better understanding of the services and care provided by the CnaR teams, as well as their suitability and relevance in view of the complexity of the context and needs of the

homeless. In our view it constitutes a fundamental step toward a future evaluation study focusing on the program's outcomes and its effectiveness in achieving the proposed objectives.[4]

Theoretical and Methodological Pathway

The proposed theoretical and methodological approach involved applying an analytical technique known as strategic analysis, that is, the analysis of the appropriateness of the intervention under study in the context of the Rio de Janeiro Metropolitan Area. Following Champagne et al. (2011a), an intervention's appropriateness or suitability depends primarily on the epidemiological, sociocultural, financial, political, and geographical contexts in which it occurs.

This type of analysis is intended to respond to a series of context-related questions, such as the following: (a) Is it appropriate to intervene in this problem, given its importance? (b) Is the proposed intervention consistent with the problem's solution? (c) Is the intervention the most appropriate in the existing context? (d) Does the intervention address the main determinants of the problem and its target population? (e) Is it appropriate to intervene in this manner? (f) Are the goals initially set appropriate to the problem's solution and meeting local needs? and (g) Are those responsible for the intervention acting appropriately, considering their functions and skills? (Cardoso et al. 2017).

The case study design used to operationalize the proposed analysis valorizes the study phenomenon in its real-life context, that is, where the boundaries between phenomenon and context are not readily identifiable. In that situation, the setting is selected deliberately in view of its relation to the intervention selected for study (Yin 2015), in this case the municipality of Rio de Janeiro, where seven CnaRs have existed since their introduction in 2009. Multiple information collection techniques were used, as described in what follows, so as to triangulate and complement the analysis (Greene et al. 2001).

Champagne et al. (2011a) consider that the first step in a strategic analysis involves describing and delimiting the problem situation that led to the need to institutionalize the intervention (in this case, CnaRs, operating under Ministry of Health guidelines). To that end, first, texts produced by the national coordination and official documents, including guidelines, ministerial orders, technical standards, and so on, were examined in order to understand the problem in relation to its national context and, subsequently, in relation to the Rio de Janeiro municipal context. In addition, workshops and conversation groups were held, with the participation of key informants, such as national and municipal CnaR managers and health personnel, so as to understand the configuration of the problem in Brazil and in Rio de Janeiro (Teixeira and Fonseca, 2015)

[4]The study was approved by the research ethics committee of the ENSP/Fiocruz (opinion CAAE No. 45742215.6.0000.5240).

The second step of a strategic analysis seeks to analyze the appropriateness of the goals of the intervention. This required constructing a theoretical-logic model and an operational-logic model of the intervention. The models are visual representations of cognitive representations. Accordingly, the theoretical-logic model—visually describing a planned intervention based on a formal theory of actions—contemplates the causal hypotheses of the intervention, together with its resources, activities, and effects, in view of the objectives and targets it is intended to attain (Champagne et al. 2011b). The operational-logic model represents how the program will achieve the goals of the intervention, that is, what resources will be needed, the activities involved, and the effects produced in the short term (products), medium term (outcomes), and long term (impacts).

By modeling this innovative endeavor to afford access to extended care for homeless people, it was possible to describe the main dimensions of the venture systematically and explore alternative working methodologies, from which it could be seen what had actually worked or where, in providing healthcare, the project could advance in integrating know-how and expertise from the domains of clinical care, collective health, and the subjectivity and singularity of the subjects involved. The third stage included an analysis of the suitability of the strategic partnerships formed, that is, whether the partnerships selected for developing and carrying out the intervention were the most appropriate in the existing political and institutional scenario in the context of the municipality of Rio de Janeiro.

In the strategic analysis, it was decided to include the various actors and parties interested in the intervention (the stakeholders) to assist in the modeling, with a view to engaging all of them in the future evaluation process (Champagne et al. 2011C). The intention behind taking a collaborative approach (Rodriguez-Campos and Rincones-Gomez 2013) was to give due importance to the knowledge of those familiar and involved with the intervention on a day-to-day basis (Cousins and Whitmore 1998). The researchers thus endeavored to create a climate of partnership with the stakeholders by alliance building through a process of interaction at various points in the project. This stage is important for the evaluation team to learn the stakeholders' interests and the types of relation they have to the intervention. The main stakeholders identified are given in Table 8.1.

Table 8.1 CnaR stakeholders in Rio de Janeiro and their functions

Stakeholders	Functions
Municipal CnaR manager	Managing and implementing the seven CnaR teams in the municipality
Institutional supporters of the Program Area Coordination	Providing institutional support for the CnaR in their respective geographical catchment areas
Health personnel on CnaR teams	Caring for homeless in their territory
National CnaR manager	National policymaking and management

Source: the authors

Results and Discussion

CnaR teams began to be introduced in the municipality in 2009, but this intensified after the federal government issued guidelines for this modality of PHC for the homeless (Brasil 2012a, b). In 2016 and 2017 (the study period), there were seven CnaR teams working in Rio de Janeiro City, comprising about 50 health personnel engaged by the municipal management. The teams generally had four to five graduate members (all had one or two doctors, with a 40-hour working week, a nurse, a social assistant, and a psychologist; three of the teams included a dentist), plus a midlevel nursing technician and two to three community health workers. Because the teams were set up gradually over the past 7 years in various different areas of the city (that is, in contexts that differ widely both socio-environmentally and in the cultural characteristics of their populations), the participatory process was fundamental to constructing a logical model that would be able to capture the singularities of practices that have developed in response to users' needs identified in the contexts of their lives (on the streets). Thus, some teams' clientele was predominantly users who abused alcohol and drugs, especially crack, and they worked in scenarios where access was more difficult and involved violence and drug trafficking. Other teams worked in more central, commercial areas of the city, with clienteles composed of sex workers and residents of temporary slum tenements. In these examples, the teams' practices involved primarily harm-reduction strategies, either toward safer drug use or protected sex, given the greater risk of sexually transmitted diseases, such as HIV/AIDS, hepatitis, other infectious diseases (tuberculosis, respiratory diseases, diseases of the skin and mucous membranes), and unwanted pregnancies, as well as the specific mental health implications of drug abuse. Another team worked in a more rural area of the municipality, close to a municipal homeless shelter, so that its core clientele was the population of the shelter; there, the strategies that gained prominence involved clinical care (for older adults or acute clinical conditions), social support, and reintegration, with an evident need for intersector collaboration. Certainly, all these activities permeated the work of the various teams, but the emphasis could vary according to the social and epidemiological profile of their specific clientele.

The engagement of the municipal managers and health personnel working on the city teams was particularly important for the participatory construction of the logical model, without which it would have been impossible to identify the particular features of this intervention. The group's diversity afforded a broader view of care anchored in a collaborative endeavor by multiprofessional teams and made it possible to capture the different traits of the personnel involved in the day-to-day work, in the often synergistic and complementary roles performed by the personnel. In this way, there were no reports of a split between those who cared for the body and those who cared for the mind, among the endeavors of promotion, prevention, and treatment, or between healthcare and social work. Although each professional had a core competence, they stressed co-responsibility in caring for the homeless, almost all of whom were high-complexity cases demanding the construction of therapy plans built on a shared, broad clinical approach (Campos et al. 2010). The initial approach and care took place wherever the individuals lived, respecting their choice

of place of residence (on the street or in a shelter), although each team did have a care setting at a referral PHC facility. In this way, the goal of care was not to get people off the streets, much less to take a hygienic, street-cleansing view requiring forced removal. Respect for people's autonomy, both in deciding where to live and how to care for their health, revealed itself to be a guiding principle in the teams' practice (Onocko Campos and Campos 2009).

To construct the models collectively through the workshop, it was necessary to agree in relation to the theoretical-logic model, the various problems that prompted the proposed intervention, the goals of the intervention proper (advocacy for the "Why?" and "What for?" of the CnaRs), and their dimensions, which are largely revealed in the features of PHC and in the "best practices" in care for this population recommended in federal government technical materials (Brasil 2011). As regards the operational-logic model, the process involved a detailed description of the numerous activities undertaken by the teams (which the researchers consolidated), the related resources required, and the expected results.

The difficulty of quantifying outcomes and products (indicators), which are important for measuring the activities carried out during the day-to-day work, was observed in the workshop. Two reasons deserve special mention. The first was the lack of standardization among collection instruments, which involves different registration and monitoring forms for the homeless. That situation is complicated even more by the multiplicity of electronic patient record formats used in PHC in the city, none of which has specific fields for care for the homeless. This diversity of information systems and records also emerged in relation to the municipal Family Health Strategy, although indicators and information output reports were standardized. This was the second difficulty found in consolidating information on the instances of care by the teams: the lack of indicators and their respective goals, defined in advance by the municipal management, plus the absence of processes for monitoring the CnaR teams' actions. As a result, provision of care by the teams was disregarded in the monthly reports submitted by the PHC facilities to municipal and federal management, although dialogues between managers and health personnel were under way in 2016 to establish basic indicators for monitoring the CnaRs, as there are for other PHC personnel in the municipality.

Information production is a source of power for managers and health personnel in a healthcare and public health situation permeated by frequent political disputes and tensions. Accordingly, as a first step toward evaluating CnaR practices, the modeling supported timely group thinking on the intervention in question, with a view to understanding its theoretical and operational dimensions in all their scope and diversity. This confirmed the importance and appropriateness of the intervention considered here, in an extremely important social and health situation and a scenario of political change. It fostered adhesion to dialogue with the scientific community and, through the media, with society at large, making for broader thinking as to the intervention's sustainability. The information so produced also furnished input to negotiations that influenced decision makers in adopting best practices, as well as in directing public policymaking and funding. The institutionalization of monitoring and evaluation of those practices, including performance indicators—fully expressing the scope and comprehensiveness of the CnaR's work—made it possible to strengthen the

intervention more broadly, giving visibility to care for the homeless, which is still scantily represented in existing information systems.

In this case, the inevitable conclusion is that little importance is given to producing and analyzing managerial and clinical information on CnaR teams. That is, what was realized from the work and participatory construction was that, in a way, because of the lack of recorded information, the teams' work was "invisible."

Nonetheless, it was found that some of these activities could be monitored systematically using quantitative indicators generated in the day-to-day work, although others—because of their complexity and singularity—required a more in-depth approach, such as quantitative and qualitative studies to capture the effects of the intervention.

The Operational-Logic Model of the Intervention

The dimensions of the logical model that are based on features of PHC are in line with the theoretical references of Brazilian public policy (Brasil 2011, 2014), as well as with those present in the Brazilian and international literature that guide the practices of inclusive, comprehensive PHC (Starfield 2002; Giovanella and Mendonça 2012). These references were incorporated into the following dimensions of the operating-logic model: main health system gateway, continuity, comprehensiveness and coordination of care (essential features of PHC), and a community, cultural, and family orientation (derived from PHC).

Workshop participants noted that all the aforementioned dimensions were considered to be of great importance to the teams' work on the streets and at the PHC facilities. By the nature of the work on the streets with an extremely vulnerable population, an understanding of the dimensions of the territory, with an emphasis on the cultural and social characteristics of the homeless, was considered just as important to the success of care. Although acknowledged as a core guideline in the field of health promotion, intersector integration is not strictly considered to be one of the features of PHC. However, the importance of activities with regard to so-called intersector integration emerged from the reports of the health personnel, and, accordingly, this was also treated as a dimension of the model.

Note that a large number of activities were identified at different stages of integration with the health system and other sectors. However, it was decided that the model should not include all the connections recommended with a view to integrating resources, activities, and outcomes. That decision was made in response to the fact that the expected results depend on a set of interconnected activities, that is, on completely accomplishing the actions in each dimension and not on isolated activities.

Briefly, two models were constructed, considering the core nature of the problem addressed by the intervention (i.e., reflecting the teams' practices). It emerged that all the dimensions were interdependent and important for the full and successful accomplishment of the intervention.

Model 1

Problem: Vulnerability in health conditions among the homeless, with high morbidity and mortality, resulting in inequities in terms of access to, and the quality of, health services offered to meet their needs.

The dimensions are strongly connected with the model of care applied to providing care for the homeless, which is a model based on defending life through a comprehensive approach to promotion, prevention, treatment, and rehabilitation actions and operating through harm-reduction strategies on the basis of an extended view of care.

Dimensions: (Graph 2)

- First-contact or main-gateway access,
- Continuity of care,
- Comprehensiveness of care,
- Coordination of care.

A preliminary analysis, drawing on health workers' reports of their day-to-day work experience, made it possible to construct analytical categories, such as equity, access, autonomy, co-accountability (or participatory governance), and enhanced comprehensiveness, that give meaning to the CnaR's work. These pillars express the principles of health promotion and PHC, demonstrating a synergy among these principles in practice and in the CnaR personnel's day-to-day work.

Model 2

Problem: social vulnerability and abuse of the basic rights and right to life of the homeless; little integration with, or access to, public policies for social inclusion.

The dimensions are strongly related to cultural and community conditions, life in the territory (on the streets), violence, stigma, and residents' relations with this environment, their social relationships, social support networks, and family relations. Given the characteristics of the context, the issues of intersector integration and sustainability of actions and strategies interface directly with the complexity of health promotion initiatives and strategies. They configure the complexity and comprehensiveness of the intervention and, accordingly, the importance of including the multiple strategies developed by the teams (Graph 3).

The resources necessary to operate the intervention were considered to be the same for all its dimensions and were aggregated into the following groups:

1. Human resources: multiprofessional team, including a doctor (which Brazilian law terms a type III, higher-resolution team);
2. Physical resources (infrastructure, materials):
   - Infrastructure: rooms equipped for individual clinical care (gurneys, screens), a group or meeting room, user reception areas, hygiene conveniences (bathrooms), settings for basic health services (dressings, vaccination, sample collection for laboratory testing, pharmacy);

- Materials: data record forms, computers with electronic patient records, equipment for clinical care by doctors and nurses, materials for educational and cultural actions, harm-reduction materials (condoms, rapid tests for diseases such as HIV, syphilis, hepatitis), materials for applying a series of health actions called for in the municipal schedule of PHC actions;
- Financial: municipal funds to pay the cost of the actions, in addition to flexible funds for day-to-day activities (outings, self-care activities);
- Other: transport (car for the team, fares for users), communication system (land and mobile phones, team calling card), food;
- Relational (communication, empathy, involvement, accountability) (see attachments).

In operation-logic model 1, the four dimensions reveal the bases for providing comprehensive healthcare for the homeless with access to quality care in the PHC domain, as well as through integration with the broader healthcare system.

To the extent that CnaR teams constitute the main health system gateway, they seem to represent a strategy or a device for reducing the barriers between the homeless and their basic civil rights. These rights include access to the national health service, the SUS, and to social rights. With their differential care approach, the teams permit this population real access to a set of rights by connecting services and users. This does indeed constitute a valorization of the user as a citizen and human being deserving of shelter, care, affection, respect, and dignity. The work of the CnaR personnel will thus guarantee recognition for a group considered “invisible to public policies,” a crucial step toward social inclusion and greater health equity.

This invisibility and lack of citizenship were evident in the health personnel’s reports of users’ lacking (lost or nonexistent) documentation needed to afford access to the social services and benefits guaranteed by the state. Lack of documents (Barros 2015) is in fact a major problem because it prevents civil registration, identification as a citizen, and, consequently, access to services, thus feeding into a vicious circle of social exclusion. One of the CnaR activities was to help obtain such basic documentation, which could be arranged free of charge, reinforcing the bond between the teams and users (who would often ask teams to hold the original of their identification document).

CnaR personnel reported that the homeless often sought care from health services in acute disease episodes, situations involving clinical emergency or risk of death, bringing spontaneous demand on the day and at the time they need care, which are characteristics of the health–disease process that do not sit well with service appointment scheduling rules and rigid routines. As a result, users were unable to have their health demands met at PHC facilities that had no CnaR function and usually had to resort to emergency care. For the CnaR, constituting a gateway meant having a reorganized, more flexible work process focused on users’ needs and demands. That is, an “open-door” approach to its work at the facility and in the territory, welcoming and offering care to individuals wherever and whenever possible, creating *windows of opportunity for access and care***.**

Work organization included recording and analyzing the clientele’s epidemiological profile in order to plan and offer the necessary actions. However, the care

also contemplated users' needs and wishes, that is, their autonomy to decide and agree on the therapy plan, in accordance with the frame of reference discussed by Onocko Campos and Campos (2009). That therapeutic relationship meant building interpersonal relations between team and user that would underpin longer-term relationships. This made for continuity of care over time and recognition for the CnaR as a reference point whenever the user was in need of such care.

Comprehensiveness, recognized in the literature as one of the structuring features of PHC and expressed in integration among healthcare, health promotion, and disease prevention, is one of the key dimensions for public health service reorganization (Brasil, 2011). By analyzing homeless users' demands and needs and the supply of services in a territory, it should be possible to adjust the practices offered and expand production of comprehensive care.

A large number of activities had a bearing on the comprehensive care dimension, attesting to the plurality of clinical practices developed by the teams to contemplate emerging needs and vulnerabilities and the most timely actions to address them. Given the threats to life and health, it was necessary to identify vulnerable groups and focalize specific care actions for this group. The "triple burden of disease" epidemiological status (comprising infectious and noncommunicable diseases, plus the violence of living on the streets and external causes) resulted in situations of morbidity and mortality that were difficult for the teams to manage. As a result, and aggravated by certain cases where the clinical outcome was not success, the health personnel reported extreme anguish and even considerable stress in doing their work and felt the need for institutional support and mediation. On the other hand, they reasserted their enthusiasm and the power of the intervention resulting from the expanded scope of the practices involved, which, in addition to the schedule of services offered to all citizens by PHC facilities (Soranz et al. 2016), was extended by specifically tailored intersector and health promotion actions.

The menu of services included multiprofessional clinical care (including dental care), preparation of more suitable therapy plans, and monitoring of mental health problems and those resulting from abuse of alcohol and drugs, on a harm-reduction basis, plus integrated sociocultural and educational activities. Priority was also given to life cycles when vulnerability is greater, particularly monitoring for pregnant women, newborns and their mothers, and older adults on the streets.

It must be clear that, given the complexity, and often the severity, of clinical conditions among the homeless, healthcare cannot be limited to the actions of the CnaR team. It may be necessary to share care with other professionals, in matrix support strategies, to develop individual and collective therapy plans, while maintaining the reported extremely important support of mental health professionals and the Psychosocial Support Network (Campos et al. 2010). In addition, referral was often necessary to higher-complexity services, such as ambulatory medical specialities, diagnostic support, emergency care, and hospital admissions. Here, the coordination dimension figured significantly in that teams scheduled such services directly, monitored or made themselves responsible for regulatory and care flows, and participated in visits to other services with users and often their families.

When a team embarks on the process of working with homeless people, it must take account of not only the complexity and diversity of this population but the

importance of current knowledge of users in places where they live, which entails a living work process and a dynamic, flexible attitude toward users' needs, a care process that must accompany the volatile behavior of people living on the street and within its flows. These are people who are itinerant by definition, often moving about from place to place. One of the teams' challenges is to maintain "longitudinal" care considering this dynamic.

One important characteristic of the homeless is that they tend to seek health services only when their situation is very severe. In that respect, our concepts of suffering and disease must be more flexible and open-ended, particularly as regards the multiple forms of psychological suffering, which demand effort and attention beyond the labels and closed diagnoses that surround mental disorders, which are often unable to account for lived realities (Trino et al. 2015). The provision of comprehensive care also included mental healthcare, on the basis of a strategic harm-reduction approach. In addition, the CnaR had to work in partnership with professionals from other points in the healthcare system, especially the psychosocial care network, as well as in collaboration with other sectors, such as the social assistance service (Brasil 2012a).

Model 2, whose dimensions are care oriented toward community, culture, family, and intersector integration, brought experiences of activities conducted by the teams that were quite peculiar in comparison with those offered by PHC teams for the domiciled population. That meant developing practices tailored to a population that resides in vulnerable territories and precarious environmental conditions and is often violent and deprived of social rights and citizenship. Providing comprehensive care while dealing with those factors is a challenge demanding an intersector approach informed by health promotion.

Intersector integration is a requirement of the contemporary public health approach that draws a great deal of criticism and causes deep dissatisfaction. It calls for approximation, dialogue, coordination, and networking among various institutions and public services, and it can become particularly problematic, mainly as regards the capacity of diverse organizations to respond to the social demands and complex social problems in peoples' lives (Ckagnazaroff and Mota 2003:31). It is an important dimension of public health management aimed at surmounting sector-based practices of public policies and services, but ends up being costly and inefficient by producing action and results far removed from stated guidelines and goals. With a view to guaranteeing rights, it is also important to assure social participation as an essential requirement for legitimating social policy, and in that regard there are initiatives geared toward involving homeless people in policymaking through their organized movements. Public policies that are understood and defined as universal must be directed to guaranteeing social and civil rights.

Prominent among the actions in this dimension are approaches in the territory by visits to users' living and social spaces, health surveillance actions, such as the active detection of users whose lives are at risk or who fail to adhere to treatment, analysis of hazards and vulnerabilities in the territory-environment, and mapping of existing health and social care systems. In this connection, it was considered of fundamental importance that the CnaR teams use dynamic maps to locate social and healthcare facilities, use flows in their health territory, and learn the profile of the

homeless in order to understand how these people appropriate public space and belong to it. Often the main demand expressed by users is not for healthcare (even if, to the health professional, that may be what is needed), but rather application for documents, food support, work, or making contact with family. Responding to such demands often made it possible to perform other care, such as testing for tuberculosis, updating vaccination status, and so on. The CnaR team, often taking on the role of key mediator of this intersector network, would perform actions that were not necessarily clinical but that fostered inclusion in public services and policies. Examples of intersector actions are arranging with popular restaurants for the provision of services other than food, referring and accompanying CnaR users to apply for personal documents, negotiating with other social facilities in the territory in order to help users gain admission to shelters, promoting access to legal guidance (mainly for former prison inmates), facilitating access to vocational skills and places of formal and informal work, and mediating situations of violence.

Comprehensive care for this population in situations of extreme vulnerability poses diverse challenges for health workers and managers, such as including the family in provision of care, strengthening support networks and intersector networks, empowering subjects and groups, and guaranteeing access to basic goods and rights that favor social integration and citizenship building.

In summary, it can be said that for the CnaR's practice to be effective, it must be performed in such a way as to integrate the activities and expected results in Models 1 and 2. The impact of such practices is expected to be seen in their effects on expanding the homeless' access to health and other basic rights, reducing morbidity, mortality, and stigma, increasing autonomy and social inclusion, and, thus, reducing the inequities in this population's conditions of life and health.

To conclude, strategic analysis made it possible, first, to map the problem and its appropriateness for the population on the street and identify the various social factors involved, second, to model the CnaR intervention, identifying and describing the necessary activities and actors involved in carrying it out, and third, to identify the partnerships that are strategic to its functioning in the political and institutional environments where the intervention was introduced, the city of Rio de Janeiro. These three steps enabled evidence bases to be built up on the functioning of the overall proposed intervention, making it possible to capture ongoing innovations and possible advances in comprehensive care for the homeless, coordinated by the Rio de Janeiro PHC system,and to identify the intervention's limitations.

Final Remarks

Modeling of the CnaR teams' practices made it possible to understand their magnitude and complexity in providing comprehensive care for the homeless, a group whose conditions of life and health make it highly vulnerable. It also made it possible to lay the methodological foundations for monitoring this intervention performing future evaluation studies, and formulating additional approaches; further, it

produced information that demonstrated its power and effectiveness at reducing social and health inequities.

One fundamental issue in the literature, for both health promotion and public health, has to do with the need to incorporate approaches that take account of both the theory underpinning initiatives and their integrity, sustainability, and outcomes (Jackson and Waters 2005). It is also necessary to integrate different methodological approaches to evaluate the singularity and complexity of these practices, as well as their effectiveness at improving population health (Salazar 2009). The strategic analysis performed here afforded an initial approximation to understanding the context and salient aspects of the theory and functioning of the intervention. The goal was to focus on the suitability of the proposal and, accordingly, on the theoretical design and the influence of context, since those aspects provide the rationale for the intervention's implementation, but as yet with no concern for the effectiveness of its outcomes; that stage will be conducted *a posteriori*.

Complex interventions entailing major interference from context raise numerous difficulties for efforts to systematize proposals, identify outcomes, and evaluate for possible effectiveness. However, using the strategic analysis approach and constructing the operating-logic model made it possible to present a model of the CnaR that highlighted the series of activities that were effective at improving access and care for this population, as well as their power to reduce health inequities. The characterization of the intervention in terms of its main dimensions (the features of comprehensive care integrated with the guidelines of health promotion) seemed appropriate, given its amplitude and complexity.

The use of strategic analysis, in a participatory approach involving diverse stakeholders, helped elicit the CnaR practices, along with the activities, the care provided, and the results expected, with due regard for the context of the homeless population's day-to-day existence and the materials provided for the teams to intervene for its sake. There is certainly no doubt that the commitment and participation of the CnaR teams and other stakeholders were fundamental to this study. In fact, the encouragement and opportunity to conduct the study came largely from their interest, because those who work with the homeless are the most interested, which strengthened greatly needed partnering between researchers and members of the health professions.

The CnaR proposal combines features of PHC and health promotion, which gives it its innovative character. For that very reason, a certain amount of effort was necessary to systematize its main dimensions. Issues such as its integration with PHC, with the broader healthcare system, and with intersector networks represent ongoing challenges, for both health promotion and PHC in Brazil, and more specifically in the municipality of Rio de Janeiro. Collective health initiatives certainly have much to gain from this integrated approach, whose goal is to reduce health inequities.

The expectation is that this study will be the first step toward future evaluation studies and will underline the need for greater concern with decision making based on the evidence of both the suitability of the intervention's design and its outcomes. It has limitations, such as users' not being included in this phase of the study, as well as the lack of direct observation of the practices or more in-depth key stakeholder interviews. The sparse information available on enrolment in or provision of care also undermined the characterization of the context and the teams' practices. It is

hoped that such systematization and analysis will be explored and that data and evaluation techniques will be triangulated in a future stage of the study.

It should be borne in mind that to date few studies have sought to develop an evaluation approach focusing on the effects of CnaR teams' practices. On the other hand, it must be stressed that these teams' strategic work, which permits access to extended care for the homeless population, constitutes a significant factor in promoting health, reducing inequities, and extending this population's rights.

Giving greater visibility to the CnaR initiative can enhance its sustainability because there are still tensions and disputes among models of care and service organizations for this specific team modality, in addition to the more comprehensive threats to the guaranteed principles of universal and comprehensive care in Brazil's national health system. Public health is in crisis in Brazil as a result of the introduction of public spending containment measures, with knock-on effects on services in all municipalities. The visibility and publicity this has brought to the system is important to managers, workers, and users, given the CnaR's potential for reducing some of the multiple health inequities experienced by homeless people.

Acknowledgments The authors thank the municipal management of the *Consultório na Rua* teams of the Municipality of Rio de Janeiro, Jane Cruz, the professionals of the teams that took part in the workshop, and those directly involved in care for the homeless.

The authors acknowledge the Vice-Presidency for Research and Reference Laboratories (VPPLR) of the Oswaldo Cruz Foundation for its support and funding for this project under the Edital de Políticas Públicas de Modelo de Atenção à Saúde da Fiocruz, November 2015.

Appendix

Fig. 8.1 Entrance door

Fig. 8.2 Link 1

Fig. 8.3 Link 2

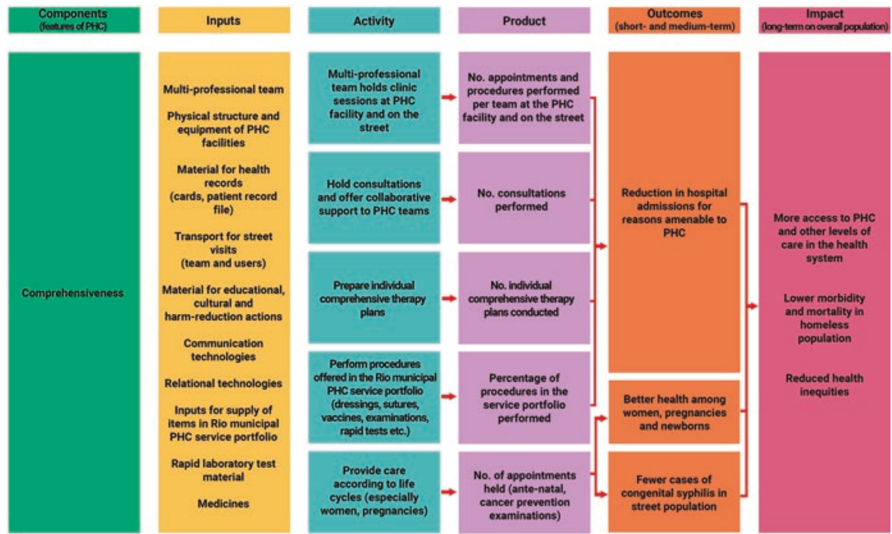

Fig. 8.4 Integrality. Part 1

Fig. 8.5 Integrality. Part 2

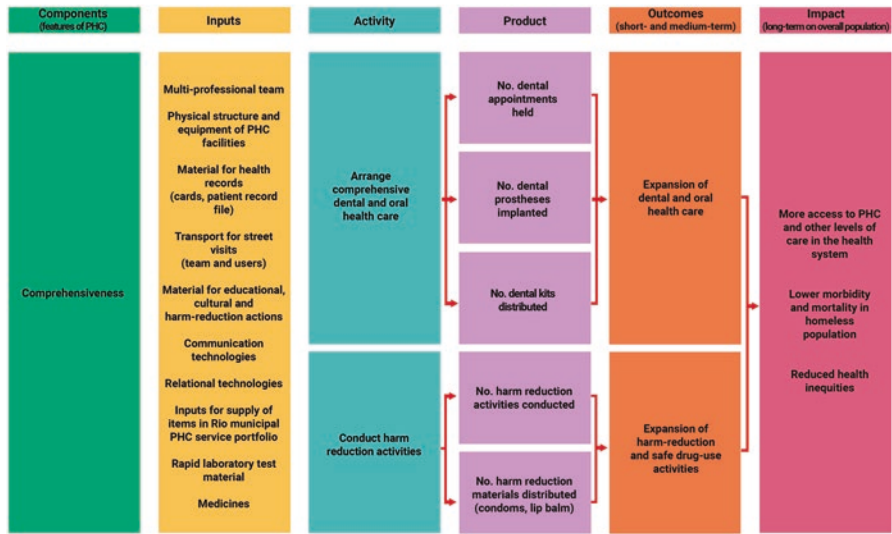

Fig. 8.6 Integrality. Part 3

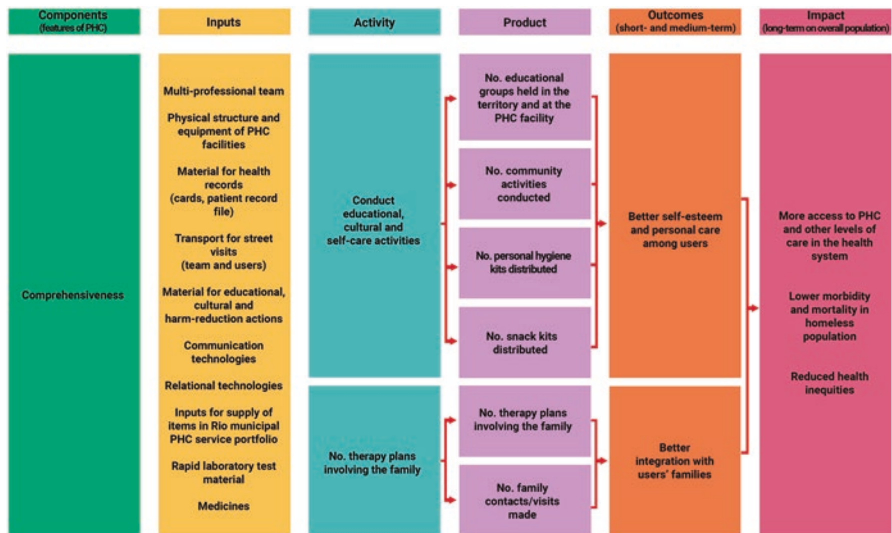

Fig. 8.7 Integrality. Part 4

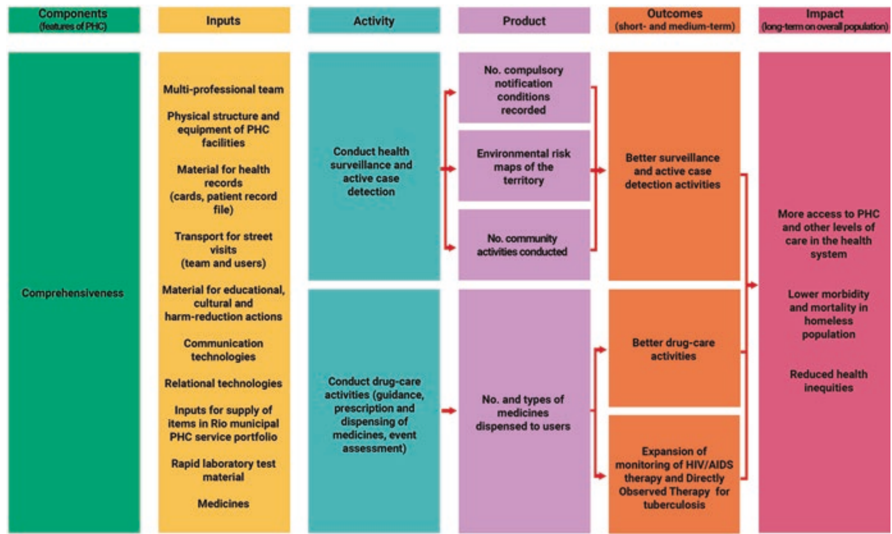

Fig. 8.8 Integrality. Part 5

Fig. 8.9 IV Coordination 1

Fig. 8.10 Community orientation

Fig. 8.11 II Intersectorialty

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Chapter 9
Linking Public Health Surveillance System to Policymaking and Local Development

Ligia Malagón de Salazar

Introduction

Despite the high importance given to public health surveillance systems as inputs for decision making, planning, and allocation of resources, in real terms, it is not very high on the list of priorities in most developing countries; on the contrary, it represent a major challenge. For years developing countries have been facing similar constraints regarding the production of timely and credible data as well as utilization of the available information. Several factors could explain this situation: (a) the low priority given by decision makers and health services providers to surveillance systems; (b) the scant resources assigned to maintain these systems; (c) poor links between surveillance results and health policy development; (d) limited local capacity related to technical issues such as data gathering, processing, and analysis; (e) utilization of surveillance data for planning, evaluation, and decision-making has been neglected and not always well received. In summary, key issues such as political will, community involvement, rationale behind decision-making processes, accountability partnerships, and communication strategies are not considered in surveillance system development despite their important role. Therefore, strategies and mechanisms for linking surveillance information to local planning and policymaking processes need to be developed through capacity building that exceeds technical boundaries.

Although some of these problems have been slightly mitigated, none has been completely eliminated, and some are even worse than before. What could be the main explanation for these persistent problems? Why have responses to the

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L. Malagón de Salazar, R.C. Luján Villar (eds.), *Globalization and Health Inequities in Latin America*, https://doi.org/10.1007/978-3-319-67292-2_9

aforementioned issues not produced the expected results? Are there alternative ways to face the limitations inherent in the problems and their solutions? Trying to respond to these questions, the Universidad del Valle, through the Center for the Development and Evaluation of Technology in Public Health (CEDETES) and the nongovernmental organization Foundation for Public Health Development, created a school-based surveillance system known by its Spanish acronym as SIVEA (which stands for "Sistema de Vigilancia de base Escolar"), which is a type of community surveillance system, having the school as the operation center. The main results and impacts, as well as limitations and drawbacks, of this tool are presented here.

Also, we will refer to issues related to the sustainability, impact, and weaknesses of the alliance between the participating sectors. In that sense, we will highlight three aspects that we consider useful for the analysis: first, the usefulness and effectiveness of interventions are not the only criteria that should be considered by decision makers; second, there is a need to articulate territorial structures and local resources to contribute to the sustainability of interventions; and finally, the role and responsibility of territorial actors in long-term transformative processes, especially government, local institutions, civil society, and international cooperation agencies that influence decisions, must be kept in mind. To better understand the results of this experience lets summarize the theory base and context where the SIVEA was developed and implemented.

Theory Supporting the SIVEA

Risk factor surveillance is based on behavioral and sociopolitical sciences, not only biological ones. Therefore, social inequities, social organization, social support, economic domination, and power relations, among others, are part of its theoretical and operative definition. It should also be recognized that scientific evidence is not enough and does not necessarily produce expected effects on events and associated factors (social determinants). As Nancy Krieger points out, "if social epidemiologists are to gain clarity on causes of and barriers to reducing social inequalities on health, adequate theory is a necessity not a luxury" (Krieger 2001).

The need to create surveillance systems that go beyond data release has been widely recognized. As a result, knowledge, communication, and action oriented toward behavioral risk factor preventions and control require new and innovative approaches, resources, techniques, and strategies. Risk factor surveillance systems have been recognized as powerful tools for building health promotion activities (Mokdad Ali et al. 2003), for predicting the future burden of chronic disease on populations, and for identifying potential interventions to reduce future burdens (Strong and Bonita 2003). Public health surveillance also contributes to the monitoring and evaluation of intervention, as has been recognized by many authors (Jekel et al. 1996), who have pointed out that repeated surveys can be used to determine changes in risk factors and changes in the frequency of disease in populations in a given period. Survey data combined with information provided by systematization

of experiences could be an effective alternative to making evaluation feasible and to increase the utilization of surveillance data. This type of surveillance should have a population-based approach, demanding that population and policymakers be co-responsible for and aware of the utility of data, participate when possible in the design and implementation of surveillance, and, finally, be shaped according to local culture.

According to foregoing rationality, risk factor surveillance systems must consider the following characteristics:

- The system should allow local capacity building to face preceived problems and challenges, as well as to reduce and control risk factors and create protective environments. The integration of surveillance with public health, health promotion, and primary healthcare (comprehensive health systems) has been widely recognized (McQueen and Puska 2003; WHO 2003a).
- The system should be defined according to geographical and social characteristics. It should be conceived within specific contexts/scenarios that motivate behavioral changes and protective environments. Gandhi, as cited by Lister, recommends, "To go back to the village"; it is in our community that true health is determined (WHO 2003b).
- Planners and researchers must be aware that motivation for behavioral change goes beyond scientific evidence.
- To ensure that surveillance results are utilized to improve health, the system itself must be a means for capacity building and not just an end. Being aware of this fact will allow us to consciously redirect our efforts toward this objective.
- The system should be oriented to define territorial structures such as schools, health centers, and workplaces, among others, so that relevant and timely answers to population needs and expectations can be provided.
- We recognized the role educational institutions could play as socialization spaces for information and knowledge production and sharing. For that, the target population and local actors must be co-responsible and participate actively in the surveillance system design, implementation, and utilization of information release.

Differences between risk factor and disease-oriented surveillance are important issues to be considered in the design of these systems. It is known that the criteria to select risk factors associated with disease have been based upon cause-effect relationships; however, the criteria to select behavioral risk factors must also consider eco-social and biopsycho-social theories.

Surveillance provides important input to generate new research questions, hypotheses, and etiological studies as part of capacity-building processes. On the other hand, there has been a tendency to adopt blame the victim lifestyle theories, which emphasize the individual's responsibility to choose so-called healthy lifestyles and to cope better with problems. In contrast, the new approach explicitly addresses social, economic, and political determinants of health and disease in a population, including structural barriers that prevent people from leading healthy lifestyles (Abel et al. 2000; Krieger 2001).

Closing the gap between information and action implies the *integration of surveillance data* with information from other sources, to get a clearer vision about not only risks, but also the feasibility of change. For that reason the information that is gathered should make sense not only for data collectors but also for primary users. In the case of behavioral risk factor surveillance, we must obtain more information about aspects that motivate behavior changes and conditions that contribute to these changes. The information has been used to design and articulate school and municipality development plans, to monitor changes in schools, to advocate for interventions related to risk factors and healthy environments, and to sway public opinion about major health determinants in the municipality.

The interdependency between individual and collective behavior, shaped by the context in which it develops, has been well recognized. Therefore, interventions must go beyond reducing risk exposure to bring about structural conditions that can promote health, social interaction, and control with a multilevel and multifactorial vision. These interventions should include interpersonal relationships, culture, public policies, and legislative and organizational features and resources.

The concept of territory is first and foremost a social construct containing various ways to, from a systematic view, understand social space, cultural production, and reproduction. The social construct does not simply refer to a mental representation, according to Moreira (1982):

> The territory is the materialization of the permanent process of social reproduction. Given that this process does not develop isolated from natural conditions, but that these conditions are permanent and allow for such a process, it must be clear that, although the territory cannot be reduced to geo-ecological conditions (whether originating or transformed), one can talk about territory (or society) without taking into account those conditions. (1982:41)

As is known, population surveillance systems, more than any other type of surveillance system, are affected by sociopolitical context: In Colombia contextual factors such as health reform, local and national infrastructures, decentralization, and privatization of health institutions, among others, shape and affect any strategy that tries to change power relations between the different service providers and decision makers. The context in which surveillance is carried out is critical. Its implementation should be rooted in local structures and resources, using appropriate methods and techniques to collect, process, analyze, interpret, communicate, and utilize information, to change health and social conditions. We are not only facing health inequities but also a lack of opportunities and unequal access to information and power to influence decision affecting our lives.

Harrison (2000) stated that surveillance systems should be developed and managed within a local context at a level where they can be understood and used to improve population living conditions. The World Health Organization (WHO) has recognized this point, stating that strategies that focus on shifting the entire distribution of the risk factors will prevent more disease than would be the case if only high-risk groups were targeted, and prevention strategies targeting the whole population aim to encourage healthier behavior and thus reduce exposure to risk (Strong and Bonita 2003). Zimmern et al., as cited in WHO (2003b), have addressed the issue of knowledge and evidence when making decisions. The authors' point of

view is that, in "making policy decisions, we do not distinguish between those two, and if evidence replaces judgment, how does that relate to the political risk that elected officials as policy makers are supposed to take in terms of making judgments?" Finally, it was mentioned that, regardless of the amount of evidence one has, a judgment about how to understand something rather than knowing it will always have to be made.

Background

The different approaches taken (at different times) by the Universidad del Valle through CEDETES to studying and serving the population of the municipality of La Cumbre have left a series of lessons that will be shared in this chapter. As a result of the alliance between the municipal government and Universidad del Valle, various studies were conducted for the purpose of strengthening the municipality's capacity to face challenges surrounding the health and well-being of its population: the school-based surveillance system (2003); perceptions of risk factors associated with chronic noncommunicable diseases (CNCDs); the community information system in primary health care (SICAPS) year; epidemiological–sociological analysis, municipality of La Cumbre (2012); social determinants of health and community participation (2014); intersectoral management for addressing inequities in health from the municipal territorial entity: capacities, limitations and challenges (2015); capacity building for local development in the municipality of the summit—Cauca Valley 2015–2018 (2016). This study presents the results of different workshops, in which the expectations and proposals of participants were identified, applying exploratory/consultative techniques, regarding key issues for building local development plan.

By the late 1990s, the Centers for Disease Control and Prevention (CDC) had been able to institutionalize four strategies to support schools and local agencies in identifying and implementing effective programs and policies to prevent health problems: (1) monitor critical health events, policies, and school programs to help reduce the risks of these events; (2) synthesize and apply research to improve school policies and programs; (3) provide support to implement policies and programs in schools; and (4) conduct evaluative research to improve such programs. The application of these strategies, along with other education and prevention initiatives at school, showed that schools could help prevent cardiovascular disease, cancer, and diabetes. The experience of the CDC has amply demonstrated the effectiveness of school-based surveillance systems in improving the health of populations (CDC 2000 Chronic Disease Notes & Reports, National Center for Chronic Disease Prevention and Health Promotion. • Number 1 • Winter 2001).

In 2003 we set out to test the surveillance system in rural areas with different social and geographic conditions, as well as needs, facilities, and resources. SIVEA is supported by the same principles, but its operation changed to respond to new conditions and challenges.

Description of Surveillance System

What Does SIVEA Mean?

SIVEA is defined as a set of interrelated elements and resources that, through different methods and techniques, collect, analyze, interpret, deliver, and promote the use of information on risk factors and social determinants of health of the school-age population and their families. It has a dual objective: create capacity to monitor and intervene with more frequent risk factors in this population, and generate information to direct policies and programs that contribute to people's health and well-being. Hence, the SIVEA system not only produces information but also promotes dialogue and consensus building between data producers and policymakers (Fig. 9.1).

Characteristics of SIVEA: simplicity, flexibility, acceptability, and opportunity. (a) Simplicity was considered in the design of the system and in the structure of its operation, which correspond to the characteristics and culture of primary and secondary educational institutions (schools); (b) flexibility consists in the inclusion or replacement of different variables of interest to improve data quality; (c) acceptability is addressed by involving the educational community and other actors and municipal sectors in the different stages and activities required for the development of SIVEA, defining levels of responsibility and agreements for compliance; (d) the opportunity criterion relates to the identification of the moments in which information is needed according to institutional and community culture.

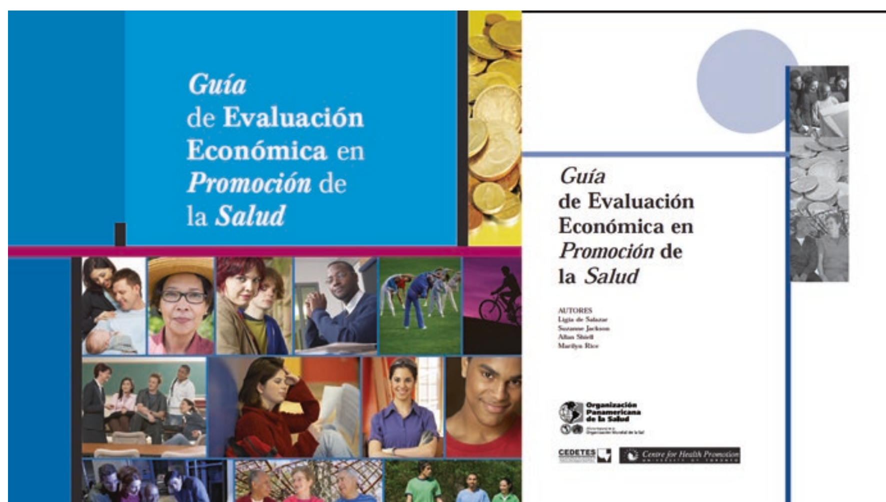

Fig. 9.1 Evaluation guide to socioeconomic status of health

Objectives

General: Strengthen individual, collective, and institutional capacity to produce and use information on behavioral risk factors and determinants associated with the health and well-being of the school population and their families.

Specifics

- Identify the occurrence and evolution of risk factors of behaviors and associated factors present in the school population and their families, using tools, mechanisms, and resources of the educational institution to produce, analyze, and interpret data and information.
- Incorporate into the school curriculum and pedagogy (pedagogical model) the actions of SIVEA and the programs available to respond to identified risks.
- Provide timely, relevant, and reliable information to decision makers and different authorities related to adolescent health and well-being that helps to reduce/control risk behaviors in this population.
- Provide information and advocacy to key actors in the territory, especially those responsible for the health of the adolescent population.
- Monitor and evaluate the effectiveness of SIVEA in terms of performance during implementation and compliance with objectives, impacts, and costs.

Variables and Categories of Study

The selection of variables was based on a review of literature on adolescents' health problems, theories about the behavioral risk factors for this population, and analysis of the structural aspects that condition their lifestyles; the adaptation and adjustment of instruments with similar purposes in other countries; and finally, challenges and structural problems identified by the participating educational institutions, as well as by the municipality. It was established that information should be collected once a year, prior to school planning. Other sources of information were taken into account in the analysis of the data provided by SIVEA. These include the municipality information system; development plans reports, censuses, and community surveys; visit records; and data from theater and games.

Implementation

SIVEA was implemented in the municipality of La Cumbre, which is a 90 minute drive from Cali the capital of the department of Valle del Cauca. Characteristics of surveillance systems, such as the systematic and periodic collection of information,

were incorporated, but emphasis was placed on the combined use of quantitative and qualitative methods and the need for information to be relevant and adequate to the interests, needs, and time for decision making at the institutional and local levels. Resources and school infrastructure were also used to implement the system.

For its operation, SIVEA is based on a pedagogical model that incorporates the functions of the surveillance system into curricular planning and daily school activities, as well as into the normativity of the educational sector. It uses the methods, structures, and physical and human resources of the locality and especially of the school. The generation of a sense of belonging of the educational community vis-a-vis SIVEA and the construction of SIVEA's capacity to obtain, process, analyze, and use surveillance information were considered key aspects.

The periodicity of the survey took into account the planning of the school period in order to provide relevant and timely information for the development of institutional educational projects, which each educational institution must formulate annually. As a result, it was established that system data should be collected once a year prior to school planning.

Strategies and Mechanisms of Communication and Advocacy

One of the central aspects of SIVEA was the implementation of a communication system to generate public opinion about the system, its achievements, limitations, as well as strategies to strengthen it. To this end, local resources, such as theater, routine school tasks, parent meetings, and social events, were used. The intention was to ensure that information reached the largest number of people, institutions, and associations in the community, as well as increase information use to satisfy the interests of users. Contribute to generate favorable public opinion against the continuity of successful interventions, benefits, and gains from working in collaboration with the education community, health sector, and academia and helped to make decisions for the extension of SIVEA to other venues and educational institutions, the municipality, and the department.

Communication and advocacy strategies were incorporated into the system based on an analysis of the actors, according to their interests and motivations for using the results. To that end, we explored answers to the following questions: Who needs the information? Why do they need it? For what? And what do they already know? Based on analyses of answers to these questions, different surveillance communication processes and products were designed for different audiences, including institutional and community decision makers. Communication committees were formed in each of the participating educational institutions.

A drawing titled "El vigilante de la salud," from which an iconographic symbol for SIVEA was selected and refined, was especially important in the initial sensitization phase because it stimulated the interest and participation of more students in the activities of the study, since one of the first alternative activities of the SIVEA was to expand information about adolescent perceptions regarding their health and

perceived risks. Likewise, with the communication committees at the educational institutions, the design and construction of a ¨situation room" in the schools was carried out as a structure that would contribute to increasing the dissemination and use of the information produced by the surveillance, reaching the educational community and the population in general. The results obtained in the survey on cultural consumption and perceptions of adolescents in relation to the media most used by adolescents served as a basis for students to develop other communication mechanisms, supported by a peer strategy and using the media available at the educational institution. Students presented to other adolescents, teachers, and parents the results of the survey for each of the themes investigated in the questionnaire using mechanisms designed by them and resources of the educational institution, such as murals. The students also presented their results to the Council of Social Policy of the municipality and made a video to inform the general community about the purpose of SIVEA, its progress, benefits, and scope.

Evaluation of SIVEA

The main feature of the methodological approach to evaluating SIVEA was the articulation of different sources of data (monitoring, surveillance, reports), which was utilized to support daily activities at the educational and health institutions.

A longitudinal ecological design was applied in which repeated measurements of events of interest were analyzed collectively, integrating quantitative and qualitative data. The evaluation results emphasized that we should not wait to have definitive results to provide decision makers with information to justify an investment in the system. The evaluation process was useful in creating awareness about the utility of this type of study. The evaluation of the system responded to decision makers' interests on three issues: the benefits of implementing the system, the comparative advantages and costs of its implementation, and the requirements to make it successful. Despite this, the information produced has served to reorient and commit resources and generate initiatives that try to improve the detected conditions.

Results and Lessons Learned from SIVEA

Many lessons could be extracted from the experience in the municipality of La Cumbre. We have learned that by using local available resources, empowering local people and communities to run their own interventions—such as the risk factor surveillance system—and applying effective strategies to increase key actors' participation and political will, our contribution to the capacity-building objective is not only possible but also effective. However, some issues and challenges need to be resolved to strengthen this effort: how can we make data relevant, credible, and desirable to multiple parties, policymakers, donors, communities, and researchers?

What is the priority? Is data quality modified by participation of laypeople and decision makers? Are there tradeoffs between meaningful and accurate data? What should be the link between surveillance systems in and out the health sector, and how should that link be established and maintained? Where should behavioral surveillance systems be placed? Who should occupy the leadership positions? How can a surveillance system be linked to other health promotion and public health functions?

Answers to the foregoing questions would help in the definition of the scope of the surveillance system and the construction of new ways to overcome the long-standing problems we have been facing. Our experience after more than a decade of working in the municipality of La Cumbre is summarized by the following key issues, which in some way try to respond to the foregoing questions:

(a) *Behavioral risk factor* s*urveillance as a catalyst of social change*. To this end, the surveillance system was linked to health promotion and disease prevention interventions at the population level. Communication strategies were applied to articulate surveillance results to decision-making processes taking place at different levels in the municipality. The WHO refers to the last issue in this way: "management decisions based on measures of overall risk are more cost-effective than those based on single risk factors….[and] individual behaviour change is difficult in the absence of conducive environmental alterations" (WHO 2003a).

(b) *Articulation of the system to power structures:* such as government, schools, workplaces, and geographic units, which serve as promoters and guarantee an ongoing process. Being bound to these structures implies that there should be accountability inside and outside these structures, that results should be used to support advocacy and create public opinion with respect to the entire population, that links to local plans and programs are critical for the sustainability of the surveillance system, that information access based on needs at different levels is critical, and that awareness of the decision process should be widespread.

(c) *Supporting structures*: surveillance systems have a population- and territory-based approach, although they may use specific or additional strategies on the most vulnerable populations. A working principle of school-based surveillance systems is the use of scenarios that may constitute support structures. This is the case of "the schools," which are part of a specific territory and able to articulate community interests around them. Schools create cohesion and articulate groups around a common purpose, such as the health and quality of life of the school population (De Salazar 1996).

(d) *Local capacity building and empowerment of key actors*: To be sustainable, a surveillance system should be treated as a tool and a means for capacity building. Capacity building, therefore, should not be limited to technical aspects, and the system should be rooted in a local context, built on collective effort, using appropriate methods to provide and use information, gain political will, and be a product of strategic planning in which multilevel action through partnerships among users, stakeholders, and society takes place. For Amartya Sen, capacity

refers to the potential that people have to achieve valuable things in life; this is understood within a broad social framework starting from which understand the approach of strengthening of capabilities (understand is, opportunities effective of self-realization and joint social wide) the strengthening of capabilities accurate of the accompaniment interinstitutional that ensure the field of opportunities and enables the realization of those runs valuable (citizenship) (sociability, partnership, mobilization, among others).

(e) *Technical packages suited to local conditions*: Develop or adjust strategies, mechanisms, and tools to the culture and specific conditions of the population and the territory. For example, we found that a single source of information was insufficient to provide inputs for all parties. Interventions should be *socially responsible*, and therefore there is a need to develop strategies aimed at strengthening skills to produce data and information, oriented toward building public awareness, encouraging participation, providing relevant and timely inputs to decision makers, taking relevant and timely actions, and making optimal use of local resources.

(f) *Monitoring and evaluation as a technical tool with political purposes*: We developed attractive and simple formats and manuals for gathering, analyzing, and interpreting data. Schoolteachers and students actively participate, as do researchers from CEDETES. School resources and daily activities such as homework, computer lessons, parent meetings, planning school activities, extracurricular activities, and school rules were used to train the school community. The rectors of the educational institutions were trained in the management and use of monitoring systems, methodologies for planning and using information, decision making, and the formulation and management of promotion and prevention projects. CEDETES implemented and evaluated a school-based risk factor monitoring system, which, following the completion of the demonstration project after 3 years, continues, not only in operation, but also in coverage and scope.

(g) *Dynamic meaning of intervention*: Finally, the intervention (SIVEA) did not have the same achievements during its implementation. Hence, its evaluation and the recommendations arising from it should take into account this dynamism and the reasons for the changes. To account for these issues we used the technical tool called "systematization of experiences," which provided very important information, not only on the evolution of the system but the factors that influenced the change.

(h) *Optimization of school and local resources:* The implementation cost of SIVEA was around US$3000 dollars per educational institution, per year, which represents a cost of US$2 per child per year, covering the whole education population of children and adolescents. This cost could be much lower after the second year since training, monitoring, and follow-up activities are included at the beginning of the system. It was assumed that after the second year the educational institution could run the process by itself without external support. Sampling methods, time between surveys, and available resources at the time the system starts account for investment differences among educational institutions.

(i) Given that the intervention was intended to affect the overall population using an educational institution as the entry point, its benefit may be greater than anticipated. A cost-effectiveness study was developed whose results were used to increase key actors' participation and political will, showing in a convincing manner why surveillance is an important investment for students and the community as a whole and showing how decision makers at different levels could take advantage of this initiative to reduce decision uncertainty.
(j) *Permanent advocacy:* Continuous use of visible gains for all parties as a product of interventions to reduce risk factors and improve health is very useful for the appropriateness of the system for different sectors. Mandatory action, along with permanent monitoring and evaluation of different stakeholders, supports the construction of a sustainable system. On the other hand, linking surveillance systems to broader initiatives in health promotion, such as healthy schools, healthy cities, and regional development plans, increases their effectiveness and sustainability.
(k) *Geographical units and subgroups of the population in a territory*: This could be a microcosm of what happens in larger populations. An example is what our group found in school-based behavioral risk factor surveillance. Although the system has been oriented toward the primary school and adolescent populations, the risk factor for chronic disease prevalence was similar for the rest of the population, which could be explained by behavior theories and interrelations among the study population and the rest of the population in a geographic unit or cultural context; however, this aspect should be subjected to further investigation.
(l) *Evaluation and evidence:* There is no single simple method by which to evaluate public health effectiveness and produce an absolute form of evidence. The appropriateness of using evidence to formulate health policy, health services, and health practice has been addressed by many authors (WHO 2001, 2003b; McQueen and Anderson 2001), drawing our attention to the relevance and utility of applying traditional epidemiological approaches to measure the effectiveness of public health and health promotion interventions and consider as scientific evidence not only those results from natural or biomedical sciences but also those from policy or social sciences. It is also recognized that the different types of science require quite different types of research methodologies. To evaluate the effectiveness of the surveillance system, we used trends produced from repeated surveys, complemented by other sources of data within and outside educational institutions. This model allows the measurement of risk factor prevalence, trends, and correlation of interventions oriented toward the prevention and control of risk factors, as well as the influence of health determinants.

Final Remarks

The objective of showing the theoretical basis and some positive results of SIVEA is to provide information that invites reflection on the reasons for an intervention like this is no longer relevant. The SIVEA experience is revolutionary in terms of

the nature and scope of what is considered within the concept of surveillance systems, that is, it transcended the production of data to expand its scope, becoming what we call a promoter instrument for transformations in a territory to improve health conditions and a population's well-being.

The alliance between municipalities and universities has had its ups and downs from 2003 to date, with changes in the nature of the alliance, actors, and participation mechanisms among partners, type and scope of results, and, most importantly, lessons on specific political conjunctures of each of the previous interventions. This experience about alternative surveillance systems started in the municipality of Cali as a school-based information system covering 4 schools with 1500 children (De Salazar 1999). Later, the information system evolved into a school-based surveillance system and was implemented in a municipality in Colombia known as La Cumbre, with 7 educational institutions reaching 1300 children. Although the decision to extend SIVEA to the rest of the state was considered by local authorities and the school community, different factors prevented this decision from being taken.

Let us examine some of the factors that we believe are responsible for this situation and that, therefore, should be considered in future efforts.

(a) Diseases receive a higher priority than risk factors for morbidity and mortality. Behavioral risk factors have become real epidemics in cities, tending to become endemic owing to worsening living conditions as a result of the rapid urbanization of the region and the dramatic changes in the state's role (De Salazar 2003). Rapid urbanization puts pressure on the physical environment and poses specific health threats to inhabitants. In many economically disadvantaged cities, the "street" has replaced the family as a provider of shelter and security for children and young people, who are exposed to a wide range of health and behavioral problems, such as malnutrition, infectious diseases, accidents, substance abuse, prostitution, and interpersonal violence, among others (Ferguson 1993). The lack of opportunities for development, culture, and progress for young people, in both large and small cities, has been growing and increasing the vulnerability to acquiring unhealthy behaviors.
(b) Therefore, monitoring the risk factors of behavior in adolescent populations becomes a priority for any community, given the effects they have on the health and quality of life of inhabitants presently and will have in the future (CDC 1990). The mitigation of social and economic costs generated by such risk factors, for example in the area of preventable or avoidable chronic diseases, becomes a priority investment for the medium and long term, in which different sectors and actors of the community.
(c) Organization and infrastructure for surveillance. A Municipal Technical Committee of SIVEA was formed; it included the municipal educational coordinator, the rector of the institution, the manager of the local hospital or its delegate, a teacher representative , and, in the implementation phase of the system, representatives of the team of CEDETES technicians. The purpose of this committee is to meet periodically to define the work plan and monitor the operation of the system, according to its nature and purpose, and initiatives or interventions designed with the information obtained on the risk factors of the

system. Behavior was investigated, and a written agreement was also drawn up in which the local hospital is committed to providing physical space and facilitating other elements that are useful for the development of the system in the municipality and to take actions to improve the well-being of adolescents based on the information and recommendations of surveillance.

(d) The results of the cost-effectiveness study of SIVEA after 8 years of operation did not provide sufficient support for the continuation of the program.

(e) Interventions to reduce risk factors were a product of strategic planning in which activities inside the school were linked to higher decision levels, so intervention goes beyond the school to cover wider geographical areas such as the municipality. For instance, surveillance results helped to develop institutional plans and public health strategies such as healthy schools. At the same time, surveillance results were integrated with municipality development plans aimed at creating a healthy municipality. In this regard, surveillance and information systems already in place could provide a better picture not only about risk factors but the determinants of health and behaviors for the entire population in an effort to link surveillance to health promotion initiatives and policy planning.

(f) Training of the educational community. To strengthen institutional capacity, to train a basic team of teachers and managers who are knowledgeable about the management and application of SIVEA to achieve its continuity and permanence, and to promote the sustainability of the system, training was provided to teachers, administrative staff, students, government school staff, representatives of the local hospital, and teachers on the development of the different phases of the surveillance system and the available methodologies and tools. Some pedagogical modules to support the implementation and uses of SIVEA were designed, developed, and applied in these trainings.

(g) Information management is not only one of the most critical activities to guarantee information use but also the most neglected. To overcome this problem, many activities must be implemented on a continual basis, such as advocacy, communication, and advertising to involve and motivate parties within and outside the school. Linking surveillance to evaluation is an efficient way to increase not only the use of data but the sustainability of the system. Also, closing the gap between information and action implies linking surveillance data to information from other sources to get a clearer vision not only of risks but also of the possibilities for change. In the case of SIVEA, we obtained additional information about aspects that motivate behavior change and conditions that make it possible.

(h) The planning and operation of programs follows a sectoral logic block intersectoral actions necessary for the achievement of the objectives to promote health and prevent risk factors of disease. The solutions proposed by the inhabitants of La Cumbre reflect the inhabitants' most basic hopes for social change. These solutions range from the more elemental viewpoint of citizens to elaborate reflections and approaches.

(i) The main objective of capacity building for local development is to have actors (institutions, people, or communities) who are empowered to strengthen their autonomy and ability to face the challenges to be healthy. The types of capacity building indicate the need for differentially (institutional, community, research) and jointly identifying how articulate efforts and resources available.

(j) The existence of various problematic situations and traditional interventions, from the point of view of sectoral logic, has made it difficult to obtain far-reaching results, given the need to have the different sectors work together under a key strategy like intersectorality. The fragmentation of programs together with unfair distribution of resources is the main obstacle to provide equitable access to health services, especially to the most marginalized population.

(k) The fundamental objective of developing local capabilities involves count with actors (institutions, people, or communities) is to empower the local community to strengthen its autonomy to develop those valuable runs. Those types of capacity strengthening indicate the need of make it differentially (institutional, community, investigative), identifying jointly how is articulate efforts and provision of resources materials and not materials.

Capacity development can stem from any effort to teach someone to do something or make better. It can also mean creating new institutions or strengthening already existing ones. Some people believe that the development of capabilities should center on education and training; others adopt a vision of greater scope and include actions to improve opportunities to exercise the right to health and individual freedom to make their own decisions (Ramos Rodríguez et al. 2015:340).

> The capacity development can be any effort to teach someone to do something, or make it better. For others, it may mean creating new institutions or strengthening existing ones. There are those who feel that capacity building has its Center in education and training; but there are also those who adopt a broader view and include improving access, rights and individual freedoms. Maybe all they are right, what the attributed meanings involve a vision from the complexity and function of each actor is to achieve the objective of the development of capacities to integrate. Perhaps College appropriate education and training for the development of capacities, others create new institutions or services may incur. (Ramos Rodríguez et al. 2015: 340)

The sustainability of problem-solving capacity-building processes requires prospective planning, flexible operational plans, and conditions conducive to change, such as the political will expressed in the budget. The sustainability of programs depends to a large extent on the balance of power relations between the different levels of society, so that the benefit of the programs is not for some to the detriment of others. Experience teaches that it is a fundamental task of government and participating actors to ensure the distribution of benefits.Experience teaches that it is a fundamental task of government and participating actors to ensure the distribution of benefits. The lack of sustainability fracture to short term it monitoring citizen on the expenditure in health, and them processes complementary (monitoring, effectiveness and evaluation) that accompany them advances of the same. The sustainability process of a specific intervention of the participation of a group of relevant stakeholders identified by their exposure to a specific problematic situation: civilians, government officials, prosocial organizations, sectoral officials. The identification and interaction of these actors is indispensable.

> There are different ways of perceiving health problems, some problems we construct or explain in terms of conflicts between our objectives and those of others (Ackoff 1981). Three strategies have been created to deal with these conflicts. The first concerns the intention to solve a problem; in this case the conditions that generated the problem are accepted and the desired outcome is sought regardless of the implications or collateral findings that

may arise. Second, we talk about solving a problem which is an intermediate situation in which the factors surrounding the problem are accepted and the benefits and losses distributed between them. Third, we talk about dissolving a problem. In this case, the conditions that produce the problem are not accepted as given (and unquestionable), and attempts are made to reconstruct the context in which the problem arose to transform people's perceptions. Subsequent actions seek to transform the context in such a way that the perceived problem disappears to give life to the idealized design. (Aldana and Reyes 2004: 4)

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Chapter 10
Intersectorality and Local Development: Municipality La Cumbre

Ligia Malagón de Salazar and Bertha Luz Pineda Restrepo

Introduction

In this chapter we will present a synthesis of the advances/setbacks of the work achieved for more than a decade in the municipality of La Cumbre with the participation of diverse institutions, especially Municipal Hall, through health sectors, education, and social well-being, as well external institutions such as the Center for the Evaluation of Public Health Policy and Technology (CEDETES), Universidad del Valle, and the nongovernmental organization (NGO) FUNDESALUD.

In this chapter we will conduct a critical analysis of the factors that have facilitated/hindered the process of capacity building in this municipality to face health challenges and associated factors. To this end, we will discuss the processes and results of the following initiatives: (a) school-based surveillance system; (b) perception and main factors influencing intersectoral work; (c) coherence between problems, interventions, and capacity to intervene; (d) strengthening of capacities for territorial development in the municipality of La Cumbre, Valle del Cauca, 2017–2019 (De Salazar 2004).

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L. Malagón de Salazar, R.C. Luján Villar (eds.), *Globalization and Health Inequities in Latin America*, https://doi.org/10.1007/978-3-319-67292-2_10

Context

The municipality of La Cumbre is located 21 km from Santiago de Cali, capital of the Department of Valle del Cauca in Colombia; it has an average population of 11,582. The majority of the population in the municipality of "La Cumbre" live in rural area (72%), and the main source of employment is agriculture. Continuing with the work of capacity strengthening in the municipality of La Cumbre through the previously mentioned partnership, it is necessary to acknowledge that the established alliance in the municipality with the participation of various actors (officials, representatives of NGOs, private companies, community leaders, leaders of associations) presents different facets, scopes, and characteristics during its lifecycle. Since 2012 the alliance has widened, both in scope and participants. This new effort gave greater importance to social issues.

A cross-sectoral workshop was held with the participation of representatives of the local government, private sector, association leaders, and hospital officials, which had as its main goal reflection on theoretical and practical approaches to intersectorality from the perspective of various municipal actors. Despite the fact that intersectoral actions benefit joint efforts to reduce health inequities, the agreements were not incorporated into the local health plan or the Municipal Development Plan. One of the reasons given is that these encounters are sporadic and have an informative, rather than participative and integrative, character.

The following problems were identified through several mechanisms and tools, which are not easy to solve because of the complex degree of transversality: precarious education, nonpreservation and deforestation of the environment, lack of guarantees of sovereignty and food security, nonexistent promotion of clean agriculture, and low social participation for decision making. Therefore, intersectoral action for structural planning and implementation of programs is needed and should be linked to municipal foresight that is not contingent on changes in administration.

La Cumbre shows a high labor informality combined with high levels of unemployment of young people (20–28 years old). "Informal employment is 93.9%" (ASIS 2013:141). In connection with this aspect, the scheme of land use (EOT) (2000:33) contains the following statement: "in the municipality, unemployment reaches a rate of 31.54%" caused by few job opportunities. According to the Municipal Development Plan (2012: 23), 45% of the population is economically active (between 12 and 25 years), 30% of the population has graduated high school.

Previous epidemiological studies carried out by FUNDESALUD and CEDETES between 2013 and 2015 identified chronic noncommunicable diseases (NCDs) as one of the main health problems in the municipality of La Cumbre demanding an institutional capacity to intervene in the different factors and causes associated with these diseases.

The municipality had the lowest risk of homicide in the department, with a rate of 17.6% (2 cases) in 2011, showing a decrease of 60%. This fact, along with the absence of irregular armed groups, made the municipality relatively peaceful and an ideal site for the realization of sustainable local development projects in which the community can exercise its rights and duties as citizens.

Problematization

The different experiences documented regarding the problems faced in becoming a healthy municipality undermine the role of the social determinants of health. However, at least in discourse, the issue of poverty occupies a priority place in the concerns of the municipality.

Among the residents of La Cumbre, 54.32% live in poverty, according to the multidimensional poverty index, and the municipality experiences stationary growth. In addition, 22.69% of the people live with their most basic needs going unsatisfied (DANE. Projections census, 2012), as does a large percentage of its rural population.

> In the municipality of La Cumbre an accelerated process of division of the land into allotments is taking place without any regulations on the use of the soil or any minimum requirement of area to build, mainly in areas with richer landscapes and forest reserves, resulting in a high demand for water and public services.…Various reports warn of the systematic neglect that has been imposed on the rural area of the municipality. The rural area of the municipality was reviewed in detail by EOT (2000), which reached the following conclusion: 80% of the area in the municipality is rural, different urban centers do not have complete utilities and have insufficient provision of health services education, telecommunications, and emerging trade (EOT 2000:48).

Inequality and Poverty

Although several of the causes involved in the emergence of NCDs correspond to risk factors associated with unhealthy behaviors, a large number of socioeconomic and cultural factors have also been identified that influence the incidence of these diseases (De Salazar 2013:41). In the cited study of La Cumbre municipality, the interviewees alluded to several problems such as inequality and the difficulties the rural population faces in overcoming poverty; the factors cited include the fact that they are not included in programs or projects, nor are they a priority for the government. What follows are some quotes by interviewees:

> In my village there is a big problem and it is that the great majority of inhabitants are not landowners, crop training would be of no use since it depends on two or three landowners… (HV/03)
>
> Our township lacks the necessary education…Therefore we have wealth that is wasted because there is a lack of education and interest in people…the financial education is nowhere to be found… (PJ/03)

Inequalities in Health

> The same treatment is not given to human beings…People are not treated equally, but depending on their social class (Interview 2).
>
> The most vulnerable population has less access to health, to education, to other services in the farther areas where people cannot access the different services, and there is no integrality among the sectors (Interview 5).

> Inequality in health is the reflection of social inequity because there is wealth and poverty. The inequities are how some people have many things and others don't have anything. Some have power, access…which if you don't have an economic income, each time you have fewer opportunities. Few people have access to alternative means. With equity, the causes of pain would be looked at. But the causes of the problems are not addressed… (Interview 6)

The NCDs constitute multicausal problems that require an integrated approach, so the search for integrality puts a focus on integration among different sectors. Intersectorality, from this perspective, implies that diverse sectors "agree" and act "jointly" in order to work in an articulated and sustained manner, oriented toward responding to a common situation, the NCDs and their contributing factors in this case. The participative analysis of the problem and its causes made it possible to identify as a central problem restrictive sectoral plans that are not articulated.

Undervaluation of the Rural and Agricultural

Identification with the urban, models of consumption, and the constant migration from country to town are factors generating among the rural inhabitants an undervaluation of the rural environment and farming as an occupation, mainly among the youth:

> Students of several villages that come to the municipal capital to study do not value the agricultural sector. The schools in this sector have fewer and fewer students. The deans of the institutions talk about not staying in production but moving toward the transformation of agricultural products, but it has not been accomplished, there has been no impact in society. (GE/01)
>
> The current political and socioeconomic development model must be changed for an inclusive model where all people are included regardless their socioeconomic condition and social stratum. People do not have an ideology, they have hunger! If I were a governor, I would give the peasant good roads to transport their products, good health institutions, as well as conditions to be healthy. The peasants are lacking incentives of all kinds, and the importance of fieldwork should be of primary concern for society … (PJ/01).

Imbalance of Power Relationships and Low Participation of Community

Participation is seen in several studies of the municipality as a deficit given that the base communities are not involved, or if participation is happens, it happens at low levels, such as communication and information, but on behalf of the same community actors, but there is a certain amount of apathy and disinterest in participating.

> There is a lot of disinterest in the things of development in the municipality; the leaders themselves do not attend meetings. I have advertised meetings through posters and megaphones, and they don't come (HC/03).
>
> The social leadership at La Cumbre is very poor; the good people that try to do something get tired…the leadership is poor, and the politicians capitalize on it…A natural leader, but someone without any way to intervene, with no resources, no proposals, gets tired; other leaders become politicized and end up cheating the people with their campaign narrative. (PJ/03)

Theoretical Framework

The causes of NCDs and the associated risk factors are determined, to a large extent, by social, economic, and political factors such as, for example, incomes, living and working conditions, physical infrastructure, the environment, education, and access to health services and essential medication, among others. Therefore, to appropriately address the issues associated with these diseases, the participation of several sectors is required. Sectors such as education, agriculture, and commerce, among others, play a very important role in establishing healthy environments and alternatives.

Intersectorality, on the other hand, aims to facilitate the strengthening of appropriate conditions for the health of the population, particularly in the most vulnerable groups. In this sense, it requires a political strategy that facilitates its implementation and planning. This political strategy benefits the continuity of the arranged activities in reducing health inequities.

> Two premises have been identified so far. First, the integration of sectors has a political foundation. Second, the integration of sectors allows differences between them to be used productively to solve problems; it creates better solutions (than the sectoral) because it allows the sharing of the resources of each sector (Cunill 2005:1–2).

Intersectoral work is not simply the conjunction of many representative voices of a territory; it requires governance practices that facilitate complex interactions among government, NGOs, society, academic institutions, and the private sector, influenced in some cases by imbalances of power relations and particular political interests. Intersectoral work requires formality and legitimacy from municipal administrations, based on the strategic objectives of governments and municipal health councils. Initiatives at the local level facilitate the active participation of the population in the planning of complementary community actions and in the development of programs and projects.

Methodology

The analysis explores the answer to different questions, for example: Do the interventions incorporate the multidimensional nature of chronic NCDs? Do the implemented interventions coincide with those designed? What are the variables of the context that facilitate/limit implementation or achieving results? How much does the intervention contribute to building local capacity to create conditions conducive to health? Was any progress made in reducing risk factors and impacts on social inequalities? Can these advances be associated with or attributed to interventions?

One characteristic of the methodology was to start from existing information and then complement it with new information, through the exercise of collective reflection, to answer the previously mentioned questions. Disciplinary visions and perspectives of various sectors and actors of municipal development and external agents were articulated through mixed methodological approaches. The design of

the methodology took into account that public health interventions are part of social processes, which must be constantly revisited in order to strengthen them and match them with the needs, interests, and expectations of the primary beneficiaries and promoters of the initiative, turning them into a product of the collective interpretation of reality and a common vision for intervening in it.

Likewise, the evaluation of programs or projects is part of systemic and permanent processes of research, reflection, and action that aim to answer questions of varying complexity. The dynamic, multidimensional, and complex nature of social interventions demands methodological approaches coincident with the interdisciplinary perspective on situations of interest.

Chronic NCDs and associated risk factors were used as the entry point for the analysis. First, the technique used involved moving from a negative view of the problems to a positive vision of the objectives to be achieved. Second, coherence among the problems, priorities, regulations, and availability of resources was established. Third, an analysis was conducted of the implementation of interventions, identifying the main factors influencing them. Fourth, agreements on how to move forward were formulated.

To perform the aforementioned activities, different tools were used, the most important being the systematization of experiences, through group discussions, interviews, and roundtables, among other activities, complemented by epidemiological data using the STATA 11.2® statistical software (technical tool) (De Salazar and Pineda 2015:6).

The results of each session were subsequently consolidated and validated with diverse key actors. One example was an exercise on the meanings of intersectorality among the participants. All these dynamics were considered as an excellent opportunity to strengthen the capacity of the different groups at the municipality level (Table 10.1).

The population's attributable risk (PAR) was used as a measure of association because it shows the gains from applying the intervention since it is a measure of the impact of the risk factor in the general population. It was difficult to calculate some association measures owing to the gaps and low quality of the quantitative data available, especially in connection with issues related to social determinants.

No up-to-date information was available on the prevalence and trends of events. Likewise, studies or reports that accounted for changes in socioeconomic conditions were absent. The quality of data is brought into question by the high proportion of "no data" and by the inconsistencies found between official information and that obtained by field workers (such as health promoters).

Table 10.1 Advantages over other municipalities

Advantages
Location—close to the capital of the department
Human talent
Climate
Strategic interventions in territory to strengthen advantages (G-11)
Availability of different types of products and services
Possibilities for economic development with environmental and social sustainability

Results

A synthesis of the study results is presented, integrating facts, figures, trends, and perceptions of various participants. The first part describes the central problem taking into account health conditions, risk factors, socioeconomic variables, and the context in which the intervention took place.

The participants understand health inequities as the result of the nonsatisfaction of the population's rights (study reflecting social inequity). A differential treatment was based on class criteria, meaning inequalities in access to services and the association with vulnerability (2015:12).

Coherence Between Problem, Response, and Results

The problem tree and goal tree techniques were used. In the latter, problems are defined as positive states. One moves from a negative view of problems to a positive vision of the goals to be achieved. A contextualized reading of health events and determining social factors was carried out.

The results of previous studies were articulated to contrast with updated information: perceptions on risk factors associated with NCDs (2013); perceptions of intersectorality and conditions for its feasibility in the municipality of La Cumbre (2013), and intersectoral management to address inequities in health from the municipal territorial entity: capacities, limitations, and challenges (2015). The information obtained from these studies was synthesized and supplemented with official records on morbidity, mortality, and the population's attributable fraction of some risk factors associated with NCDs.

Techniques and methods of qualitative and quantitative research were applied, such as participant observation, individual and group interviews, and semistructured and in-depth interviews. Several meetings were held to socialize the results of this exercise, generating a participative process and reflection on the practice. Tools were used to identify priorities: strategic measures such as the risk approach (RA); epidemiological measures such as the identification and distribution of risk factors (RF) and PAR, or the population attributable fraction (%PAR); and social and political measures aimed at reducing inequities.

For the calculations of %PAR and in the absence of data on relative risks of RF, proxies were used combining local data with studies in similar localities in order to sensitize authorities and municipal officials about the usefulness of these tools in defining priorities and guiding the programs.

Overweight was the risk factor with the highest percentage of PAR; its removal may reduce hypertension by approximately 58%. It follows in importance the consumption of cigarettes, with a reduction of 35%, and unhealthy diet, 31%. It is necessary to take into account that being overweight is related to the other risks that are part of this study. For this reason, sometimes it is necessary to intervene not just on a single risk factor but on a set of them to have a greater impact, in this case on NCDs. In the review of the Municipal Development Plan 2012–2015, only activities

related to a behavioral risk factor (sedentary) were present. The other risk factors (overweight, cigarettes and psychoactive substances, unhealthy diet, alcohol abuse, and pregnancy in adolescents) were not considered.

The PAR% of three studies was compared, one in Latin America for cardiovascular diseases, the second using data on behavioral risk factors for NCDs in the municipality of Cali, and the third in the municipality of La Cumbre. Wide differences were found; however, the comparison raises concerns and awareness by having other benchmarks of comparison.

There is a broad national regulatory framework in risk factors and problems related to NCDs, but it suffers from insufficient application in the local context; public policy is not reflected in local plans and programs, not only because of a lack of knowledge of local authorities and local administration officials, but also because of a lack of training and mechanisms for national public policies to be expressed locally. The education and health sectors are making an effort to respond to the identified risk factors through projects aimed at increasing fruit and vegetable intake and physical activity, but these projects are not associated with determinants of social inequities in health and are not integrated into the Municipal Development Plan.

What Intersectorality Means for Stakeholders

Perception of intersectorality: The importance of this action for the reduction of inequities in health has been widely recognized. It was defined as follows:

> The joining of forces that could work independently but decide to work together to achieve several objectives, to identify and achieve several common problems, to design action plans and implement them generating alternatives that might not have been submitted before. The work of intersectorality depends on several things; one is the strength of each sector (De Salazar and Pineda 2015).

The findings of the leaders' opinions are summarized in testimonies about state structural problems such as poverty, lack of education, lack of continuity of projects, and the need for training, including financial:

> Here in the municipality we have many problems and we do not know how to eat well. At school they eat a lot of junk food ... There is malnutrition in many families that cannot eat well because of economic factors. Above all is ignorance and the fact that people do not know how to eat properly. For example, the people of the municipality of La Cumbre no longer consume guava because the production of this fruit went down; many say that cider is for pigs, like chachafruto; they prefer to buy soda instead of making juice with those fruits. People do not farm; they have land but they are too lazy to cultivate it. These are problematic in this culture (PJ/01).
>
> It seems to me that the most important thing would be to rethink education, especially financial education, which is not spoken of, something that is transversal and is needed... (PJ/03).
>
> With regard to health risks, the problem of teen pregnancy and its negative consequences, as well as difficulties associated with sex education in families, and the limitations of sex education in educational institutions were brought up. Girls thirteen or fourteen years old are pregnant, and their lives are damaged because their lives are over and they harm the lives of their parents. (PDF, 02)

The interviews carried out in the study "Intersectoral Management to Address Health Inequities from the Municipal Territorial Entity: Capacities, Limitations and Challenges (2015) yielded the following testimonies:

> Resources are not being used where they should be….It is necessary to establish permanent resources for the operation of municipal intersectorality. The processes are closely linked to people; there is no mechanism to guarantee the continuity of visionary processes … . Cultural changes require many years...the greatest must be trained because he has a Development Plan. Training him, focusing on governance, working with people in the city.…We cannot do it alone. Work between the sectors is not the only necessary work: education and health are also important, but advances are few (2015).

Capacity to Undertake Intersectoral Work

The central problems identified by the participants (meeting March 16, 2015) in the municipality of La Cumbre (Colombia) regarding intersectorality are as follows:

… disarticulation between the different sectors; poor communication among government and community; limited knowledge of the population on plans, forms of participation, and perception of not being heard; centralism influencing planning to follow national guidelines, rather than the reality of the town; a lack of interest in collective processes; lack of knowledge of the regulations and methodologies to do intersectoral work; not having a permanent space to undertake articulated planning; nonexistence of a leading actor.

Individualism was also identified, supported by a traditional vertical, sectoral, and disciplinary work culture. The consequences of this problem according to participants were as follows:

> Sectoral management; weak capacities to intervene intersectorally; misinformation; distribution and execution of resources not according to the needs of communities; low social participation. According to what has been expressed by the participants, all these problems hamper the implementation of territorial development plans. There is no teamwork...there is a lot to do. The municipality has many needs, there is ignorance; we are missing a lot, we all work individually; it is a small municipality and is divided by political and ideological differences; this limits the development of people...there are no public policies… (De Salazar and Pineda 2015:13).

The information obtained allowed the identification and understanding of the main topics to be addressed for strengthening capacity building in order to establish a culture of intersectoral work in the municipality. In addition, opportunities were identified for future actions. An advantage identified at a workshop on intersectorality (2013) is that it allows for collective action on different operative levels. Further, intersectorality is strengthened by the development plan. In the municipality there are good memories associated with intersectoral work from monitoring risk factors in adolescents. This is an advantage because health and education mobilized the majority of the population: there are 2700 registered students and more coverage at the hospital (2013).

Final Remarks

The findings described are not exclusive to the municipality studied; they are a reflection of what happens in many Colombian municipalities and in developing countries. The challenge is not new; on the contrary, every day becomes more complex and demands urgent answers.

The perceptions of different inhabitants of the municipality regarding current issues and real opportunities for change show not only a critical and committed position with the social and economic reality but also the inhabitants' potential to undertake initiatives using their own resources. They identified convictions and co-responsibility of municipal social actors, as well as ways in which they contribute to the reduction of social and health inequities.

> Because implementation research is embedded in reality, people working in the real world (practitioners as opposed to people "doing research") often ask questions that serve as the starting point for new thinking, making sure that those questions are heard and that the research is undertaken. The same capacities make implementation research a useful tool for helping organizations develop the capacity to learn, enabling them to assimilate and put into effect knowledge developed on an iterative basis. Implementation research is, then, of immense value in shining a light on the often bumpy interface between what can be achieved in theory and what happens in practice. Engaging with the real world, and drawing much of its strength from real-world practitioners and the communities they serve, implementation research generates context-specific insights that are simply not available from narrower research perspectives (Peters et al. 2013)

A final conclusion of this study is that we underestimate the capacity of people to understand their own reality, as well as their ability to cope with it. This is replicated at all levels: municipality, country, and region, in international and global scenarios. It requires a humble attitude and wisdom to recognize that we ignore an enormous amount of information, because we do not recognize that knowledge is produced and enriched by sharing, confronting, and renewing based on real experiences.

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Chapter 11
La Cumbre, Valle del Cauca. The Challenge of Implementing Sustainable Territorial Development Initiatives. Critical Factors and Consequences in the Reduction of Inequities in Health

Roberto Carlos Luján Villar

Introduction

> It is not enough to passively understand social, political, economic, and cultural reality; it is necessary to understand them actively, strengthening theories, methods, approaches, and interactions, at different levels, to intervene and move toward their possible transformation.

Different critical factors complicate the process of sustainable territorial development in a municipality. The structural and strategic factors make difficult the creation and consolidation of the conditions required to carry out sustainable development processes by systematically increasing phenomena of a different nature, including social inequalities and the delay of their greater competitiveness (financial, managerial, and structural capacity) at the departmental level. This situation is rarely associated with consequences regarding the reduction of health inequities, and the social–health inequity perspective does not seem to be very clear.

Existing studies and experiences related to the purpose of generating innovations and increasing productivity and competitiveness emphasize the need to establish dynamic strategies (intersectoral, intercompany cooperation, business–institutional articulation, and public–private partnerships) with enabling sectors (education, health) and mobilizers (university).

The difficulty with the process of sustainable territorial development in a municipality, considered as an essential anchor to a place or territory in which to operate the process, is a situation that inevitably influences the complex processes involved in reducing social and health inequities; this represents an enormous challenge—even for a small municipality, owing to factors such as limited financing and weak

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L. Malagón de Salazar, R.C. Luján Villar (eds.), *Globalization and Health Inequities in Latin America*, https://doi.org/10.1007/978-3-319-67292-2_11

response capacity to permanent and emerging problems—that requires the interaction of different sectors and organizations at all levels.

The reduction of social and health inequities requires coherence, identification, initiative, and proposals (regarding priorities, interests, regulations, and availability of resources) by agents of change such as the private sector, representatives of the local community,[1] and local government, which should influence the strengthening of institutional and community capacities.

The mentioned axes must correspond to the interests of society, making it part of the decisions, that is, the administration and progress in all orders positively impact the quality of life of the inhabitants of a territory, and the idea of innovative processes in the economy has as part of its content the welfare, not of the few, but the many, with a high democratizing and qualitative impact.

Contextualization

The municipality of La Cumbre, classified as category 6,[2] presents a worrying socioeconomic and environmental reality that, in addition to influencing the health status of its population, slows down its productivity and competitiveness in the region. The document "Socioeconomic Structure of Valle del Cauca: An Analysis of the Labor Market of Cali and Its Metropolitan Area" (2012), classifies La Cumbre, not between fast-growing or slow-growing municipalities, but among those with steady growth. This complex situation calls for forward planning and synergistic processes with the participation of educational institutions, the state's social enterprise, private institutions, social and community organizations (all of which are understood as being health-promoting institutions and local structures that stimulate change processes) focused on doubling efforts within the framework of intersectoral comanagement[3] that enables integral sustainability in the municipality in the long term.

The University of Valle, through the Center for the Development and Evaluation of Technology in Public Health (CEDETES) and the nongovernmental organization (NGO) Foundation for the Development of Public Health (FUNDESALUD), has

[1] Conformed by the inhabitants of the neighborhood sharing common interests and interacting in a physical space, based in the practice of social values such as solidarity, reciprocity, and trust, conforming organizations, private corporations of local development, user leagues, community action boards, and observers' functions, all nonprofit.

[2] Category 6 municipalities in Colombia are those with a population of less than 15,000 inhabitants. Also this category groups the municipalities with lesser volume of Free Destination Current Income. In 2007, 89% of the municipalities in the country were classified as category 6.

[3] In synthesis, intersectoral management is a process of capacity building focused on strengthening a holistic perspective of health, linked to the territorial plans of health, by including in all territory policies the subject of health, based on the strengthening of intersectoral action through the effective implementation of policies and sectoral plans deployed in the framework of a territorial development plan with the explicit aim of reducing health inequities.

carried out several studies in recent decades to identify the aspects that must be taken into account to complement and deepen the analysis of social, economic, and health conditions in the municipality, through the application of participatory mechanisms that contribute to the strengthening and promotion of intersectoral actions articulated to the plans of different sectors in order to respond to the structural, intermediate, and proximal determinants of health inequities and chronic noncommunicable diseases (CNCDs). Similarly, these studies aim to apply health education tools and participatory action research to generate local capacity building processes, in order to identify the problems, resources and opportunities to address them. Through different encounters with various actors of the population, several seemingly disconnected problems were reflected on. One example is the problem of unemployment[4] (owing to scarce labor resources, it has gradually resulted in a high percentage of informal employment), which is closely related to food security, education, and health. This closeness to the different authorities of the municipality confirms that trust is a key factor for any success of social and health programs.

Previous Studies and Experiences: Contributions and Critical Aspects

The studies that will be mentioned in what follows are intended to provide as complete a diagnosis as possible of the health situation in the municipality based on the identification of and access to the available sources of information. These studies were initially oriented based on the need to identify the municipal health conditions, as well as on the analysis of the quality, relevance, and adequacy of the Community Information System in Primary Health Care (SICAPS-CISPHC). Therefore, this exercise of reconstruction of some experiences can be understood as an input to view and strengthen further studies, emphasizing some critical aspects found in connection with the quality of data and absence of information in various sectors other than health and emphasizing methodological limitations.

These experiences, given their particular scope, examined different institutional statistics and community information and surveillance systems, establishing their availability, relevance, data quality, absence, or sufficiency of information from different sectors, thereby facilitating better referencing of the most affected population (its municipal location, intensification of actions to be deployed based on a model of social determinants of health), in turn potentiating the existing capacities for their timely and adequate response, encouraging the active participation of all committed actors.

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[4] "In the municipal mayor unemployment reaches a rate of 31.54%. The high growth of the economically active population (EAP) translates into higher unemployment in the face of few job opportunities" (EOT 2000:33). Forty-five percent of our population is economically active (PEA) (between 12 and 25 years), 30% of the entire population have graduated from high school (PDM 2012:23).

1. The study "Design and Implementation of a Community System for Monitoring Risk Factors of Adolescent Behavior, SIVEA," conducted by De Salazar[5] (2004), was a pioneering effort in this municipality for attempting to describe its health conditions and capabilities. Since then, the documentation has included studies developed by FUNDESALUD: *Evaluative research: social policy instrument. Confronting theory and practice for the approach of chronic noncommunicable diseases: evaluation contributions*; and *the Intersectoral Management for the Approach of Inequities in Health from the Municipal Territorial Entity: Capacities, Limitations and Challenges (2015),* led by De Salazar and Pineda (2015).
2. The study "Epidemiological-Sociological Analysis, Municipality of La Cumbre" (2012), Aragón and Luján (2014), jointly carried out by an epidemiologist and a sociologist, attempted within the framework of a mixed study to unify the quantitative and qualitative through a sociological analytical reading of numerical information. Thus, we analyzed the SICAPS, the data on reported morbidity, mortality, and sociodemographic characterization. Thus, a profile of the health situation in the municipality was evidenced from an interdisciplinary perspective based on the collection and analysis of the institutional information provided (variables, frequencies, health indicators, and coverage), complemented by sociological analytical possibilities.

This study concluded that in the case of mortality, the causality in this regard in the municipality of La Cumbre in 2012, reported by SICAPS in the case of chronic diseases, was of 12 deaths in men and 10 in women, without being able to establish specific pathologies, age groups, or the specific geographical area (2014:47). This is an important limitation since it makes it impossible to carry out targeted actions in order to reduce inequities of all kinds.

CNCDs are among the causes of morbidity and mortality in the municipality of La Cumbre, especially among young adults.

Critical Aspects

Quality of data found in information system: The only source of institutional information came from SICAPS (health information, with basically some possibilities of seeing sociodemographic aspects), and at least one other institutional source was needed to verify the data recorded. In this sense, it was not possible to count with the information coming from the education sector, nor with the official source of the mayor's office. Nor was it possible to count with the information of the Ministry of Health and Commissary of the municipality (important regarding adolescents and risk factors).

During the study, a meeting was held to listen to the health promoters and inquire about how they obtained basic information (social and health) from the community.

[5] The mentioned study is one of the cases achieved by De Salazar in this section.

After reviewing the questionnaires prepared for the information system, it was suggested that adjustments be made to enunciate brief, easily understood questions to the addressed population. Likewise, sections that identify aspects of the place: locality, block, housing number.

No similar case studies were found that can be compared with this. It was not possible to establish a methodological triangulation that would connect the quantitative with the qualitative combination of methods and techniques, an approach that would integrate the theoretical foundations of the research and the necessary articulation of the different levels of analysis. "The absence of quantitative information from other sectors, different depth factors, social determinants of health, community participation, employability social ascending, education (low schooling, conditions and/or difficulties to finish secondary studies), individual and associative potential, as well as the visibility of initiatives and institutional development implementations (micro and macro)" (Aragón and Luján 2014:50–51).

3. The study "Perceptions of Risk Factors Associated with NCDs, Social Determinants of Health and Community Participation, Inputs to Generate Intersectoral Actions for Their Reduction and Control in the Municipality of La Cumbre," prepared by Luján (2014), recorded the reflections and perceptions of different groups of social actors and interest, obtained in several municipal meetings in which the development of an exercise was proposed based on three interrelated actions: listening to each other with other actors and sectors, thinking and expressing their perceptions to interact in regards to the social factors affecting their health, and preventing the construction of an integrated local development project, which depends on the parallel progress of their different systems, among them the health priority. To provide clues to identify the areas in which they are perceived, the training processes should be focused on enhancing their knowledge, interests, and revealed expectations, referring to different social and health phenomena, thus constituting not only an important and complementary source of information but active agents for social change. In this sense, the execution of a local development project must be carried out based on joint strategies in which community participation plays a leading role, according to the need to overtake activities of prevention and health promotion.

The collection of information coming from the perceptions of different social actors was carried out through field work, which shows that being in situ does not guarantee absolute reliability, so the procedures of collection and systematization should be refined. Semistructured interview and focal interview techniques were used. Participants included members of social organizations, teachers, and students, among others. The interview participants were randomly selected and took into account their active role in different domains of local development.

The semistructured interview was built as an application tool to investigate different aspects: (1) identification of problematic situations; (2) the relationship established between the prevalence of social determinants and the state of a population's health, by different age groups; (3) possible answers or alternatives for their resolution in the short and medium term; (4) those actors who must participate jointly in the

Table 11.1 Capacities and competencies for the reduction of inequities in health

Identification of problems, factors, and mechanisms (normative, resources of different nature, human and technical) needed for solutions	Improvement of quality of information systems	Strengthening level of interactivity and interinstitutional communication needed to undertake participatory processes oriented toward social change	Evaluation of operations (impact and effectiveness) of different programs implemented	Governance, advocacy, and strengthening of local physical structures

process of these resolutions; (5) strengths and opportunities of the municipality. The interviews were recorded in audio, some in video, and were transcribed (Table 11.1).

This study of perceptions identified some capacities and competencies to be strengthened by the different municipal actors, committed to territorial sustainable development and the enhancement of intersectoral work focused on the reduction of inequities in health:

Critical Aspects

There is a need to form a group of representatives (or those interested in social change) of civil society, who are expected to manifest felt needs and provide other points of view (systematically obtained through a perception study with techniques of collection of information such as semistructured interviews and focal interviews), complementary to possible solutions to problematic situations exposed. It is possible that not all relevant actors would be represented, which requires a prior review of the broadest list of actors in rural and urban areas, from the most visible to the most invisible.

The problems are usually characterized by causes (conjunctural or systematic), manifestations (social and health events), and consequences (health inequities). Problem situations are not independent of the actors who produce, control, and overcome them. In this sense, it is relevant to wonder: (a) Who does the problematic situation directly harm (potentially affected in the short and long terms)? (b) Who does the problematic situation directly benefit (or who will it benefit in the future)? What are the relevant variables of the problematic situation? How do the institutions directly responsible for the execution of interventions allocate and distribute resources that will sustain them?

4. The report “Capacity Building for Local Development in the Municipality of La Cumbre—Valle del Cauca 2015–2018” (2016) identified and recorded the deficiencies and challenges of the municipality through documentary evidence produced by official institutions at different levels. It consulted, complemented, and deepened the analysis of the main problems of the municipality of La Cumbre and its relationship with social inequities based on an exercise of collective identification with representatives of the local community, local government, private sector, and so forth of the municipality, with the goal of strengthening institutional and

community capacities to respond to the social determinants affecting noncommunicable diseases (NCDs) in the municipality of La Cumbre, 2015–2018. A workshop was held with different authorities and agents of change of the municipality, for the purpose of exploring aspects such as existing social inequities, the role played by the municipal government, the private sector, the processes of civic education, the environment, social mobilization, agriculture and agro-industrial sustainable production, and entrepreneurship.

This work required an organization to arrange, classify, and analyze available information, with the objective of producing a document that consolidated the information found in official sources, contracted with the information provided by the inhabitants of the municipality. In this sense, this report presents a "consultative" approach that strengthens the exchange of knowledge with participants or agents of change in the municipality, not necessarily academic, who contributed indirectly to the generation of knowledge. Therefore, this form of coproduction, by means of an "integrative" model, valued the formulation of questions and answers of actors of the municipality. This aspect arose from the need for balance in power relations, which, owing to their historical imbalance, have generated social inequities, expressed in accumulated disadvantages that prevent the participation of individuals in equal conditions and in accordance with their needs.

Proposal: Sustainable Territorial Development and Health

A proposal is made here for an integral transformation outlined through a decalogue of academic, governmental, and community initiatives with regard to social and determinant factors in health, which seek the articulation between the process of sustainable territorial development, the municipal development plan (MDP), and the territorial health plan (THP). which facilitates a process of reduction of social and health inequities, based on an intersectoral system[6] in which an analysis is carried out of unsatisfied basic needs (UBNs) (access to housing, health services, and education and economic capacity), the role played by municipal political, social, and economic forces, and their impact on the population health status. This made it possible to identify the critical aspects and feasibility of strategies aimed at reducing social inequities in health, planned under the stewardship of intersectoral and nonvertical, sectoral, and disciplinary work.

The foregoing description, subject to the rationale that includes the social determinants of health, according to the World Health Organization, as "the circumstances in which people are born, grow, live, work and age, including the health system. These circumstances are the result of the distribution of money, power and

[6] Understanding this system as a management model constituted of different areas, organizations, and actors that, collaboratively and in a structure facilitating a logic of joint action, reduce conceptual and operative complexity, guiding the system's actions with common proposals without reduplicating efforts unnecessarily.

resources at the global, national and local levels, which in turn depend on the policies adopted." However, we underline the idea of not thinking in terms of circumstances, but rather about the conditions (determined by structural, nonconjunctural factors) in which individuals experience life trajectories characterized by accumulated disadvantages that affect their adequate development. ECLAC (2012) mentions the possibility of sustainable development in its different aspects:

> (1) economic, linked to a genuine increase of productivity; (2) social, related to the improvement of people's living conditions and the reduction of inequality; (3) cultural, linked to the strengthening of community identity, the valuation of diversity, and respect for indigenous and Afro-descendant people; (4) policy, linked to democratic participation and the exercise of rights; and (5) environmental, associated with the sustainable use of natural resources and the protection of local and global ecosystem balances (2012:12).

La Cumbre, like many other municipalities of similar characteristics in Colombia, presents difficulties in the implementation of a process of sustainable territorial development. This challenge becomes more complex in municipalities that are not prepared for development that must be managed with scarce resources trying to solve urgent problems related to UBNs, without a strategic plan for sustainable territorial development (articulator of industrial, social, and environmental policies).

Failure to evaluate the costs and consequences of UBNs and social determinants of health (SDHs) in the short and long term fractures the possibility of better expectations in the territory and in the quality of life of its population. It allows for the renewal of ideas of governance, governability (balance between social demands and the ability to provide timely and effective responses), new foresight capabilities, and planning system exercises that overcome short-term thoughts and strengthens the construction and vision of the future.

The different social struggles and advocacy efforts made in favor of equity have not achieved the expected results in the countries of the Latin American region, perhaps because the following has occurred: (a) different vindictive efforts are often mobilized and interact in a circumstantial manner; they are held inarticulately and do not follow structural transformations (they correspond to temporary action, with no governance or sustainability) as governmental response to concrete problems (UBNs, for example), without the resources to act in a permanent way in terms of basic training such as citizen participation and the empowerment of the civilian population; (b) because the expected results correspond to country goals with limited temporary horizons, without continuity or the prospective that lines up all the long-term efforts to advance from the complex decrease toward the end of the problems of social and health inequity; (c) because each government administration seeks to accomplish goals presented within the framework of its management, without a prospective vision that goes beyond temporary reductions.

There is a need to undertake prospective studies in the municipality on which to base the need for a transformation of the territory, articulated to the analysis of the complex economic and social situation, as well as demographic and cultural, generating an integral perspective (multidimensional) that propels the encouragement of

sustainable economic policies based on agricultural development given the vocation of the municipality, therefore benefitting the consolidation of the land and the stimulation of the cooperative system based on agriculture. It is needed to implement a policy of rural development, directed at the increase of production and commercialization of agricultural products and food security, which results in opportunities for the employment of the rural population, significant growth in its income, the credibility and integration of the rural area.

This strategic proposal demands the active participation of social organizations in the planning processes (local instances, strategic goal agreements, participative budget) in order to widen the decision alternatives. A strategic bet of sustainable territorial development requires the regulated autonomy of the local governments. The following are a few main issues to be taken into account in the exercise to understand the contents and possibilities (frameworks for the action) of the territory transformation (Table 11.2).

Table 11.2 Central questions to understand the transformation of territory

The territory: Unit of analysis for action and transformation. Central issues for objective approach.
Understand transformation: Why, who, how, where and when?
What kind of transformation is possible: Political, economic, social, cultural, environmental structure?
How to enable a transformation under a holistic approach that makes possible the conciliation of the previous aspects?
How does this transformation occur and what is its temporal horizon (capacities to be strengthened)?
How is the transformation planned (municipal foresight: technical-political/analysis of future alternatives potentiated by regional agendas of competitiveness, science, technology and innovation)?
Which sectors, agents of change, and organizations participate in this process (what are the mobilizing interests of each and how do they intersect)?
How does the population of a municipality participate in this process (e.g., informational, consultative, participatory level)?
What does the idea of transformation mean for the inhabitants of a municipality? (The territorial action integrates, builds identity, and generates co-responsibility)
How have the factors that prevented this process been systematically established (review of the municipal, departmental development plans and their articulation to the THPs?
How do policies, regulations, and legislation influence this process, from territorial ordering (territorial management, population demands, and welfare), territorial division, territorial planning, or territorial policies?
Does the THP play a role in this process, as an instrument of public policy that allows for incorporating health into all the policies of the territory?

Decalogue of Initiatives (Strategies and Actions) for the Integral Transformation of the Municipality of La Cumbre

The following is a decalogue of academic, governmental, and community initiatives within the framework of an intersectoral system with regard to the identification of facilitating factors that can be considered within the framework of a process of sustainable territorial development with a focus on reducing social and health inequities in the municipality of La Cumbre:

1. General diagnosis of the municipality. This diagnosis, based on documentary review work with regard to the management of the municipality from different types of documentation, can identify the financial-economic resources degree of productivity and competitiveness in the region and population health status. Thus, a systematic review of the following documents is suggested:

   MDPs; schemes of territorial ordering (STOs); THPs; government plans (last three administrations); municipal action plans (e.g., health, government, education, housing); epidemiological bulletins; environmental audit reports; certificates of annual operational planning health investments (AOPHI), 2012–2015; recognition of basic health conditions; report on natural resources and environmental effectiveness (2006–2016); DANE; municipal documentation and information system; comptroller management reports; institutional statistics; analysis of health situation (ASIS) at departmental and municipal levels; UBNs and municipal records Departamento Nacional de Planeación (DNP), among others.
2. Intersectorality. Diverse challenges must be faced to make intersectoral action a reality; the most prominent relate to the complexity of interventions aimed at reducing social inequities and their consequences on health and the general well-being of the population. This complexity is revealed in different aspects, which are analyzed in the framework of intersectoral management (planning and management): consensus among the sectors and organizations involved (tensions due to particular interest based on sectoral responsibilities and logics), identification and targeting of priorities, availability of resources, and negotiation of levels of responsibility and profit for each participant.
3. Analysis of the SDHs and UBNs. The different and interrelated factors, understood as basic needs, have a very close relationship with the health status of the people living in a municipality. In this sense, it is necessary to associate to health access to housing (dimension of housing quality), access to health services (availability of drinking water, sources of water supply in the house, and human waste disposal), in association with the presence and prevalence of acute diarrheal diseases, access to education (illiteracy), and economic capacity (associated with occupation and unemployment). According to Wilkinson and Marmot, these factors have been identified as adequate to construct an index of UBNs and are referred to in the health sector as the influential SDHs: education

(schooling), employment and working conditions (occupational safety), economic income, safe and clean physical environments (healthy environments), health services. Meanwhile, Lip and Rocabado (2005) in a complementary way, mention other determinants:

> The characteristics of the general physical environment, of the workplace and housing, and the places where the population usually travels are important determinants of health. There are important determinants of their health that derive from air pollution—including secondary exposure to tobacco smoke—water and food contamination, level of exposure to infrared rays, oxygen content in the air we breathe, safety in the design of homes, schools, roads, and workplaces (2005:62).

The UBNs are critical factors that are identified based on the revision of the different available documents on the municipality, generated at different levels (departmental, national, and municipal). These factors are understood to correspond to noncompliance in the implementation of public policies, the nonsustainability of strategies and actions that reduce UBNs, and a lack of established goals for housing projects in the MDP with regard to qualitative (improvement) and quantitative aspects (number of homes built).

4. Capacity strengthening: The capacity of an individual can be understood as the probability that he/she will potentiate qualities, or skills, especially intellectual, that facilitate the qualification and development of activities, functions, and performance of a specific task. Capacity strengthening enables the generation and strength of sustainable processes of change in order to qualify even the capacity to analyze, understand, and transform reality.

   The strengthening of capacities at a collective level requires the accompaniment of the organizational order (interinstitutional) that accompanies and makes possible the realization of the different functions of individuals: citizenship, sociability, and association. In municipalities, government support and the provision of the necessary tools for the development of organizations and microentrepreneurs according to the economic base of the municipality should be promoted in a sustained way, through the application of existing public policies.

   According to PAHO (2007:7–8), some types of identified capacities that need to be strengthened are the following: (1) human talent: trained workforce for efficient service delivery through planning; (2) information systems and technological development: data sources based on population information, correlated with institutional databases (including data collection, processing, analysis, interpretation, and use of information). Among the main sources of information the prominent ones are censuses, household surveys, and vital records systems. Technologies, in this case, refer to those used in information systems. These elements benefit information systems generating data that must be appropriately fed and fed back in order to have adequate and timely data quality for decision makers; (3) organization: refers to institutional and management capacity (through a set of rules and regulations), governing the functioning and operation of a public health system; (4) resources: categorized as

financial (fiscal), referring to the acquisition, use, and management of available resources, and physical, which include existing structures equipped with instruments, equipment, and so forth (installed capacity).

5. Sustainability: The sustainability of the intervention processes developed to resolve a *problematic situation* requires prospective planning that integrates aspects such as their need, operational feasibility, implementation, and adequate conditions for the development of its execution, regardless of the influential political factors (government, officials, or policy changes). Long-term sustainability requires a comprehensive balance of powers in order to avoid a situation where some agents are the biggest beneficiaries, in economic terms, to the detriment of other agents.

   Experience shows that it is a fundamental task of government and participating actors to guarantee the adequate distribution of accrued benefits. In the short term, a lack of sustainability fractures citizen oversight on health expenditures and the complementary processes (monitoring, effectiveness, and evaluation) that come with the progress of the same. The process of sustainability of an intervention requires the participation of a group of relevant actors identified by their exposure to a specific problem situation: civil population, government authorities, prosocial organizations, and sectoral officials. The identification and interaction of these actors is indispensable, as is knowing and understanding how different actors perceive a specific problematic situation, who it mostly affects, who will face certain problems, and how and under what conditions they will face them.

   The causes of nonsustainability of social change processes and interventions that have shown their effectiveness and cost effectiveness are associated with programmatic and sectoral policy factors. Many projects are carried out in a conjunctural way, through initiatives of different organizations (NGOs) that encourage interaction between different actors who traditionally act in isolation, making the reduplication of efforts unnecessary. These projects are not usually part of the prior planning of local or departmental development plans.

6. Evaluation and monitoring. This aspect is one of the most important municipal challenges. It requires the ratification of an integral commitment to the issue of health and sustainable territorial development, which requires the strengthening of different capacities: human resource, technical, information management (registration, processing, analysis, and timely use), permanent monitoring of health indicators, documentation and systematization of the implemented strategies, and evaluation of the management of the territory.

7. Mapping of the most vulnerable areas in health. Gradually, the geographical area has been understood as a determinant of health. Therefore, it is very important to identify geographic areas with worse socioeconomic and health indicators (greater vulnerability), which will facilitate the implementation of focused and priority interventions in the territories.

The municipality of La Cumbre, Valle del Cauca, as well as other Colombian territories with similar characteristics, has not developed a mapping that identifies and plans adequate, timely, and prioritized areas with worse health vulnerability indicators for the actions of extramural teams and interventions in health. According to the different studies consulted and elaborated in the last decade, and despite the enormous effort from municipal authorities, the absence of this type of evidence has been verified, clearly showing the rural and urban areas with greater vulnerability in health. Identifying the areas with the worst indicators of vulnerability in health through mapping is relevant to identify in a timely manner the processes (of various kinds) that affect the appearance, prevalence, and progressive deterioration of the health status of the inhabitants of La Cumbre, Valle del Cauca, as well as those processes focused on initiatives that cannot be replaced by structural change that benefit through timely and adequately planned actions and integrative intersectoral development and health promotion as key strategies for the attainment of the highest health status.

Mapping can be considered a technique in the collective elaboration of maps, as well as a conceptual and methodological proposal that allows for constructing an integral knowledge of a territory, as well as the profile, characterization, and perspective in the health of a population. According to Ramasco-Gutiérrez et al. (2016), a health vulnerability map (HVM) is

> a spatial representation of an area inhabited by a population characterized by high UBN and low resource and health asset opportunities. This instrument enables the identification and prioritization of situations and groups toward which to direct interventions (2016:1).

Elaborating a map of vulnerability in health makes it possible to offer the possibility of graphic information, generating an additional visual impact that proposes another type of identification and visualization of existing problems. This process of identification-action can be replicated as valuable experience, understanding it as a demonstrative zone in municipalities with similar characteristics.

The lack of mapping for the identification of areas with greater vulnerability is reflected in general and nonfocused actions, with partial results that could be improved and systematically observed in the development plans of different municipal governments. In this sense, De Salazar and Pineda (2015:18) recently found the following: "In the review of the Municipal Development Plan 2012–2015, it was found that only for one behavioral risk factor (sedentary) were programs, projects and goals established. Other risk factors (overweight, cigarette and psychoactive substance abuse, unhealthy diet, excessive consumption of alcohol, and teen pregnancy) are not considered in the Municipal Development Plan. The Municipal Development Plan refers to problems such as poverty, rural and agricultural undervaluation, and low community participation, but in practice there are no programs, projects, and targets to address them." For mapping, technological tools can be used, such as Google Earth 7 (software) and

Google MAPS (Web map application server that offers scrollable map images as well as satellite photos of the world).

8. Analysis of social networks (ASN). Social networks can be described as well-defined sets of actors—for example, individuals, groups, organizations, communities, and global societies—linked to one another through a relationship or a set of social relations (Lozares 1996:108). The social capital built up by the different individuals, groups, and organizations should result in the construction of a health capital, with all that the notion implies: information, education, and communication that are adequate and timely for the community of a municipality in general. The analysis of social networks seeks to study the social processes (in this case, the processes that affect or benefit the population health status) from their particular configuration in networks.

   According to Freeman (2004), an ASN has four characteristics that distinguish it from other types of structural analysis: (1) it is motivated by a structural intuition based on the search of bonds that link social actors; (2) it is systematically based on empirical evidence; (3) it uses graphs and morphological analysis as central heuristic tools; (4) it relies on the use of mathematical or computational models for the formalization and generalization of its propositions (Aguirre 2011:12).

   The analysis of social networks can be carried out with the use of programs such as Socnetv and Payek.

9. Development of a sociological study based on a photographic-documentary record. Onsite audiovisual documentation allows individuals to be captured or recorded in their life scenarios: housing, work, recreational, and play spaces in which they socialize and are exposed to risk factors and protective situations. It allows the recognition and resignification of reality in order to rethink habits and determined practices and determinants of health.

10. Identification of the economic production of the municipality based on the development of the intervention lines: agricultural practices, structuring and processing of projects, technical assistance, and access to financial services (credits). The same goes in terms of capacity building (productive units), cofinancing resources, productive improvement, business management, and access to information technologies. Identification of some *local particularities* regarding certain practices, attitudes, and dispositions (peaceful coexistence, low intensity of conflict), by inhabitants and external observers, represents a key occasion to rethink strengthening and the processes oriented toward a social transformation based on strategies of community empowerment. The presence of and constant interaction with the community generates trust. The bonds of trust should be strengthened between academia and the diversity of actors in the municipality through the socialization of the undertaken studies. Once completed, the achieved studies should be shared with the different agents of social change.

Appendix

Table 11.3 Developed studies, instruments, and documents available on the health situation in La Cumbre

Source	Instrument	Available studies	Author/date
CEDETES		Design and implementation of a community surveillance system for behavioral risk factors for adolescent population, SIVEA	Ligia de Salazar (2004)
Hospital Santa Margarita	Community Information System in Primary Health Care (SICAPS)		Hospital Santa Margarita
Hospital Santa Margarita	Community-Based Information System (SIBACOM)		Hospital Santa Margarita
FUNDESALUD-CEDETES		Perceptions of risk factors associated with CNCDs, social determinants of health and community participation; inputs to generate intersectoral actions for health and local development in the municipality of La Cumbre (2013)	Roberto Carlos Luján (2014)
FUNDESALUD-CEDETES		Epidemiological-sociological analysis Municipality of La Cumbre (2012)	Aragón, Natalia and Luján, Roberto (2014)
Hospital Santa Margarita		Alliances and intersectorality: a priority path in APS	Ligia Elvira Viáfara (2013)
FUNDESALUD		Evaluative research: an instrument of social policy; confronting theory and practice for the management of chronic noncommunicable diseases: contributions from the evaluation.	Ligia de Salazar and Berta Luz Pineda (2015)
FUNDESALUD		Intersectoral Management for the Approach of Inequities in Health from the Municipal Territorial Entity: Capacities, Limitations and Challenges (2015). FUNDESALUD. Cali: Colombia.	Ligia De Salazar and Bertha Luz Pineda (2015)
Town hall MUNICIPALLA CUMBRE—VALLE		Synthesis of tensions of PTS La Cumbre 10-year public health plan PDSP 2012–2021	
Town hall MUNICIPALLA CUMBRE—VALLE		Municipal Health Territorial Plan La Cumbre Valle del Cauca	Andrés Osorio Pazmiño (2015)
CEDETES		Capacity Building for Local Development in the Municipality of La Cumbre—Valle del Cauca 2015–2018	2016

Other types of documents identified

Municipal Development Plans (MDPs) of La Cumbre Schemes of Territorial Ordering (EOT); Territorial Health Plans (THP); government plans (last three administrations); municipal action plans (e.g., health, government, education); epidemiological bulletins; POAI certificates; environmental audit report La Cumbre; POA (Annual Operational Planning of Investments in Health 2012–2015), recognition of basic health conditions; report on natural resources and the environment effectiveness (2006–2016); DANE; DNP; Governorate of the Valle del Cauca; municipal documentation and information system; controlling management reports; institutional statistics; EOT documents; analysis of health situation (ASIS) departmental and municipal; unsatisfied basic needs and municipal records DNP, among others

Table 11.4 Actors, actions, spaces, and public health programs, by type of community organization in municipality of La Cumbre

Type	Scenarios of participation	Actions	HP programs	Population
Associations, leagues, alliances, user committees (COMUSAN, hospital user representative, Altosano aqueduct, natural resource users leaders, natural resources committee),	Propositional and Advisory Councils COMPOS City council Territorial Planning Council Training	Campaigns Elaboration of food security projects Forums, accountability meetings Participatory training Sexual and Reproductive Health Policy Evaluation	Oral health, mental health Infectious diseases Chronic diseases Maternal child	Population in general: young, adults, disabled, rural and urban.
community participation committees, cooperatives	Proposals and advisory councils committee on epidemiological surveillance (COVE COMPOS)	Health and disease specific forums Home visits controls canines	Controls Sexual and reproductive health Oral health Mental health Infectious diseases Chronic diseases Maternal child	Population in general: young, adults, disabled, rural and urban.
Watching (ASOJUNTAS)	Watching (ASOJUNTAS) propositional and advisory advice committee on epidemiological surveillance (COVE COMPOS), municipal council	Training campaigns on patients' rights ensure adequate management of health resources, health brigades (vaccination), sexual and reproductive health promotion and prevention	Controls sexual and reproductive health, oral health, mental health, infectious diseases, chronic diseases, maternal, child	Population in general: young, adults, disabled, rural, and urban.
Community action boards (Bitaco)	Community action boards (Bitaco), propositional and advisory councils committee on epidemiological surveillance—COVE municipal council	Management in health (promotion and prevention), health brigades (vaccination), vaccination of dogs and cats	Infectious diseases, chronic diseases	Population of communes of rural and urban area
Local Propositional and Advisory Councils	Epidemiological surveillance committee—COVE	Management in health (promotion and prevention), health brigades (vaccination), vaccination of dogs and cats	Oral health Maternal, child	Population of localities and communes of rural and urban area
Board of health and local social protection, propositional and consultative councils.	Epidemiological surveillance committee—COVE	Home visits for management of healthy environments (housing), calls from community organizations for promotion of healthy living habits	Controls sexual and reproductive health, oral health, mental health, infectious diseases, chronic diseases, maternal, child	Population of localities and communes of rural and urban area

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Chapter 12
Innovation in Small Farmers' Economies (IECAM): Good Agricultural Practices of Healthy Agriculture with Associated Rural Enterprises in the Northern Cauca Area in Colombia

Myriam Sánchez-Mejía

Introduction

In a highly urbanized society, a commonly recognized relationship between agriculture and health has to do with the production of food or raw materials for processed food.[1] Even more, related institutions refer either to food production or to food consumption, leaving out interrelations, implications, and the complex system they belong to.[2]

A complex approach to the agriculture and health linkages makes it possible to identify additional dimensions, determinants of health, for intersectoral action related, at least, to food and nutrition security, environmental and ecosystem sustainability, and rural development. Some of the aspects to be taken into account include access to food and food security; availability and use of nutrients, natural ingredients, and supplements with improved nutritional value (iron, beta carotene, essential amino acids), food substitutes for contemporary challenges and trends

[1] According to the author's perception of students, the urban population identifies food with processed products or with supermarkets. Some do not know natural fruits in crops or the implications for ecosystem services used to produce them.

[2] For example, the "5 fruits a day" healthy consumption policy promoted in Colombia.

Please consult the final report of the project: "Innovación tecnológica para empresas agroindustriales de alto valor agregado en la economía social campesina." Caso: Buenas prácticas de Agricultura Saludable en la agroindustria del plátano con empresarios rurales asociados del Norte del Cauca" CB, January 2014. This chapter is based on that report. It is supported by information and contributions from collective learning processes with multiple participants, mainly within a related project coordinated by Corporación Biotec together with Corporación Vallenpaz and AgroCauca, from 2012 to 2014, cofinanced by Colciencias. It includes as well the author's conceptual developments, directly and within projects, with her participation.

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© Springer International Publishing AG, part of Springer Nature 2018

L. Malagón de Salazar, R.C. Luján Villar (eds.), *Globalization and Health Inequities in Latin America*, https://doi.org/10.1007/978-3-319-67292-2_12

(sugar, salt, and others), diet, food habits, and related diseases[3]; use and conservation of ecosystem services, mainly water, soils, and biodiversity; management of fertilizers, chemicals, and pollution; climate change; quality of life and well-being of the rural population; access to education and technological innovations; improved productivity of small farmers' production; recognition of local and empirical knowledge and its remuneration; recovery and respect for local gastronomy[4]; diet, identity, and traditions; social and commercial inclusion of local production; and added value in small farmers' production chains.

Colombia is recognized as one of the potential global breadbasket countries (IDB 2014) based on its agricultural diversity. To effectively take advantage of this opportunity, decisions need to be made to shift from a raw material economy to a competitive, sustainable, and inclusive knowledge-based bio-economy. In this context, the Colombian National Science, Technology and Innovation System (SNCTI, by its Spanish initials) has identified needs for improvement, mainly related to coordinating the different agents and interests in the system, to face the most pressing challenges to contribute to the development of the country (OCDE 2013).

In this context, Corporación Biotec (CB), in a highly participatory, interdisciplinary, and interinstitutional process, has identified the diverse and complex relationship between agriculture and health as one of the convergent strategies to "intervene" with science, technology, and innovation in the regional ecosystems in the Pacific region of Colombia.

CB works within the concept of sustainable high-added-value agricultural systems (Sistemas agrícolas sostenibles de alto valor agregado) for research, development, and innovation processes and social and productive appropriation of knowledge, integrating agriculture, agro industry, and bio industry. Complementing this concept, a whole chain of beneficiaries are recognized, from farm products to nutraceuticals, plant-based medical products, including gastronomic interests and processed food. In all cases, quality and sustainability regulations, compulsory and voluntary, are referenced for healthy production. In this sense, CB has developed a model, Healthy Agriculture Culture and Seal ("Cultura y Sello Agricultura Saludable®"[5]), to accompany small farmer communities to improve productivity, increase revenues, and establish goals to protect them against harmful health impacts. The model Innovation in Rural Economies (IECAM, based on the Spanish *innovación en economías campesinas*),[6] a learning-by-doing model, is used for this purpose to build local capacities.

[3] Relation between food/diets and CNCD

[4] Rediscovery of quinoa is an example of the richness of ancient American food, misvalued for long periods of time.

[5] Generated by CB since 2010.

[6] Indicators of quality of life in rural areas in Colombia show a wide gap compared to similar indicators for urban areas in the country (Ocampo 2016; Olarte 2015; DANE Censo agropecuario 2015). According to different studies and experiences, agriculture, a key activity in rural areas in Colombia, will require a technological transition to become a strategic factor of change.

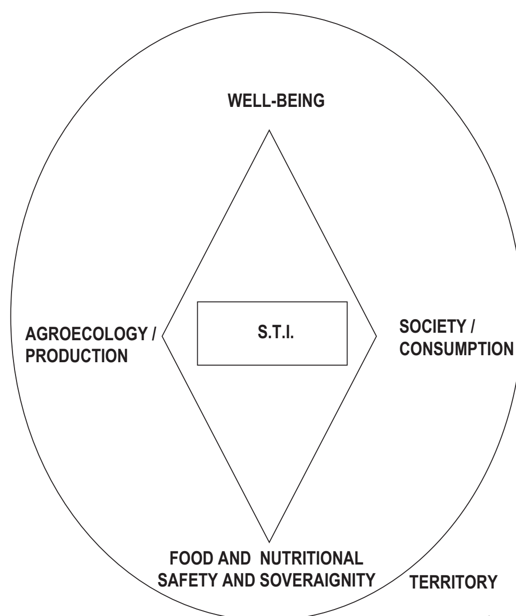
The case of IECAM, good practices of healthy agriculture with associated rural enterprises in a Northern Cauca area in Colombia (Innovación en la economía social campesina-IECAM: buenas prácticas de Agricultura Saludable con empresarios rurales asociados en el Norte del Cauca-Colombia), presented in this chapter, is developed within this context.

This case is based on and develops the following key concepts:

- Complex thinking in the relationship between agriculture and health;
- High-added-value sustainable agricultural systems;
- Innovation in rural economies;
- Healthy Agriculture Culture and Seal® for better living.
- Practice as a collective learning tool in rural development: 1×10×100 cascade, for knowledge transfer and appropriation.

A conceptual framework is presented in Fig. 12.1.[7] It includes, in a science, technology, and innovation–based system, the food production and consumption chain in society, oriented toward food and nutritional safety and sovereignty for human well-being in a territory.

Fig. 12.1 Conceptual framework (adapted from CC-Alimentos UV 2017)



[7] CC-Alimentos UV 2017, Project in formulation in Universidad del Valle with the participation of Corporación Biotec.

In the northern part of Departamento del Cauca,[8] small farmers grow and harvest at low levels, for local consumption, around 30 varieties of plantain (green banana), of which 5 commercial varieties are produced for regional consumption.

The plantain has been a basic food in the diet of this region for many years, and cultivating it has been a productive activity, main source of employment, revenues, and rural entrepreneurial developments, and fundamental to improving the quality of life of peasant communities. Diverse studies in the zone have shown that knowledge and practical skills exist from local traditional production and that the use of these varieties represents for the local community a high potential for the generation of added value for food and nutrition security (Dufour et al. 2007). The recovery of processes for food and other uses, based on the experience of the community in dealing with the specific characteristics of the fruits, has been seen to be of special importance.

The plantain, a basic food in Northern Cauca, is part of the everyday life of the community and small farmers.

Recovery of this knowledge and experience, as an opportunity for community well-being, has been proposed based on the deepening of scientific and technological knowledge about the properties of these varieties and innovation in the traditional processes for food products and other uses relating production to needs in the community and trends in the markets.

Quality and environmental sustainability are key issues that are central to the desired improvements to contribute, respecting small farmers' identity, to fight inequality, reaching better productivity and community challenges, without generating harmful health or environmental impacts. To add value and make better use of these agricultural resources in urban and rural regional areas in the neighborhood is a main goal

Associated rural entrepreneurs of Northern Cauca supported by Corporacion Valle in Paz have developed empowerment and organization of the community of farmers for the production and commercialization of plantains and derived products as well as other crops. Based on these social processes, CB was invited to join the community to contribute with technological innovation. Together with the community, there was an agreement to implement the culture and seal (brand certification) from the Healthy Agriculture Model (Agricultura Saludable®).[9]

The project, coordinated by CB, was for the producers to build the capacity and culture of data registration and quality requirements and to identify potential agro-industrial products to go further in the added value production chain.

As a step forward, associated rural entrepreneurs of Northern Cauca—AGROCAUCA, Corporación Vallenpaz, and CB—identified an opportunity to incorporate innovation in the traditional agriculture and agribusiness sectors to improve the competitiveness of the production chain of plantains, adding value

[8] Municipalities of Guachené (20.000 inhabts, 75% in rural area) and Padilla (10,000 inhabitants most percentage rural) in departamento del Cauca, Colombia. Vulnerable communities located in areas of influence of diverse types of violence.

[9] Corporación Biotec\Vallenpaz\Colciencias 2009–2010 Project "Contribución a la competitividad de la producción agroalimentaria de una comunidad campesina mediante la aplicación del Sello Agricultura Saludable y los Servicios Tecnológicos de Acompañamiento."

to the social rural economy in Northern Cauca in integrated development efforts. To do that they put in place in 2012 the project IECAM: good agricultural practices of healthy agriculture with associated rural enterprises in a Northern Cauca area" ("Innovación tecnológica para empresas agroindustriales de alto valor agregado en la economía campesina. Buenas prácticas de Agricultura saludable en la agroindustria del plátano con Empresarios rurales asociados del Norte del Cauca"). The generation of added value in the social peasant economy is seen as part of a comprehensive development process.

Answer to an Identified Problem

The project addressed low productivity in the production chain of plantains, low quality standards in final products, and low revenues within the whole community of producers along the production chain in Northern Cauca. This community complains of not receiving technical assistance. Even if the community recognizes its traditional knowledge and practical skills with high potential that will help obtain better results, they still need technological support. Especially because growing markets in neighboring urban areas such as Cali demand those products to be included in the regional diet. Plantain has become part of food and nutritional security..

The Intervention

In a learning-by-doing process, for the implementation of the Healthy Agriculture model, it all starts with an agreement with the organized community of producers of an agricultural chain on the need and potential for innovation.

The community acts as co-researchers, and the whole team becomes stakeholders.

The project started out by identifying with the farm producers and agribusiness entrepreneurs eight "links" in the production chain, already set in Guachené and Padilla, within the concept of high-added-value sustainable agricultural systems (Fig. 12.2).

The production chain targets, as markets and beneficiaries, are identified in a wide user chain from consumers of fresh products to consumers of plant-based medical products.

Objectives of Intervention

The established general objective was to improve the competitiveness and sustainability of the agribusiness chain of plantains in Northern Cauca within the rural economy, under good agricultural practices of Healthy Agriculture, to contribute to better living.

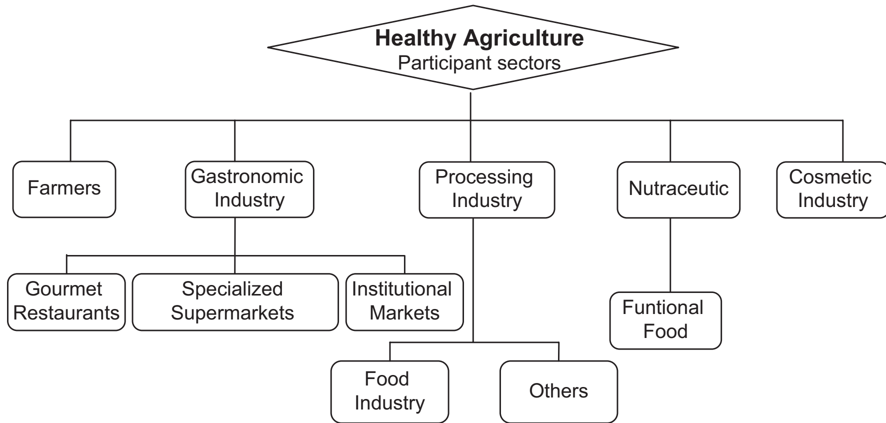


Fig. 12.2 Links of production chain—beneficiary production sectors

Specific Objectives

1. To identify and design "lines" of farming systems and agro-industry processes to add value to the production chain of plantains within the peasant community of Northern Cauca (Guachené and Padilla);
2. To select and produce planting material of local varieties of plantain to be used by rural associated producers;
3. To promote capacity building within an associated community to articulate management processes of the improved production chain, strengthening the organization, rural entrepreneurship, and Healthy Agriculture principles adoption.

Methodology

The interinstitutional team, designed together with the community in participatory dynamics, using a methodological model, is presented, with three underlying components:

– Establishment of a baseline for the eight identified links, mainly through fieldwork taking into account a lack of available registered information and data;
– The Creative Plantain Fair to present products and experiences from the community, organized in the old market plaza of Padilla using stands for each of the eight identified links;
– Identification of potential and desirable interventions in specific processes (within the links), and prioritization of five interventions for innovation developments. The dynamic helps to identify the main areas of competence or components in which research, development, and innovation are needed.

The complexity of the initiative and the recognition of it as a cultural process make it a long-term effort, for which different types of results are reached and expected in different periods of time.

Two important results from the underlying project are the improvement of production of planting material through combined methods, traditional and *in vitro tissue culture*, and the quality improvement in the production of a very popular traditional food product: aborrajados de maduro. Both had a demonstrative impact. We comment on them in what follows.

Innovation in the Improvement of Production of Planting Material Through Combined Methods, Traditional and In Vitro Tissue Culture

- The main needs identified are the sanitary quality of the material and the reproduction of the adapted local material;
- The community performed in *vitro culture* learning, with protocols developed for plantains (green bananas);
- Communities established areas of selected elite material;
- Protocols were collaboratively developed to combine traditional methods with the *in vitro culture* of plantain seedlings;
- The expected result was the production of planting material of healthy local varieties;
- Human resources were trained in the use of protocols.

Innovation in Quality Improvement in the Production of Aborrajados de Maduro

- A production especially developed by women of a traditional product especially appreciated in the region, distinguished by the use of the selected variety (guayabo green banana);
- After checking the quality of the ingredients, especially the cheese, points at which the processes could be improved to guarantee the required quality were identified;
- Producers were selected to complete high-level training in food laboratories at the University of Valle, by agreement with the project;
- Aborrajados de maduro could be a nutritionally optimal product for school breakfasts that would replace industrial products with lower nutritional value, thus creating a market for local production; although this objective was not achieved, an opportunity for local consumption was revealed;
- Students from the food engineering program at University of Valle food engineering conducted postgraduate studies on topics related to aborrajados, seen as technical challenges.

The complexity of the process, which implies a production and cultural transformation, the richness of the methodology proposed for the introduction of IECAM, the complementarity of the project actors and alliances generated, from CB and Corporación Vallenpaz, mainly with SENA in Cauca, food engineering at the University of Valle, Icontec, and CIAT, among others, made it possible to generate in the 24 months of the project three results that were complementary to the proposed objectives:

- Generation and visibility of an innovation ecosystem in the project area,
- Development and provision of a technological tool kit,
- Identification, management, and awareness of initiatives for sustainability and continuity of the process.

These processes, however, require continuity, diverse actions, articulated actors, and medium- and long-term support.

The IECAM model, validated in this project, is available to the country, at a particularly opportune time to contribute to the peace agreement for agriculture and rural development. It is collective learning in action: practice as a tool for learning and building sustainable local capacities.

Discussion

Some studies estimate that peasant production in Colombia contributes between 50 and 68% of the total national agricultural production and that 35% of Colombian household consumption is in food products that come from the peasant economy (Leibovich et al. 2013).

The model designed for the contribution of technological IECAM, applied and validated in the case of reference in this chapter, identifies at least eight processing links in the plantain production chain, to which technological innovation contributes to increased productivity and improved quality, so that competitiveness of the chain is increased, as is, hence, the income of small producers and their contribution to regional food and nutrition security.

The relationship between agriculture and health seems no to have been discussed. A holistic view of the issue could be disseminated for implementation.

Although theoretical bases and conceptual elaboration of similar experiences were taken into account, the project developed an empirical process of collective learning with bases for the systematization of a theoretical framework.

A system for monitoring the increase in competitiveness (MIC, based on the Spanish term), was initiated in the project. Further registration of data and continuity is required to provide information on this.

Evaluation Note

- The basic approach of the project was confirmed: collective construction among experts, technicians, producers, and the community at large enriched knowledge and experience and generated associative processes that, by valuing local knowledge, incorporated technological innovations appropriated socially and productively by all actors.
- The IECAM proposal "Technological Innovation in the Peasant Economy" is a model designed, validated, and made available for application in other cases, for other crops, and in different areas of the country, where it can serve as the basis of collective construction processes with local actors.

The peace process and the transformation of the countryside in Colombia could use this model to implement it in the rest of the country.

- The model, both conceptually and operationally, was implemented in the case of the plantain production chain in Guachené and Padilla and demonstrated its benefits for the improvement of production chains based on technological innovation, with results that contribute to local and regional food and nutritional security (access and food safety), from the production of small farmers who in the process improve their well-being.
- The model implies cultural and technological processes that make it complex and long term, although with short- and medium-term results.
- The institutional complementarity between CB, Corporación Vallenpaz, and AgroCauca was a fundamental factor for the success of the project.
- The project also mobilized public and private resources (SENA-Cauca, ICA Cauca, Fedeplátano, the University of Valle Food School, CIAT: Biotechnology, Phytopathology Laboratory, CIRAD/RTB, Guachené and Padilla municipal governments). This teamwork additionally generated an associated work culture that facilitates long-term sustainability.

Promoting the formation of an "innovation ecosystem" around the production chain was based on the recognition of a regional "innovation platform" that contributes to the sustainability of the technological innovations implemented. The mobilization of existing resources is important in this type of model.

- The development of the project involved innovative strategies to take into account. A competition between students from universities in the region to propose improvement initiatives in the chain showed advantages in the generation of dynamics and in the involvement of young professionals in areas and topics traditionally far removed from the interests of universities. Another example is the linking of the master's thesis to the elaboration of traditional food products (aborrajados), evidencing problems for food engineering involved with this type of food.
- Reviewing vocational training in universities in order to relate them to communities, deepening the relationship between agriculture and health, is a recommendation.

Achievements

If we summarize the achievements of the intervention, we may refer to the contribution to closing productivity gaps and compliance with quality standards, thereby contributing to the sustainability and competitiveness of the chain and, consequently, the peasant economy and to food and nutritional security. The relationship between agriculture and health is strengthened by this experience as a contribution to well-being by direct and indirect effects of the intervention.

- The cascade scheme 20×10×100, which has been deepened in this project, has shown its measurable benefits in the project's inclusive call and in the "sponge" attitude that the producers show to assimilate all the contributions of innovation offered to them. In turn, they contribute with their knowledge as a complement to the process, linking it to other secondary students in the area, which contributes to sustainability over time.
- The training of human resources in specialized training programs and in practice is a recognized and verifiable achievement of the project.
- As lessons learned, it is important to note the need for paradigmatic changes in the training of professionals working in the field so that they are able to recognize the value of empirical knowledge, to work as a team in so-called systems of innovation, and to identify the differences and complementarities between traditional knowledge and expert knowledge. It is also important to have a clear concept of sustainability and return to the investment in innovation in the peasant economy.
- The design and publication of a kit of technological tools for a production chain makes it available to wider communities. The production of documents, posters, and dissemination material makes it possible to describe the experience such that it can be replicated.

Difficulties

- Linking these research and innovation projects to a variety of different players in innovation systems (Biotec Corporation's way of working) requires learning for all and adjustments in roles and responsibilities, which is neither obvious nor immediate. It is key that the participants recognize that, despite this being a learning process, it is essential to generate tangible products in established timeframes. It is a challenge that also requires discipline and learning.
- Achieving long-term funding or institutional continuity to "sustain" the process is probably the greatest difficulty. Communicating this situation to public policy entities and allocating resources is an ongoing challenge.
- Intersectoral vision and action using a complex thinking approach is a challenge that brings greater challenges to interventions. Agriculture and health, related to local diets, environmental quality, and general welfare, has proven to be a necessary and convenient convergence strategy to contribute to the well-being of a community.

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Chapter 13
Research in the Strategy of Healthy Communities in Mexico: Learning for the Transformation of Practices Against Social Determinants of Health

Jorge Laureano Eugenio and Elisa Gil Hernández

Introduction

At the first World Conference on social determinants of health (SDH), convened by the World Health Organization (WHO) in Rio de Janeiro, Brazil, in 2011, member countries were committed to respond to five key areas that would involve the design, implementation, and evaluation of public policies, including governance, promotion of community participation, alignment of priorities and actors, and monitoring of progress (Balladelli et al. 2012).

Also in 2011, in the region of the Americas, the directive council of the Pan American Health Organization (PAHO) designed solid policy tools to promote specific work plans vis-à-vis the SDH, approved by member states, emboldening the countries to ensure they have the tools they need to bridge the inequality gap, strengthen and expand networks in the region, and monitor and evaluate actions (collection and greater breakdown of data) (Balladelli et al. 2012).

In the execution of actions with a focus on SDH and sustainable development, the processes of health promotion, within the framework of primary health care, are recognized and repositioned as the key strategy of action of governments needing to develop and strengthen technical and intersectoral cooperation in order to design, implement, and, above all, evaluate public policies that seek to create healthy environments, promote social mobilization, and guide health services from an equity perspective, an assessment that allows for the construction of knowledge and reflects the faces of the sociocultural context in which it develops (OMS, OPS 2013; Martínez 2014).

In Mexico, the federal government in recent years has generated and intensified actions that address the SDH in different areas of the country, transforming its social

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© Springer International Publishing AG, part of Springer Nature 2018

L. Malagón de Salazar, R.C. Luján Villar (eds.), *Globalization and Health Inequities in Latin America*, https://doi.org/10.1007/978-3-319-67292-2_13

and political agendas and, above all, the role of the state in unveiling an increasing commitment to equity and social justice, actions that are difficult to implement in light of the deep socioeconomic inequalities prevailing in the Latin American region: low- and middle-income countries facing a critical health situation combined with reversed progress of neoliberal globalization (Franco 2011; Frenz and Titelman 2013).

Since 1995, one of these actions has been the Healthy Municipalities strategy, a program with health promotion activities at the municipal level involving the participation of the community. In 2001, this program was strengthened, even changing its name to the Healthy Communities program, a change that was influenced by events in developed countries with the "Healthy Cities" initiative promoted by World Health Organization and in Latin America, in developing countries, through PAHO, the Healthy Municipalities and Communities movement (Gobierno Federal 2014).

The Healthy Communities program was launched to address the public health challenges faced by the most vulnerable populations in Mexico, aiming to generate and strengthen health promotion in and from the country's municipalities, with the participation of different sectors (public, private, and social), through actions that position the municipality as the most appropriate level to carry out the integral work of health promotion, against the social determinants of health identified at the local level (Ander 2003).

The program's main objectives are to generate basic sanitation and services, preserve the environment, promote hygiene and cleanliness, encourage healthy behaviors and lifestyles, seek equity, and establish health services to meet the remaining needs of prevention, treatment, and rehabilitation. The importance of community participation in the generation of alliances with existing groups in the community and with the population is emphasized, which will make it possible to work in an organized way to achieve together better health conditions.

However, in the Health Secretariat of Jalisco, Mexico, the Healthy Communities program has been implemented for more than 15 years, but in all this time, there has been no clarity on the mechanisms making it possible to identify the impact of actions since it has only focused on the evaluation of process indicators, noting the actions carried out, but not the effectiveness and sustainability of the process of health promotion at the municipal level with respect to SDH.

Because of the Health Secretariat of Jalisco's interest in the generation of knowledge derived from the processes of the Healthy Communities program, in 2013 the Department of Research of this same institution participated in efforts to incorporate the scientific method into a project of this program. These efforts involved the project's design, implementation, monitoring, evaluation, and sustainability. It was an experience that needs to be reflected and shared so that it can be applied to improve and transform our own practices in health promotion with respect to the SDH.

Description of methodological component within Healthy Communities program project: To identify the scope and limitations of the lessons learned as derived from

systematization work, this section describes two aspects in general: (1) methodological moments of the Healthy Communities project and (2) methodological aspects for the systematization of the experience.

Methodological Moments of the Healthy Communities Project

Origin: The experience began in May 2013, when the area director of a rural health unit requested that the research department incorporate the scientific method into a project of Healthy Communities to be carried out in a rural locality of Jalisco, Mexico, assuming that, based on this experience, it would be necessary to have evidence of the scope of these intervention projects, which he had been doing for 10 years in other localities. Based on this request, a health educator and a field epidemiologist were formed into a research team, and, together with the area director, they analyzed the proposal of the Healthy Communities project and designed a research protocol.

Considering the subject of study, the objectives of the Healthy Communities intervention project ("Reverse malnutrition, overweight, and obesity, as well as eating disorders, in the population") and the elements of the rural context, the research team decided to use a critical and dialectical methodology, participatory action research (PAR), as a systematic circular process and with a focus on primary healthcare, which would allow actions to be taken that would promote health and educate people about health, such as mechanisms to deal with the socio-cultural, economic and geographical factors that generate malnutrition in the locality (Jara 1998).

The idea of carrying out applied research rather than traditional scientific research was considered since the goal was to document the meaning, effectiveness, and sustainability of three actions proposed by the Healthy Communities project to be developed in cooperation with the population: (a) physical activity, (b) training for adequate feeding, and (c) healthy cooking, integrating throughout the entire process ten methodological moments that considered both quantitative and qualitative techniques (Table 13.1)

The consolidation and implementation of the ten moments was from January 2014 to December 2016, which did not necessarily follow a rigid linear scheme, but were configured in response to the nature and meaning of the participatory process, which involved actors from different sectors and communities in decision making; this allowed them to guide the process, make a critical assessment of their living conditions, a search for the causes of their problems and the generation of concrete and viable strategies, which were concretized in the work agendas with a continuous reflection on the praxis, making the process more and more emancipatory and transforming of the context.

Table 13.1 Methodological moments of PAR process

No.	Methodological moment	Description
1	Knowledge and outreach to community	Walking and vehicle tours to identify actors, ideological factors, ways of local organization, and epidemiological characterization of population
2	Generation of primary group	Reflective dialogical work with community and institutional leaders to identify and reflect the population's problems, the objectives of the Healthy Communities project, and the identification of ways to participate to reach objectives
3	Generation of work commissions to achieve "social mobilization"	Work in community participatory tables between primary group and other municipal government and health authorities, under a conceptual model of action-reflection, generating work agendas to achieve objectives set by project
4	Understanding of beliefs and knowledge	Qualitative work (natural groups, individual interviews, and ethnographic observation) to understand beliefs and knowledge of population against social determinants of food
5	Socialization of the strategy to the whole community through community assemblies	Development of community assemblies by primary group to socialize strategy with entire population and facilitate social mobilization for activation of work agendas
6	Baseline measurement of variables of interest for study	Application of quantitative instruments to perform first measurement of variables under study and to document changes in population effected by Healthy Communities project
7	Beginning of actions	Initiation of basic intervention actions proposed by primary group through systematic and reflective circular educational process
8	Growth of educational process	Configuration, implementation, and sustainability of local work networks within process, highlighting the value of the population's culture in them
9	Bimonthly measurement of variables	Application of quantitative instruments to carry out measurement and follow-up of variables under study
10	Quantitative evaluation at end of project	Application of quantitative instruments to perform final measurement of variables under study

Methodological Component of Systematization

In December of 2016, at the end of the process of intervention, the group of researchers and health authorities at local, regional, and state levels considered it important to come up with a critical interpretation of the Healthy Community project that would make it possible to learn from the experience of incorporating the scientific method in a health promotion project at the municipal level, objectify the experiences, and analyze them, posing as the objective of the systematization to understand the implications, opportunities, and challenges when incorporating the research into the Healthy Community project, such as actions of health promotion with respect to the SDH, applying the methodological proposal of Oscar Jara. The methodological moments of work are described in Table 13.2 (Santos 2011).

Table 13.2 Methodological moments of the systematization process

No.	Moment	Description
1	Elaboration of systematization plan	Agreements between local health staff, health authorities, and researchers to propose systematization of experience in incorporating the scientific method into a Healthy Communities project, considering the following elements:
		– Records of experience: documented protocol, database analysis, field diaries, work materials with population, activity reports, minutes of agreements and meetings, workshop memories, photographs, and so forth
		– Definition of moments and place of work
2	Definition of aspects to be systematized	From the experience, the researchers defined that the objective of the systematization was "to understand the implications, opportunities, and challenges of incorporating research into projects of healthy communities, such as actions of health promotion against SDH"`
		To participate in the systematization, key individuals who had participated in an educational process in an activity related to the research were considered:
		– Management staff of local, regional, and state health
		– Local health staff
		– Representative of population and other sectors
		– Research team
3	Recovery of lived process	First session: A facilitator of the process (research team) guided the process with all the participants to rebuild the story from a graphic chronology; using the "snake" technique, by drawing on paper the silhouette of a snake, they wrote on the tail the start date of the process and on the head the end date. Inside the snake significant moments of the research process were placed and above each one of them, the difficulties experienced and under them the facilitators, guiding the facilitator of the process, the organization and classification of information with the participation of all stakeholders
		Second session: Following the organization of information, in two discussion tables approved by all attendees, each moment was reflected with its difficulties and facilitators, trying to determine the logic of the process, putting in order the disorganized knowledge and dispersed perceptions of the first part
4	Deep analysis	Third and fourth sessions: The researchers formulated the critical interpretation of the data, taking as conceptual framework the SDH, the categories of analysis being described by other studies: theoretical debate on the relationship between social inequalities and health and multidimensional perspectives in its approach, measurement, and follow-up (Santos 2011)
5	Arrival points	(a) Elaboration and writing of lessons learned, conclusions, and recommendations achieved by incorporating the scientific method into health promotion projects at the local level

Lessons learned when incorporating the research into a Healthy Communities project: To better understand the lessons learned from this experience, they are presented in three aspects: implications, opportunities, and challenges in incorporating the scientific method into Healthy Communities projects as actions of health promotion against SDH (Tables 13.3, 13.4, and 13.5)

Table 13.3 Opportunities to incorporate the scientific method into Healthy Communities projects as actions to promote health against SDH

No.	Reflective axis	Description
1	Document effectiveness of actions against SDH	– It allows rethinking and understanding the nature of the projects in the municipal scope: sociocultural processes of education, reflection, consciousness, and mobilization at personal and group levels, seeking to transform a social reality through empowerment and networking, strengthening the social fabric at different levels of action for the generation of changes toward a reality desired by the population
		– Let the population know and reflect on their achievements, scope, and limitations when implementing and participating in a Healthy Communities project
		– Contribute to the generation of mechanisms (guides, manuals, certificates, evaluation instruments, technical documents, among others) for the qualification and understanding of health promotion strategies, generating practical knowledge that feeds the processes and can be resumed or replicated in other contexts
		– Opportunity to spread the findings and be able to consolidate a theoretical and conceptual framework of the practice of promotion at the municipal level, to modify the SDH
		– The possibility to step away from institutionalized governmental processes, to move to the generation of knowledge in a different way, recovering the sense of practice and generating possible processes of theorization that deepen the experience and facilitate the incorporation of new visions and interpretations
2	Learning and training of work and health teams	– Opportunity to generate integrated work at the institutional level, that is, to link the actions carried out in isolation by the health team (doctor, nutritionist, nurse, and health promoter), as well as local, regional, and state level management, allowing a mutual enrichment of what each one performs, giving direction and meaning to the entire intervention project to achieve the final objective
		– Allow mechanisms for health teams participating in Healthy Communities projects to identify, document, and analyze their achievements, difficulties (risks and threats), and coping mechanisms in order to recover and socialize these learning processes and be able to apply them in future projects
		– Opportunity to understand health promotion by health professionals as a process of social mobilization that involves empowering the population, emphasizing groups in conditions of vulnerability or difficult access

(continued)

Table 13.3 (continued)

No.	Reflective axis	Description
3	Incorporation of new elements for decision making	– Opportunity to socialize the results of the intervention project through exercises of transfer and the use of results, with local stakeholders and above all with decision makers from different sectors that are involved (e.g., education, health, social development, economy), allowing them to understand the nature and scope of health promotion, consolidating better management processes, and, above all, giving identity to the rectory of health promotion in actions against the SDH
4	Document the role of women in social development processes	– Possibility of documenting how the processes of health promotion make evident the overcoming of limitations and the breaking of social invisibility of the leading role of rural women in local development, highlighting the decision making between men and women, with the establishment of new forms of empowerment between them

Table 13.4 Implications to consider in the incorporation of the scientific method into the Healthy Communities projects as actions of health promotion against the SDH

No.	Reflective axis	Description
1	Development of skills and competencies for research	– Health professionals, at their three levels (state, regional, and local), must have training or experience in public health research, since otherwise they show a distant attitude and lack of interest in the processes of the scientific method, especially in evaluation, systematization, and follow-up
		– The research team must have the knowledge and skills to be able to transfer theory and research findings into more effective public policies
		– It is necessary that in the Healthy Communities projects those responsible for incorporating the scientific method be creative and flexible, have leadership qualities, and be capable of making decisions
2	Assurance of resources necessary for the sustainability of the research	– Consider that the budget should be not only for infrastructure and materials for health education actions but also resources for monitoring, evaluation, and systematization of the intervention process; otherwise, the feasibility of documenting the effectiveness of the intervention in the medium and long terms with the scientific method would be at risk
		– The universities that participated as external evaluators of the participatory process should be involved in the design and implementation, not only at the end of the evaluation, which allows them to understand the process in its entirety, taking into account the opinions of the population and other stakeholders participation
		– The research team should be integrated into the intervention project from design to final systematization and consider the costs involved in the Healthy Communities project budget; otherwise, no resources will be available from other sources to carry out this scientific work

(continued)

Table 13.4 (continued)

No.	Reflective axis	Description
3	Use of methodologies with a transformative critical perspective	– Researchers need to define methodological and theoretical constructs that respond to the nature of Healthy Communities projects and, above all, to the health problems of a globalized world, assumptions on which the communicative strategies of health and social development allow the people to have a critical view of the conditions in which they live, that is, identify the sociocultural, biological, economic, and geographical aspects that condition health and disease. Some of these theoretical and methodological constructs are popular education, community psychology, liberation theology, Participatory Action Research, among others, leaving behind traditional models that focus on only influencing individual risk factors
4	Involvement of all actors in the health promotion process	– In the design and implementation of research, as well as in the reflection on, analysis of, and dissemination of findings, all social actors (individual or collective) should be involved, locally defining objectives and work plans, starting from a point at which all want to act, taking into account the elements of the context that allow the scientific method to include the biological character, but also the sociocultural, economic, and political nature of health, taking into account all actors involved, and be able to awaken in them a critical vision of their reality with the generation of networks for local territorial management
5	Modification of program operating guidelines	– In the guidelines for the implementation of Healthy Communities projects, it will be important to consider two modifications: (1) temporality to spend resources: it is important to extend the time to spend the resources of the project, since currently the established times are short (months) and do not allow in the long term, contemplate expenses that are generated as participants' needs when participating in the project and (2) document sustainability and effectiveness of the project: clear mechanisms should be established in the call to document the effectiveness of the intervention and the sustainability of the project, with a minimum of two years of implementation, having to build indicators of results and not only of process, as well as a methodological proposal to systematize the experience
6	Ethical considerations in research processes	– The application of the scientific method at the municipal level must take into account that these projects use a methodology that facilitates social mobilization, which can be used in political campaigns by people who want to be elected as mayor, which can generate conflicts of opinion and tensions between population groups, creating divisions and hindering social mobilization, as well as not reaching the objectives established by the research team, but without the generation of a process that helps the organization and social awareness to modify their living conditions
		– When incorporating the scientific method into the Healthy Communities projects, these will be evaluated and dictated by a committee of research and ethics, ensuring that all the actions carried out are in accordance with current regulations in the field of research, highlighting the respect for the integrity of the people involved and respect for the desire for transformation, autonomy, and freedom to act

Table 13.5 Challenges with the incorporation of the scientific method into the Healthy Communities projects as actions of health promotion to modify the SDH

No.	Reflective axis	Description
1	Research work with multidisciplinary teams	– All the conceptual and theoretical constructs of the research process must be analyzed by multidisciplinary teams, which allows building, feedback, and projecting the entire process within the framework of the SDH when considering the diversity of approaches that can be used in Healthy Communities projects
		– The multidisciplinary work must be dynamic, open, and participatory, generating proposals that go beyond their technical and operational aspects and are revitalized from social, cultural, and political processes, producing a constant renewal and integration of knowledge and skills of research teams
2	Favor the evaluation and formulation of public policies	– The research findings should become valuable input for the reflection, evaluation, and reconfiguration of public policies (taking decisions that take into account the evidence), especially those that are linked to social development, since currently the paternalistic attitude of the government is evident, which has changed the conception and sense of actions, without giving voice and vote to the citizens to decide on the construction of their health
		– These evaluation processes should analyze SDH within the social, historical, and cultural context of the population where it is implemented, since interaction between social actors and institutional actors makes it possible to discuss the assumptions of the role of each member of society when generating questions in the form of creating and applying a social program
		– It should be understood that the evaluation processes of Healthy Communities actions address not only the medium- and long-term effects but also the evolution and meaning of the whole process, ensuring that these evaluation actions are participatory and with affordable costs for those who cover them
		– The research with a critical-participatory approach should be seen as an opportunity to understand from locals the way in which globalization has delinked the institutions of the various social actors, also giving elements to the governments to analyze the economic aspects against the sociocultural and to generate actions of social development, but above all, to propose creating a strategic plan and the political and cultural democratization of knowledge embodied in the projects of Healthy Communities
3	Cross-sectoral research	– Find a way to generate research in Healthy Communities projects that integrates the different sectors that have a direct or indirect relationship with the subject to be addressed, emphasizing the management and exchange of knowledge generated throughout the process
		– To ensure that research is conducted as a tool that promotes equity, understanding, and an integral approach to SDH, a strategic and scientific approach to creating more reflective cross-sectoral debates on health promotion processes, as opposed to social development, must be developed above all to provide evidence of the benefits that decision makers wish to know

(continued)

Table 13.5 (continued)

No.	Reflective axis	Description
4	Assess the moments and difficulties for the development of research	– Past experiences of organization at the local level should be taken into account without concrete achievements, as the population shows a lack of interest in starting a new project that involves social mobilization
		– Some municipal intervention projects, being of a multidimensional nature, with diverse interventions by different sectors and social actors, run the risk of dividing the process, not consolidate efforts, and end up identifying in an established way the effects that each participant managed to obtain
		– The research team must be integrated at all times with the diverse social actors involved in the management and implementation of the Healthy Communities project; otherwise it may present difficulties to understand the language of research, the times and resources that are required to carry out the study, and, above all, the way to articulate the scientific method with a project of social and political action
		– The campaign times of political parties for presidential elections put at risk community participation, as they create an environment of division and uncertainty to join projects proposed by the current government. Likewise, there is a risk that political parties will resume the actions of the Healthy Communities project as spaces of political campaign against the population
		– In community intervention projects, where the aspects of empowerment and community capacity building vis-à-vis the SDH are not visible for local government, it will be more difficult to monitor and demonstrate the long-term effects through the scientific method
		– In some regions of the state and of the country, the integrity and safety of the research team will be at risk due to illicit local practices, social movements that in some way influence the dynamics of health promotion processes. This situation must be considered from the planning of the proposal of the Healthy Communities project since this will guide the relevance of incorporating the participatory scientific method, which implies greater penetration and involvement with social dynamics and a work of at least 2 years visiting the population while ensuring the necessary conditions for the safety of all participants

Conclusions

The incorporation of the scientific method into the Healthy Communities strategy, from a critical theoretical perspective, enables the generation of knowledge from the processes of health promotion and not about them, taking into account the different contextual political, social, cultural, and historical elements that happen together with the actions of territorial management against the SDH. Likewise, research can be assumed by the Healthy Communities projects as an opportunity to identify and document the mechanisms that make it possible to describe how the actions of local government in conjunction with the population and the various sectors allow to reduce inequities, in a seedbed of conceptual and theoretical referents that shape and give meaning to the practice of health promotion in the municipal sphere in the country.

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Chapter 14
Territorial Management of Health Promotion: The Dengue Epidemic Case in Perú

Edwin Peñaherrera Sánchez

Health Status

The year 2015[1] had the highest dengue epidemic activity out of the last 25 years in Peru. A total of 34,273 cases were reported by epidemiological week 31, including both probable and confirmed cases. This exceeded the number of cases reported for all of 2014. In 2015, the dengue epidemic stretched out over the largest geographic area since 1990, involving 18 departments and 269 districts with dengue transmission. The department of Piura alone reported 1517 cases by epidemiological week 22[2], including both probable and confirmed cases. By epidemiological week 30, 22,101 more cases were reported in 2015 than in 2014 by the same week. This is three times as many cases as in 2014[3].

A total of 35 deaths occurred due to confirmed dengue diagnosis in Peru, of which 22 occurred in Piura and 1 in Tumbes. Eight other probable dengue deaths also occurred in Piura[4] Because of this, the regions of Piura[5] and Tumbes[6] were declared to be in a health emergency, and the immediate intervention of the National Health Strategy for the Control of Vector-Borne Diseases was sought. This office, staffed by personnel from the General Directorate of Health for the People DGSP,

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[5] DS N° 008-2015-SA, que declara en Emergencia Sanitaria a la Región Piura.

[6] DS N° 005-2015-SA, que declara en Emergencia Sanitaria a la Región Tumbes.

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L. Malagón de Salazar, R.C. Luján Villar (eds.), *Globalization and Health Inequities in Latin America*, https://doi.org/10.1007/978-3-319-67292-2_14

its initials in Spanish; note that, except for the Ministry of Health, all abbreviations will be given according to their Spanish initials), the General Directorate of Environmental Health (DIGESA), the General Office of Communications (OGC), the General Office for Planning and Budget (OGPP), the General Directorate of Epidemiology (DGE), and the National Institute of Health (INS), was responsible for drafting the National Plan for Chikungunya Fever Response, Peru, 2015.

Problem Situation Identified

Traditionally, a dengue epidemic is defined by the Ministry of Health (MoH) once it has analyzed the case report sent by the regional health installations, following the biomedical approach predominant in the health sector. Then the MoH issues a state of alert, decides what measures to take, and communicates with the local authorities for actions needed. The regional president and the local governments organize their response based on the alert, and the MoH spearheads the response activities. This chapter describes a different approach to dengue epidemic response based on the health promotion paradigm. Health promotion moves beyond the biomedical approach to focus on the social determinants of health behind diseases. The experience of the fundamental leadership role of the General Directorate of Health Promotion in responding to the dengue epidemic in Northern Peru and how this directorate contributed to its control will be described.

There is a dengue epidemic in Northern Peru every year during the rainy season because rain water is deposited in all kinds of containers: used tires, flower vases at home or in cemeteries, tubs, and bottles, for example. Natural water containers allow for the growth of *Aedes aegypti* from larvae into adults. Moreover, in rural areas of Tumbes and Piura, there is a lack of piped potable water systems, so people need to store water in large containers at their homes. In spite of MoH reminders to the population to clean containers regularly and keep them tightly covered with lids, the precautions are not always taken owing to household and work chores that families are involved in on a daily basis. This form of water storage facilitates the presence of larvae and their rapid evolution into adult mosquitoes.

Part of the problem, as highlighted earlier, lies with the MoH's predominantly biomedical approach, which prioritizes health care and recovery for cases detected. Preventive actions are basically aimed at providing information to the population regarding risks and measures to take, on the one hand, and door-to-door spraying for abatement to eliminate live mosquitoes, on the other hand. In the first case, the approach appeals to the cognitive process on the assumption that having knowledge is enough for people to change their behavior and adopt self-care practices, but this is known to be insufficient. In the second case, there is certainly a positive impact on the population because live mosquitoes are eliminated; however, larvae in containers are not killed off, so the epidemic is not controlled. Another issue with spraying is the fact that house visits are conducted during working hours, and because of this, many houses do not get sprayed and become mosquito-transmission foci.

The Intervention

In contrast to previous years, in 2015 the dengue epidemic was accompanied by high mortality, which led to a declaration of emergency in the regions of Piura and Tumbes. As in years before, the DGE was responsible for the intervention, with the participation of other general directorates, particularly DGSP, which is responsible for health services; and the DG for health promotion is responsible for interagency coordination. Both of them drafted a plan of action. The DGSP focused on door-to-door spraying, ensuring early detection of cases and prompt and adequate care of symptomatic cases. The DG for Health Promotion designed a plan centered in the framework of territorial management of health promotion as approved by the MoH Policies and Procedures (ROF 2015).

> Territorial management and governance allow for the determination of individual and collective responsibilities, as well as the guidelines needed from distinct government agencies and levels to address the profound causes of health inequity. In this way, they contribute to the establishment of synergies among government sections within the wheels of political, economic, and social power, with the goal of dealing with social determinants behind health inequities.

The DG for Health Promotion proposed a plan of action centered on strengthening regional and local government leadership, as well as active involvement of other government agencies responsible for addressing social determinants that promote dengue spread, such as education, housing, economy, tourism, and the civil society at large, through community leaders. The DG for Health Promotion appointed a public health and health promotion psychologist, who in turn appointed an 11-person team made up of teachers, communicators, physicians, and nurses, organized in teams of 3 or 4 people. These teams deployed to the regions of Tumbes and Piura, and their mission was to help organize the local and regional emergency committees (COER) to prepare concerted action plans. The multidisciplinary nature of these teams was crucial to design intervention strategies that extended beyond the biomedical approach, and the conducted activities among the distinct sectors, including community participation. At the same time, at headquarters, a high commissioner was appointed for each region, with the goal of coordinating actions with their corresponding regional health offices (DIRESAs). The commissioned physician, aware of the limitations of the biomedical approach and of the potential for health promotion deriving from interagency actions, decidedly supported the work of the DG for Health Promotion team. This was a very important technical and political decision (Fig. 14.1).

The space approach places, in the center of activity planning, interagency and intergovernmental coordination and social participation as strategic axes to improve life conditions, leading to better health and ultimately contributing to individual and collective development in an integral manner. The design and implementation of public policies, based on the health promotion approach, are central aspects of the designed strategies (establishment of interagency alliances, preparation of concerted actions, and community participation are central aspects of the designed strategies) (Fig. 14.2).

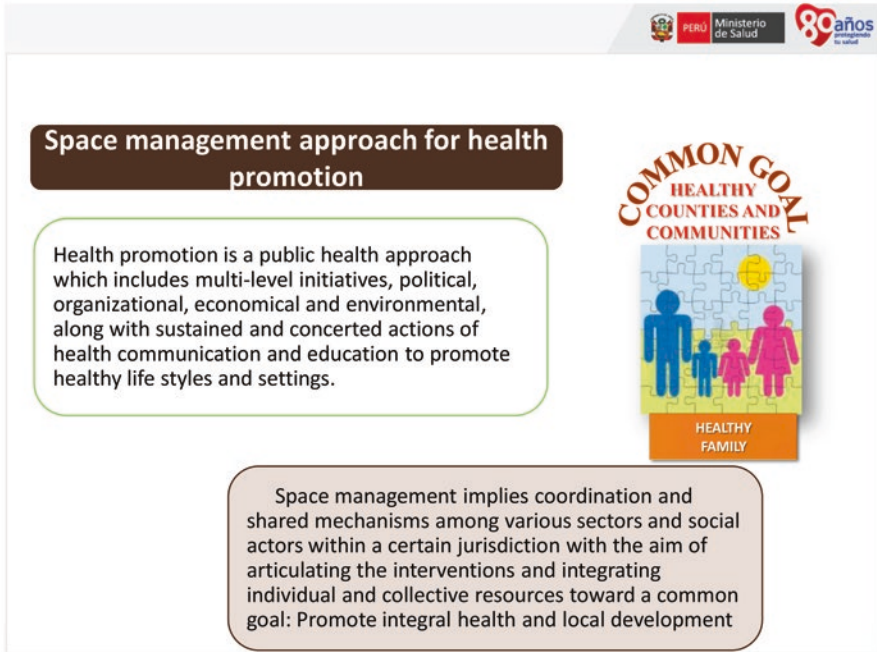

Fig. 14.1 Territorial management approach to health promotion (Source: Author)

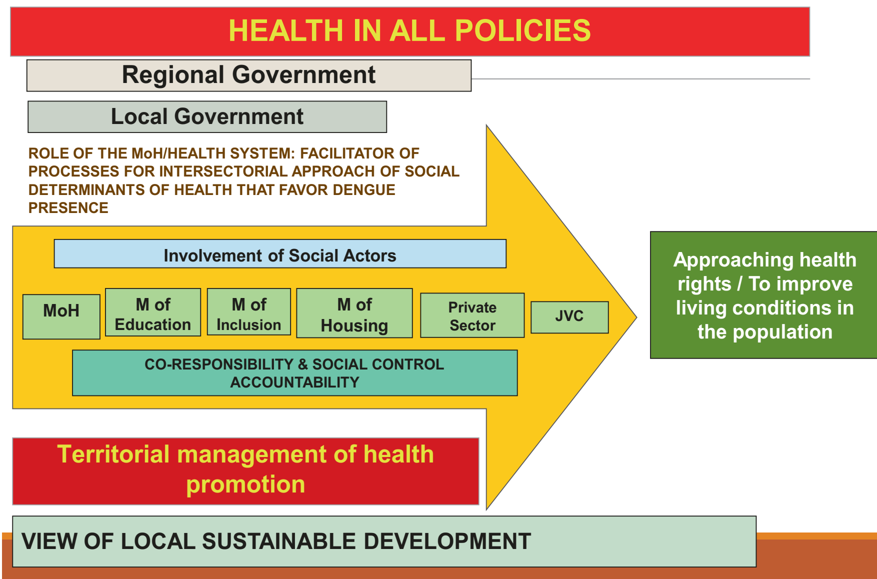

Fig. 14.2 Health in all policies (E. Peñaherrera, 2015; personal report)

In close coordination with the health promotion team, high commissioners worked on two fronts, one with the DIRESA and health networks through meetings with the Emergency Operational Committee (COE by its Spanish initials), the other through intersector activities in coordination with the regional and provincial COEs. Local governments and local sectors have participated on this front, with responsibilities within their functions and areas of competence for epidemic control. In both cases, permanent coordination levels were established in conjunction with the community, which organized into community neighborhood boards (JVC).

The following strategic actions were taken:

(a) Setting up of district emergency committee (district COE)
(b) Preparation of an intersector work plan
(c) Identification of volunteers in district
(d) Social mobilization of community
(e) Dissemination of messages throughout mass media

Strategies

Recognition of three important aspects in the relationship between the dengue and the chikungunya epidemics was the starting point for the design of strategies:

1. Social determinants (living conditions in the population) are factors that favor disease occurrence, such as the epidemic of dengue and chikungunya vectors.
2. The social determinant approach requires a shared commitment (co-responsibility) among social sectors and actors. Because of this, public health does not rely exclusively on actions performed by the MoH.
3. Regional and local governments are the natural leaders on site, and as such, they are called on to plan actions in their territory to address dengue-associated social determinants. These actions will be closely coordinated with various sectors, with the society at large, and with community leaders. The MoH shall provide all the technical assistance as the agency responsible for people's health (Fig. 14.3).

The following were the main strategies adopted:

- Articulate actions among sectors and the local and regional government to identify and eliminate potential foci for mosquito reproduction in neighborhoods and homes. These actions may involve recycling points, recycling houses, trash disposal areas, tire disposal areas, cemeteries, and water storage and flower vases in homes, among other mosquito reproduction sites.
- Create awareness among community leaders and the community at large to actively support the identification and elimination of potential mosquito reproduction foci.
- Prepare an intersectoral work plan of joint actions with local government, government sectors, local institutions, community representatives, and nongovernment organizations (NGOs) in schools and neighborhoods, with the active involvement of neighbors.

E. Peñaherrera, 2015; personal report

Fig. 14.3 Local government—wellness and social equity. E. Peñaherrera, 2015; personal report

- Prepare a work plan to perform joint actions with the Regional Education Directorate (DREL), with local units of education management (UGEL), and with directors of educational institutions within the intersectoral plan of the Ministries of Health and Education, to confront dengue and chikungunya.
- Provide technical assistance and advice to DIRESA and local and regional governments.

Activities Conducted

Advocacy actions conducted by the technical health promotion teams at central and local levels with local officials led the Piura and Tumbes Regional Government to declare their regions under a health emergency. This political decision resulted in the preparation of an intersectoral plan, which was signed and endorsed by the involved social actors.

Each sector assumed responsibilities for the results proposed in the regional plan and in accordance with their institutional mandate. In this way, during the intervention, the health promotion team provided technical assistance for the following activities:

- Incidence and coordination meetings to favor intrasectoral articulation, with the participation of general directorates of communications, health promotion, environmental health, national defense, and epidemiology at every participating Regional Health Directorate (DIRESAS);

- Incidence meetings with mayors, governors, and officials of the various sectors at regional, provincial, and local levels to activate the COE;
- Definition of key communication messages to be disseminated among the population, jointly designed by the high commissioners and the DIRESA teams;
- Technical assistance and support to the DIRESAs during intersectoral meetings and weekly coordination to assess the progress of each sector's commitments;
- Technical assistance and support to the DIRESAs to inform the community about dengue and measures to control its spread, also to highlight the importance of allowing designated personnel access into homes;
- Identification, selection, and training of community and university volunteers in coordination with the DIRESA health teams;
- Technical assistance to the coastal district municipality of Los Organos, in preparation of the technical details for water and sewage projects;
- Development of advocacy actions at health installations to assign personnel to health promotion actions, who received oversight from the national level team assigned to the area;
- Actions of political incidence with local companies to support and fund educational activities and volunteer mobilization (house-to-house educational sessions);
- Implementation of information campaigns at cemeteries, house-to-house educational sessions, parades, among other actions aimed at schoolchildren, teachers, college students, community agents, and civil society organizations, to create awareness regarding the emergency situation and the main prevention measures;
- In coordination with Regional Health Directorate, joint actions with Health Universities Network in Piura, to select and train students from colleges and other higher education institutes to conduct health education activities in their communities;
- Technical assistance to the micronetworks and health establishments for training members from religious organizations, educational institutions, social organizations, civil associations, county police, national police, workplaces, markets, hotels, and restaurants in self-care practices to decrease the probability of vector incidence;
- Technical assistance to school teachers to help them draft programs or projects related to learning self-care practices for dengue and chikungunya prevention;
- Technical assistance to educational institutions (IIEE) for the implementation of a peer surveillance strategy. Through this strategy, students become responsible for verifying and using the checklist and ensuring adequate water storage at the homes of their assigned school mates.

Results Obtained with Intersectoral Participation

Tumbes

- Thirteen local governments performed actions promoting neighborhood participation for dengue and chikungunya prevention.
- All of the districts with the highest aedic index promote and participate in vector rearing site elimination activities in their areas.

- Thirteen space agreements are in place with country officials and strategic allies for the recovery of shops that are closed, empty, or unwilling to collaborate with the elimination of vector rearing site.
- Active participation of the sectors involved in the intersectoral plan is at 100%.
- All of the homes were visited for educational or fumigation activities.
- One hundred schools individuals schools participate in the collection and elimination of mosquito rearing sites in coordination with the Educational Management Unit (UGEL) and its county.
- Three selective campaigns were launched to collect and eliminate mosquito rearing sites or containers conducted by public and private workplaces from 13 districts.
- There are 850 teachers involved in promoting self-care practices for dengue and chikungunya control at their schools and activating the febrile system at all 214 IIEEs.
- There are 430 active school patrols promoting and supervising health practices for dengue and chikungunya control in 214 IIEEs.
- There are 214 associations of parents of school children trained in the promotion of health practices and the elimination of mosquito rearing sites in their own jurisdictions.
- A total of 476 social organizations and neighborhood committees in all 13 districts participate in and promote activities for the elimination of mosquito rearing sites in their own neighborhoods.
- A total of 168 JVCs promote health practices among families, sending out notifications about risks and febrile cases in their own jurisdictions.
- Some 382 community health agents from all 4 micronetworks participate in the promotion of health practices for dengue and chikungunya control and in the recovery of shops that are closed, empty, or unwilling to collaborate with vector rearing site eliminations.

Piura

- 1500 families use water storage containers properly in their own care.
- All educational institutions in five priority districts conducted learning sessions or learning projects on dengue and chikungunya
- 1500 college students have been trained.
- 200 college students participated actively as volunteers in community activities in the priority districts.
- 1171 teachers were trained to develop teaching content, including in connection with dengue and chikungunya, as well as in prevention for educational institutions.
- 2742 students were trained to serve as school guards at IIEEs in the Luciano Castillo Colonna health subregion in Sullana, the Morropon-Chulucanas Network, Piura Network, and Castilla district.
- Two research projects were launched in connection with self-care practices and settings in priority locations and were submitted by medical school students from the Universidad Nacional de Piura.

- The local UGEL in Sullana issued Directive 04-2015-UGEL SULLANA-DAGP to conduct a dengue prevention and control campaign among the school population in the province of Sullana.
- Talara and Los Organos Counties issued guidelines to sanction people who interfere with dengue prevention activities.

Critical Assessment of Process and Results Obtained

- When evaluating the success factors of this intervention in the Tumbes and Piura regions, the first aspect to take into consideration is the fact that the health promotion intervention was conducted with a health promotion approach in the space administration, as approved by the new 2015 policies and procedures of the MoH. This fact was essential for success because intersectoral coordination was, for the first time, a general directorate responsibility.
- Having a nonphysician professional in charge of the DG of Health Promotion also contributed to the success of the project because clear guidelines were provided to the technical teams to ensure intersectoral coordination and community participation became a priority.
- The territorial management approach defined by the DG of Health Promotion considered social determinants to be a central aspect, and this necessarily implied joint coordination with other sectors for those activities they needed to conduct to confront the dengue and chikungunya epidemics.
- The regional and the local government were persuaded to take on a leadership role, bringing other sectors together and obtaining commitments from the corresponding sector based on formal agreements. These were supervised and monitored by the regional and central health promotion teams, which resulted in adequate supervision and in making needed adjustments.
- From the start it was clear that the number of symptomatic cases would not decrease without coordinating activities with other sectors. Strategies implemented aimed at all times to strike a balance between patient care and recovery and addressing social determinants using the territorial management approach to health promotion.
- Activating the COE was critical because it allowed for the participation of local sectors and agents, both to design a joint plan and to conduct and monitor said plan.
- The territorial management approach to health promotion was an essential factor in containing the dengue epidemic and the onset of chikungunya in Northern Peru.

Intervention Aspects That Need Improvement

- In Peru, multisectoral committees have long existed to confront problems that need to be approached from different sectors. However, their impact is limited because there are as many committees as problems to deal with. In the long run,

this in itself renders the committees unoperational. In this particular case, the dengue epidemic occurs in areas where the mosquito lives on a permanent basis. Because of this, officials should design health policies facilitating self-care practices among the population. For instance, they should strengthen community organizations by training their leaders and ensuring that they, in coordination with their county and their communities, adopt self-care practices, such as periodic disposal of unused containers, placing protective screens in their windows, not leaving water in flower vases during visits to cemeteries, avoiding water pots at home, and covering water containers. Setting up a new COE every year to confront the dengue epidemic proved to be inconvenient and a waste of time and resources. In terms of budget investment, it is expensive to fumigate or deploy personnel for weeks at a time from the central level to regions, including travel expenses. In addition, there is a risk of people dying. A multisectoral committee, no longer an emergency committee but a permanent one, would be more beneficial.

- During interventions, we should have taken the opportunity to talk about social determinants of diseases as part of the agenda, using the media or other spaces. This debate is important because it allows everyone to focus on two central aspects of public health: first, the fact that health is intrinsically linked to people's living conditions, such as having access to water, a decent job, and access to quality education and health services, and second, the fact that social determinants cannot be approached from the health sector only. In dengue, having water for human consumption inside the home without having to store it in containers, for example, would decrease vector population and proliferation. Interventions in the housing sector speak for themselves.

Results[7]

1. Between the week prior to the intervention and the last week of the intervention performed by the national health promotion team, there was a significant reduction in the number of probable and confirmed dengue cases in the Tumbes and Piura regions. In the Tumbes region, the number of cases fell from 431 cases identified in week 23 to 233 cases identified in week 26 (46% decrease). In the Piura region, the number of cases dropped from 1374 cases in week 23 to 690 cases in week 46 (50% decrease)
2. The sustainability of these strategies contributed to the reduction in the number of probable and confirmed cases all the way to week 30 in the engaged regions post intervention. In Tumbes, the number of cases decreased by up to 89% (from 431 in week 23 to 48 in week 30), and in Piura by up to 93% (from 1374 in week 23 to 107 in week 30) (Table 14.1)

[7] Lic. Susan Mateo Lizarbe. Dirección General de Epidemiología. MINSA 2015. Boletín epidemiológico. Volumen 24—Semana Epidemiológica Nº 30.

Table 14.1 Probable and confirmed dengue cases per department, Perú (week 30, 2015)

Department	Epidemiological week																Total	%
	1–15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		
Piura	3920	1203	1190	1461	1439	1498	1489	1517	1374	1175	886	690	562	335	203	107	19,049	56.1
Tumbes	2633	377	392	446	517	405	372	354	431	377	288	233	186	156	112	48	7327	21.6
Loreto	1383	75	62	46	38	23	42	30	53	39	35	30	15	18	23	6	26,376	77.6
La Libertad	157	25	62	57	71	109	107	169	235	188	161	123	147	131	91	41	1874	5.5
Lambayeque	261	25	42	63	33	26	52	45	49	83	50	50	32	11	1	0	823	2.4
Madre de Dios	393	46	47	52	31	19	16	27	25	16	14	12	7	3	4	1	2697	7.9
Ucayali	463	13	14	9	11	12	5	9	13	11	7	10	10	16	20	9	632	1.9
Junín	286	12	16	15	11	9	6	20	10	13	21	15	18	11	12	2	477	1.4
San Martín	184	12	20	32	18	29	19	10	17	16	18	13	11	7	11	1	1109	3.3
Cajamarca	44	7	2	6	13	8	13	12	13	17	8	11	10	15	4	1	184	0.5
Huánuco	122	5	1	6	4	5	3	0	1	4	1	0	1	1	0	0	154	0.5
Ancash	0	0	1	3	5	14	4	11	19	35	15	7	15	6	8	0	338	1.0
Ayacucho	0	1	2	4	1	16	17	32	12	12	5	6	12	6	4	4	134	0.4
Amazonas	7	0	0	0	2	4	6	3	7	2	3	2	2	3	0	4	45	0.1
Cusco	2	0	0	0	1	1	2	11	3	4	2	3	0	1	2	1	179	0.5
Lima[a]	3	0	0	0	0	0	1	0	0	2	1	2	5	5	1	1	21	0.1
Pasco	14	0	0	0	0	1	0	3	0	0	0	0	0	0	0	0	18	0.1
Ica	0	0	0	0	0	0	0	0	2	0	2	1	0	0	0	0	39	0.1
Research cases[a]	1	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	3	0.0
Total	9873	1801	1852	2200	2195	2179	2154	2253	2264	1994	1517	1208	1033	726	496	226	33,971	100

Source: Epidemiological Bulletin (Lima) 24 (30)
Dengue cases were not confirmed in those locations at that moment (investigation to confirm)

Analysis of Results

Results published in the MoH epidemiological bulletin reflect the positive effect of a multilevel intervention using the health promotion space approach. Using this approach, we were able to strengthen the local and regional government leadership. The role of the DG for Health Promotion team was crucial to promoting the empowerment of both the officials and the community as well.

The high commissioners acknowledged the strategic role played by the health promotion team when they prioritized the active participation of all social actors, mainly the governor and the county and district mayors. Their leadership was crucial to the intervention because their communities responded to their appeal and listened to their message, even more so than to the MoH. In Peru, the MoH at the central level cannot issue guidelines to other sectors that are under the jurisdiction of the regional government.

The political decisions and commitment of higher officials at the national, regional, and local levels have been the crucial factors.

- The MoH is the office that declares states of health emergency and assigns a budget for interventions;
- The MoH appoints high commissioners in each region.
- The DG for Health Promotion defines the space administration approach for health promotion as the core of interventions and appoints a multidisciplinary team to provide technical assistance in each of the affected regions;
- Governors of the Piura and Tumbes regions activate the regional COE and lead intersectoral activities;
- Mayors in the prioritized districts activate the local COE and provide permanent monitoring of implemented activities; they have a budget and human and logistical resources to address dengue epidemics;
- Principals at schools and heads of institutions of higher learning allow health personnel to train teachers and conduct educational workshops to deal with the dengue epidemic (Fig. 14.4).

Intersectoral Activities

- Commitments by various sectors and institutions present were generated in each region, allowing each to take over its own responsibilities in accordance with its functions
- Activities were articulated with representatives of the Minister of Internal Affairs and with the national police to provide security to teams conducting house-to-house fumigation, to persuade households that declined participation,

Fig. 14.4 The regional governor of Piura and DG of Health Promotion supervise campaigns by university volunteers to deal with dengue

to help in the fumigation of vehicles entering the region, and to keep tourists informed.

- Participation of community organizations was promoted with the Ministry for Development and Social Inclusion, involving soup kitchens and organizations preparing meals (in Spanish, these are called *vaso de leche*). The goal was to get these organizations to perform self-care practices and to highlight the importance of self-care practices in connection to dengue.
- Fumigation activities at restaurants and hotels in the region, in addition to the provision of useful information to their workers and guests, were coordinated with the regional chamber of commerce.
- Fumigation and campaigns in cemeteries, particularly during Father's Day, were coordinated with the Peruvian Society for Public Welfare.

Activities coordinated by the high commissioners and the team from the Health Promotion General Directorate and the local health team saw high turnouts, motivating local officials and engaging the directors of health installations to assign full-time personnel to implement these activities to create awareness and motivate social participation among JVCs and teachers from schools and institutions of higher learning (Fig. 14.5).

Fig. 14.5 The regional governor of Piura, MoH, and other regional and local health authorities make a public commitment to implement actions to deal with dengue

Conclusions

1. Health promotion is a public health approach that prioritizes multilevel initiatives that are political, social, environmental, economic, and community-oriented in nature. These initiatives aim at addressing social determinants that influence practices and settings that are part of people's everyday lives.
2. The space administration approach, in addition to the health promotion approach, is a conceptual and operational paradigm that highly favors the PAHO health strategy in all policies. This approach highlights the responsibility that every government sector has in reversing the living conditions that lead to disease outbreaks.
3. Although the biomedical model is effective at preventing or identifying, at an early stage, disease epidemics and providing timely and quality health care, it does have limitations when it comes to addressing living conditions influencing the spread of the dengue vector and the spread of other diseases.
4. Participation of the education sector (i.e., schools and institutions of higher education) is essential for starting a discussion on the importance of recognizing that living conditions affect people's health, and to address this, we need an interdisciplinary approach, not just one that largely relies on health professionals.

Lessons Learned

1. Political decisions at the central level, commitment by higher officials, intra- and intersectoral coordination, competent health teams, and empowerment of the population are necessary strategic elements in addressing social determinants of health in an intersectoral manner.

2. It is not possible to generate widespread participation of government sectors, civil society, and communities without the leadership of local and regional governments.
3. The role of the health sector is crucial to providing technical assistance to other sectors in facing dengue epidemics (not necessarily for the purpose of leading operational actions in field) and to highlighting the importance of addressing the social determinants of health behind it.
4. It is important to appeal to the Ministry of Economy and Finances so that they recognize that public health requires a larger budget than what is currently available. Without an adequate budget, the possibilities of conducting successful and sustainable interventions are limited.
5. Professionals in health and other sectors, in local and regional governments, require a training process that will allow them to learn about the positive implications that the space administration approach has for confronting social determinants of health.

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Part III
Proposal

Chapter 15
A Bet for the Reduction of Health Inequities in Accordance with the Conditions of the Latin American Region

Ligia Malagón de Salazar

Presentation

In previous chapters, critical aspects related to the implementation of strategies aimed at reducing health inequities were identified, as well as the fact that regardless of the strategy to address health inequities, the strengthening of territorial capacities (e.g., community, institutions, government, civil society, key actors) is needed to ensure the strategies' success.

The definition of a holistic health approach to delimitating priority problems and interventions that transcend the clinical approach and involve social determinants of health (SDH), is necessary. Theoretical and operational approaches are needed in accordance with the structures and available resources in the territory, and more importantly, conditions should be promoted to systematically strengthen local capacity to analyze, understand, and transform reality. Several questions and concerns arise around the sustainability of these processes of change; even though there is extensive information on what needs to be done, but the challenge is precisely how to do it, and what conditions are required.

Unfortunately, the aforementioned information is absent in most publications in our region. This might happen because, although we recognize critical aspects of practices, we fail to document them or we are not aware of their importance. International cooperation agencies have contributed to this situation because they privilege information about outcomes rather than the process of knowledge generation and knowledge translation as well as information necessary to strengthen the territorial capacity to respond to situations threatening population health and well-being.

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L. Malagón de Salazar, R.C. Luján Villar (eds.), *Globalization and Health Inequities in Latin America*, https://doi.org/10.1007/978-3-319-67292-2_15

The political and social nature of processes of change reminds us that they are not static; on the contrary, they could be highly dynamic, sometimes unpredictable, and therefore, the results are not the same in all contexts and at all times. The questions that emerge from this characteristic are: What could be standardized and what is sustainable? And under what conditions?

This session generates inputs to answer these questions, along with the following concerns: What should be done to strengthen the territorial capacity to cope with health inequities? The answer has many facets, so we will not give a definitive response, but we will provide arguments to formulate a pragmatic and appropriate one. In our opinion, the theoretical concepts to some extent could be applied in diverse contexts, but not their implementation, which is circumstantial and contextual. This last aspect incorporates and defines the type and importance of the relations and interactions between the different living forces of the territory and its structural components. These and other concerns will be subjected to further analysis.

Likewise, the know-how is not necessarily replicable in all contexts without a comprehensive analysis of the assumptions and conditions that guarantee the feasibility of results. The concept of "territorial identity" is an important issue to bear in mind. Hence, we do not refer to it capriciously but, defending a concept and identity of the territory, as a social construction with relationships, interactions, power relations, values, and culture, all of them relating the past to the present to envision a future.

A composite strategy will be presented in order to contribute to the reduction of negative effects on equity and population health stemming from socioeconomic policies and considering what is feasible to achieve from the local level.

Background

A number of studies are available that present information and evidence on the burden of disease, as well as the type and magnitude of the problems and risks of contracting diseases from a biomedical perspective. However, there is insufficient information about the factors underlying health inequities, their interaction to produce certain effects, as well as the identification of groups for whom the effect is less or greater or does not exist. It is also important to identify those groups with the greatest negative impact, that is, the most vulnerable groups and territories, those who benefit most from the interventions, and the structures and mechanisms that improve the equitable access to services and opportunities, among others.

One of the components of health promotion (HP) and primary healthcare (PHC) strategies focuses on the reorganization of services, including changes in the type and functioning of structures to guarantee the right to health. The gray literature reviewed showed a large proportion of interventions to solve problems related to the type of services and providing institutions, leaving immutable the structures that

have historically influenced the implementation of interventions to fulfill the principles underlying these strategies.

When comparing the results of the studies carried out by De Salazar (2012) on the state of the art in health promotion in Latin American and Caribbean (LAC) countries, a coincidence was observed in relation to the type of topics addressed, as well as the scope and depth of theoretical approaches and implementation issues. It is striking to find that the actions in fields closely related to equity were not considered as actions of health promotion, because they were developed in sectors other than the health sector. This is the case of public policies for the reduction of poverty and improvement of access to education, housing, and employment. The findings are consistent with the statement made by Galeano et al. (2012), who pointed out a gap between the broad and inclusive postulates posed by the literature on PHC and HP interventions and the orientation they have in practice.

Likewise, the state of the art of health promotion in Union of South American Nations (UNASUR) countries (De Salazar 2012) shows partial evaluation results focused on problems related to disease and risk events from a disciplinary and sectoral perspective. These evaluations emphasize the performance of programs in terms of compliance with scheduled activities, without interpreting this information in the light of the specific context and circumstances responsible for the findings. The evaluative proposals also reflect large gaps in concepts and theoretical and methodological approaches to assessing other aspects that directly influence outcomes, such as the quality of intervention designs, the evaluation of performance, and the impact and effectiveness of these interventions. De Salazar (2012) refers to this topic, alluding to the results of evaluation research in most Latin American countries whose emphasis is on output and outcome indicators. Likewise, it shows that there are insufficient inputs to use the results of evaluation in strengthening the theory and practice of these strategies.

> It is well known that social interventions are supported on the basis of a high social and political content and have their own dynamics, not necessarily reproducible in others scenarios. However, gaps in the theoretical foundations of these interventions, as well as in the formulation of the problems, and the implementation processes are acknowledged in studies. The influences of the context on both the problem and the effectiveness and impact of the responses are not described (De Salazar 2012).

> "Evaluation is often concerned not only with assessing worth or value but also with seeking to assist in the improvement of whatever is being evaluated" (1993:175). Therefore, there are two main purposes of evaluation research: providing evidence of the merit and worth of social work practice and striving to improve practice itself to respond to the changing needs and contexts, for the betterment of society (Kazi 2003:2).

The situation described is presented in several countries and low- and middle-income countries (LMICs) is not the exception:

> ...with few exceptions most studies refer to results, and less to information regarding the quality of designs, implantation and implementation processes, despite the high recognition given to these issues. Borland (2009) and Jorquera (2011) describe the influence of health systems management on interventions; Carmichael et al. (2012) identify barriers and limitations to integrate sectors and agendas in the territory; Grundya et al. (2009) compare

current health needs with the relevance of health system response; Sosa et al. (2013) strengthen the view that health planning should incorporate other sectors; Castell-Florit Serrate and Abreu (2012) find that what sectors perceived was different compared to what evidence shows (De Salazar 2012).

In summary, it may be said that a significant volume of studies focus on disease or risk factors regarding the reduction of the magnitude of biological-clinical problems. A very brief description is given on how changes have been achieved and, in a fewer cases, whether and why they could be attributed to the interventions.

Strategy to Contribute to the Reduction of Health Inequities: Promoting Human and Territorial Development

Why have strategies to reduce social and health inequities not yielded the expected results, despite efforts by Latin American countries? There is not a single answer to this question but a series of interrelated factors, closely related to demographic, sociopolitical, and cultural factors influencing countries' capacity and power to decide.

The proposal made here does not pretend to be the solution to all challenges that we have faced historically, but it does provide inputs so that countries, especially (local) territories, can undertake and sustain more autonomous transformation processes, using and optimizing their own resources and using external resources to facilitate the development and sustainability of their own agendas. This position has direct implications in the processes of elaboration, financing, implementation, monitoring, and evaluation of territorial development plans. This in turn influences power relations within and outside territories, which directly affects their governance.

As will become clear, we cannot continue using structures and negotiation mechanisms that have traditionally demonstrated their inability to respond to new and complex challenges but that, on the contrary, maintain the status quo. Considering the aforementioned points, the strategy proposed seeks in a synchronous and permanent way to transform the structures of power in territories, adapt territorial normativity to local conditions, and optimize available resources, including technical tools in favor of health equity matters. To fulfill this complex task we have given the monitoring and evaluation (M&E) of the public health function a leading role in promoting and invigorating transformation processes (Fig. 15.1).

To this end, M&E research should broaden its scope to become a technical tool to be used for social and political ends, contributing to the health and well-being of the population.

The proposed strategy has three interrelated and complementary components oriented to (1) building human and territorial development, (2) strengthening territorial capacities to negotiate and intervene using supportive structures and technologies, and (3) monitoring and evaluating results to support the two previous components.

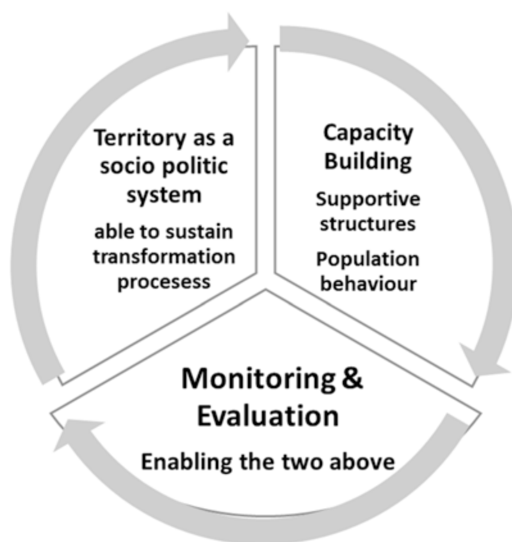


Fig. 15.1 Strategy to cope with health inequities. Source: Author's elaboration

Strengthen Territorial Identity and Development

The strategy proposed is setting based, where the territory is conceived as a political and social system, to integrate and enhance transformation processes. This commitment means that the guidelines for strengthening the territorial identity and local capacity to deal with social and health problems (health inequities) are supported by political, physical, organizational, and social structures, as well as the local culture and available resources. The proposal is built considering those aspects through which institutions, social organizations, and governments interact according to their interests, legislation, and regulations. Any such proposal must have as reference for the action the territory with all its subterritories.

Different experiences have been reported in LMICs, making clear that strategies to increase production and labor using local resources have restored the confidence and increased resilience in the population to address determinants of social inequities.

In this regard, Pollice (2010:9, as quoted by Dallabrida 2008), states that territorial identity generates and guides the processes of territorialization. Likewise, we believe that these actions of territorialization reinforce the process of identification between community and the space it inhabits, generating territorial alternatives that establish an identity relationship. In this analysis, it is important to take into account what Bauman et al. (2013) pointed out, 'The new public governance describes the context in which the strategies are implemented. A better understanding of the actors and the context in the different political scenarios where health is advocated will provide a greater opportunity to intervene in the structural determinants of health inequities'" (Fig. 15.2).

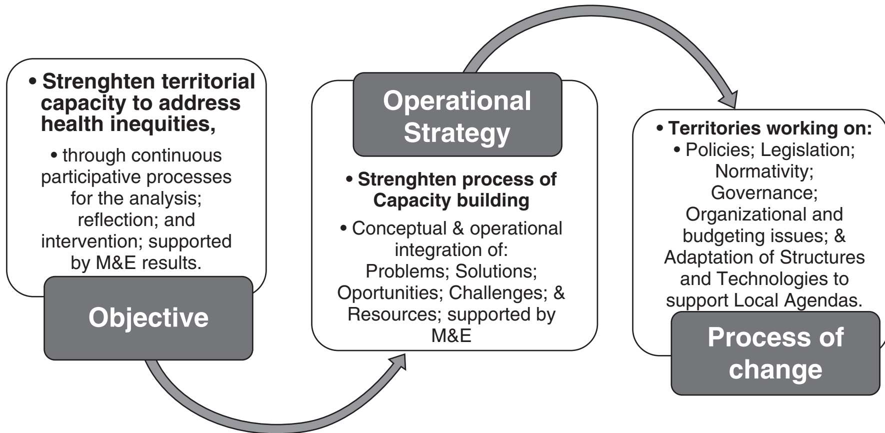


Fig. 15.2 Rescue of territorial identity and local potential. Source: Author's elaboration

Management for Intersectoral Action

The term *intersectorality* has different meanings, including "a public health practice, with potential to allow local public health units to address the social determinants of health and reduce health inequities. It refers to actions undertaken by sectors possibly outside the health sector, but not necessarily in collaboration with it" (National Collaborating Center for Determinants of Health 2012). Intersectoral action is also a mechanism or an action component that acts in any initiative aimed at reducing social and health inequities. Governance is one of the most relevant concepts and has been widely described by different actors (McQueen et al. 2012) exemplifying three concepts immersed in this type of intervention: Health in All Policies (HiAP), social determinants of health (SDH), and governance. According to Rozas Ossandon and Leiva Benavides (2005), it is fair that it is not necessary to work integrally: to form a separate set of the forces expressed sectorally, the health sector, education, housing, employment, and so forth (Programa de las Naciones Unidas para el Desarrollo (PNUD) 2004).

Therefore, intersectoral work should be considered not as an isolated action but as a process of cultural change around the aforementioned aspects, starting from actions of the health sector to strategies responding to health inequities. It can be seen also in both perspectives: immersion in complex and long-lasting processes of change to transform reality. Some authors have pointed out that multisectoral actions are necessary, but they are not enough to constitute intersectoral work; in this way, vertical actions, even if they are multisectoral, do not constitute intersectoral actions. The question is which of these definitions is the closest to the concept of intersectorality from the perspective of SDH and health equity; which conception is the most feasible in our territories?

Intersectorality in various experiences is a state of institutional transition, ranging from the transition between types of institutional management centered on procedures that reflect the segmentation of reality toward a type of management focused on the impact of a more integral institutional nature. Hence, when implementing intersectorality, challenges arise related to the distance between the institutional perspective emanating from the central government and the planning dynamics and priorities for development from the perspective of regional governments; there is also a gap between local governments, municipalities, and the priorities of regional governments.

One of the limitations on developing intersectoral actions is the availability and quality of information and evidence regarding the mechanisms that facilitate the harmonic articulation/integration of sectors around the type of response and "know-how," incorporating the shortcomings and strengths as an integral intervention, which facilitates the development of a systematic articulated mode of action.

Social Participation, Social Capital, and Balance of Power Relationships

"Never make history who ask for permission" Appadurai (2011)

There is a vast literature on social and community participation but very limited studies where participation for intersectoral work is concerned. Participation, like all concepts related to social changes, are dynamic according to specific philosophical positions and political junctures; this is the case of participation seen in intersectoral action, where the main feature is the balance of power relations and access to information that qualify the type of participation necessary to achieve effective intersectoral work. Intersectorality is not only a practice but also a means to generate the capacity to be part of social transformation processes. This issue is not always recognized.

> The study carried out in Southern Common Market (MERCOSUR, from the Spanish *Mercado Común del Sur*) countries (Health 2009) highlights as a major obstacle for the viability of community participation a "lack of economic resources." An evaluation of municipal health councils in Brazil (Moreira and Escorel 2009, cited for Kliksberg 2011) indicated that the greatest deficit in their operating conditions is the limitation of financial resources (Kliksberg 2011:31).

The sociological notion of *social capital*, closely related to health promotion, refers to both the relationships existing in the immediate social areas of individuals (streets and neighborhoods) and those degrees of insertion connected to the formal integration of these into organizations in which social values and social bonds such as solidarity and trust, among others, are usually strengthened. More recent definitions view social capital as informal relationships of trust and cooperation (family, neighbors, colleagues), formal community participation in diverse organizations,

and the normative and value-based institutional framework of a society that fosters or inhibits relationships of trust and civic commitment.

The strengthening of social capital is considered a fundamental strategy to overcome inequalities and poverty and, consequently, improve the health situation, particularly for the poor and excluded.

When the concept of social capital is incorporated into strategies that societies have devised to overcome poverty, it is possible to observe strong cooperation between the powers of the state, union and entrepreneurial structures, and various social groups. In general, strategic consideration of social capital generates instances of cooperation in society, which results in the production or strengthening of structures that facilitate the implementation of related initiatives, creating a climate of solidarity and attenuating the impersonal forces, which historically have been the institutions that support social policies aimed at overcoming poverty (Rozas and Leyva 2005, cited for Kliksberg 2011). On the other hand, the concept of social capital provides an important component of integrality to direct social action. Inasmuch as social reality is an inseparable whole, an adequate form of work must consider the different dimensions in which the social is expressed, not segmenting social reality into isolated sectors but integrating it under joint and coordinated actions.

> Fetterman et al. (1996) and Fetterman (2001) refer to the empowerment evaluation approach as a means to increase the capacity of program stakeholders who plan, implement, and evaluate their own programs. The purpose of empowerment evaluation is (a) to provide a tool for assessing the planning, implementation, and evaluation of programs and (b) to make the mainstream evaluation become part of the planning and management of projects or organizations (Fetterman and Wandersman 2005, cited for Khaiklenga et al. 2015:1396).

The collective mobilization of different actors and the actions undertaken by them have produced different interactional activities and citizen initiatives, with different contents—expressions of different social tensions, specific problems that can be grouped together as a set—and defined as collective actions.

> "A social movement is a form of collective action, and the existence of a collective action implies the preexistence of a conflict, of a tension that tries to resolve—making it visible, giving it dimensions—that collective action" (Ibarra and Grau 2000:9).

Issues related to a population's health have been on the agenda of social movements in two ways, direct and indirect. The social movements that consolidated during the 1970s established important agenda issues such as feminism (including sexual and reproductive rights), land tenure, basic services and antimilitarism, and later religious and antiglobalization movements. Some of these initiatives have enjoyed the participation of neighborhood associations and with different social groups (seniors or senior citizens). In Brazil, the Popular Movement for Health was formed by several neighborhood associations based on social principles such as, for example, solidarity, cooperation, and participation.

> The population would mobilize to obtain water, electricity, pavement, security, transportation; fight against price increases on certain commodities or services, but not for health, at least at a manifest level. The same can be said of rural communities, where health appears to be less significant than other needs. (Menéndez 1995:16)

Social movements with their protracted actions over time have identified the basis of the problem and its consequences:

> No one fights in association with others and for the well-being of others if "solidarity capital" has not previously been generated, which makes action associated and detached in a social good recognized, welcomed, sought after, and accumulated by the agents of social action. This capital of solidarity would be a kind of symbolic capital that, over time and through its generalization, gives historical continuity to social movements. (García Linera 2008:389–90)

In general, the agendas of social movements have included the theme of health from different perspectives, through the various social determinants, which have mobilized different collective actions:

> The functional structuralism of Talcott Parsons saw in social determinants as "tensions" the drives of collective action. Similarly, R. Turner and L. Killian (1957), based on functional structuralism, viewed social movements as a creative phenomenon of change. From the macro viewpoint, Smelser, in *Theory of Collective Behavior* (1962), saw in collective action the collective response to the tensions of society. (Pont Vidal 1998:261)

The dimensions (population, environmental, economic, and social) essential to development require a broad perspective, a systematic approach, which has to do with the interaction between constituent elements, the whole and the parts. The relations of the parts to one another and to the whole are logical-functional.

> In the 1990s, in spite of the weakening suffered by many of Latin America's social movements, due to the crisis in the socialist countries of Eastern Europe and the rise of neoliberal policies and sectoral and structural reforms imposed by multilateral organizations, the Latin American Movement of Social Medicine (MLMS) maintained its defense of health as a citizen's right and a duty of the state (Mejía 2013:32).

According to the *Lancet* Commission on Global Governance for Health (2014), sustainable development is one of the key aspects, coupled with global solidarity and shared responsibility—on which it must be supported—without neglecting the leading role of economic systems and global politicians.

> With globalization, health inequity is increasingly translated into transnational activities that involve actors with different interests and degrees of power: states, transnational corporations, civil society and others. The decisions, policies and actions of these actors are based on global social norms. Their actions are not aimed at harming health but may have a negative side effect that generates inequity in health. We call political determinants of health the norms, policies, and practices that arise from global political interactions that cross all sectors and affect health....We should no longer consider health as a biomedical technical issue but rather recognize the need for global intersectoral action and justice in our efforts to address inequity in health. (Ottersen et al. 2014)

Latin America mobilizes around health and well-being, but it has not advanced as expected owing to complex challenges to be faced. The importance of social movements as scenarios for debate, knowledge exchange, generation of proposals, and social mobilization is indisputable. Questions arise in relation to their scope, their influence on national and international policies and agendas to reduce social and health inequities, and, finally, the scope of actions to confront the consequences on the globalization of knowledge and decisions that limit the capacity of countries to act. If little can be done, what should we do?

Popular grassroots social movements in Brazil have been notable for including in their agendas the health issue (for the right to timely access and quality). Thus, the initiatives carried out in previous decades by some grassroots social movements, at least in the case of Brazil, regarding the consolidation of the Unified Health System (SUS) are considered relevant. According to Stolkiner (2010:94), "In Brazil and with the impulse of the collective health movement, health was established as a constitutional right and the Unified Health System (SUS) was founded, which aims at universal and free benefits."

> Historically, grassroots social movements have played an important role in the struggle for the right to healthcare and in the construction and consolidation of the Unified Health System/SUS, and their initiatives have important contributions in prevention, promotion and healthcare actions. This is evidenced from the moment they discuss, construct, practice and socialize their knowledge, thus contributing to the reflection and practice of doing in health. (Chaves et al. 2014:1507)

Within the framework of a collective health movement in Latin America, different authors have understood community health, also known as community medicine, as a movement that puts into practice some of the prevention principles, clearly focusing on minority social sectors and leaving the social mandate of conventional medical care (Almeida Filho and Silva Paim 1999:5). Community health is indeed considered by Almeida Filho and Silva Paim to be one of the components of the discourse of ideological movements historically constructed in the social field of health.

The term *social medicine*, adopted in most Latin American countries with different connotations, has also been termed *critical epidemiology* and *community social epidemiology* (Mercado-Martínez 2002). In Brazil, social medicine has been termed *collective health*, according to Iriart et al. (2002:128), "because the health movement that emerged in that country considered it important, based on the analysis of the set of health practices and organizations, including medical practice. Its emphasis is on giving importance, in addition to the medical act for the health/illness/care process," to the broader social understanding in which these collective processes have their origin (social, economic, and cultural conditions). Social medicine or collective health confers on the health/disease duality analytical importance as a dialectical process and not as a dichotomous category (Iriart et al. 2002).

Social medicine has been regarded as a movement that has made important contributions to research, teaching, and medical practice for several decades in Latin America (Waitzkin et al. 2001, in Mercado-Martínez 2002): According to Stolkiner (2010:89–90), it has fulfilled "a role in the theoretical and political task of building the postulates of dominant discourses in the field of health." It has made important contributions to research, teaching, and medical practice for several decades in Latin America (Waitzkin et al. 2001, in Mercado-Martínez 2002:3).

Despite the great contributions of some movements in Latin America, it is necessary to reflect on what makes them discontinuous, dependent on government, issuing theoretical and rhetorical messages that do not materialize in practice.

> It must be assumed in all their significance that collective health movements that seek social transformation in specific or generic terms are not only discontinuous, but their work and their practical and ideological effect last a short time given several processes, a system of transactions that must be performed inside and outside the movement or group, to ensure a minimum of efficiency and its self-reproduction. (Menéndez 1995:20)

One of the central ideas of collective movements for health revolves around the essential social changes required for progress in achievements related to the complex idea of integral development. The movement of the Brazilian Health Reform constituted a strong social movement that had as its main goal the defense of citizens' right to health.

Permanent Capacity-Building Processes: Learning from Practice

Learning during and through M&E is a pedagogical and sociopolitical permanent process that seeks to strengthen social cohesion around common or concerted aims to transform reality in favor of human and territorial development. It is clear that the imbalances generated by the globalization process and the increased health risks far exceed the established capacities of the various national health systems, even though many of them have undertaken substantial reforms in recent years. "It is this limitation that makes it urgent to build a new international institutionalism that succeeds in successfully tackling the risk aspects of globalization in health matters" (León 2006:152).

What Type of Capacity Is Needed?

A look at the concept and scope of *capacity* will help to identify the changes that must be made in territorial structures and resources to establish coherence between theory, convictions/values, and expected quality of life. This coherence should be established from the heart of our culture and environment. Capacity in general can be defined as the ability to develop a particular activity. This capacity, once qualified, is transformed into specific competences that the individuals, institutions, organizations, territories, and countries possess and potentiate to anticipate problems and to structure timely, integral, and sustainable solutions based on the implementation of M&E mechanisms. According to Mark et al. (2000:9):

> Evaluation assists sense making about policies and programs through the conduct of systematic inquiry that describes and explains the policies' and programs' operations, effects, justifications, and social implications. The ultimate goal of evaluation is social betterment, to which evaluation can contribute by assisting democratic institutions to better select, oversee, improve, and make sense of social programs and policies. (Kazi 2003:2)

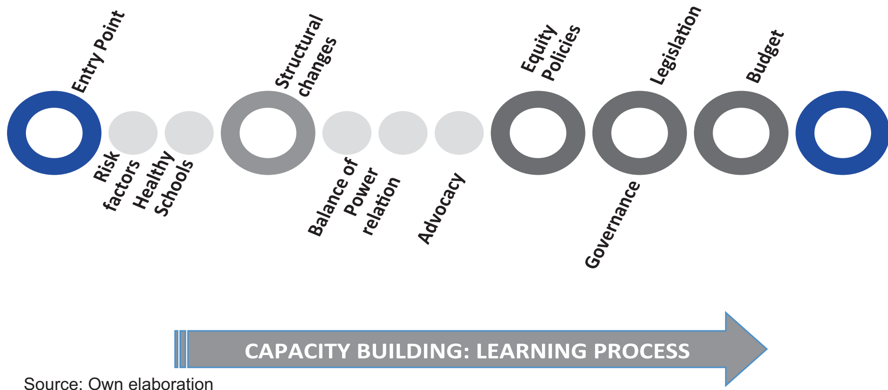


Fig. 15.3 Capacity-building processes. Source: Author's elaboration

In the traditional idea of capacity building in public health, focused on individual performance, there are important elements that demand the extension of this approach, one that covers not only individuals but also the structures with which they interact. Faced with the phenomenon of globalization in the political, social, economic, and cultural spheres, societies and territories must strengthen their identity and cement their values and resources in the service of a cause and shared bet (Fig. 15.3).

The dimensions of capacity should be complemented by the inequity perspective. The transformations of traditional structures constitute a huge challenge, which is not an exclusive responsibility of the health sector; it is a question of co-responsibilities that demand the visibility and weighting of equity as the guiding axis of territorial development plans as a collective purpose of the transformation process. As described by Zhou et al. (2017) and Llambías Wolff (2003), equity is one of the critical concerns when policymakers and managers allocate limited capacity to multiple demands. Unfortunately, to the best of our knowledge, capacity allocation that considers equity has received limited coverage in the literature. Few studies have considered equity in problems related to allocating capacity (Zhou et al. 2017:620): "Challenges lie more in the ability to promote paradigmatic changes that can implement policies around a reconceptualization of health, as an integral part of economic and social development and transform it into a valuable and ethical indicator of modernity" (Llambías Wolff 2003:237).

Shankardass et al. (2011, cited for Spiegel et al. 2012) commenting on national and regional HiAP, concluded that if the vision of health at a national level is broader, then a broader "palette of action" involving several stakeholders is more likely to be adopted. The same seems to hold true for the local level. Any national tradition or advocacy for intersectoral action (ISA) was often considered to influence the adoption of similar approaches at lower levels of government. A study on

municipal ISA in Cuba likewise noted that the national public health strategic plan in the period 1992–2000 sharpened the focus of public health on intersectoral collaboration (Spiegel et al. 2012).

Several common facilitating factors and challenges were identified: national and international influences, the local political context, public participation and use of support mechanisms such as coordination structures, funding mechanisms and mandates, engaging sectors through vertical and horizontal collaboration, information sharing, M&E, and equity considerations. As Rantala et al. (2014) reported, "The literature on certain aspects of ISA, such as monitoring and evaluation and health equity, was found to be relatively thin."

What kind of governance is required, and how is it achieved? Territorial governance, necessary to address health inequities, shall be rooted in territorial mechanisms and legislation for territorial management of development plans. In our opinion, this is a key strategy to preserve the identity of communities and to be resilient to the negative impacts of phenomena such as globalization and its neoliberal policies; therefore, it should be seen as an indicator of territorial capacity. This way of understanding capacities refers to the need for entrepreneurship, a differentiated strengthening that requires the content endowment of the knowledge, attitudes, and practices of individuals and their participation in processes for the resolution of problems, as well as meanings and abilities possessed by individuals and communities.

McLean et al. (2005) emphasized: "In order to understand capacity, researchers should employ methods that allow interpreting the meanings of the participants in their research and engaging in dialogue with participants and other researchers about the validity and usefulness of such interpretations." Meanwhile, Reygadas (2004) emphasizes the association between intervention effectiveness and capacities regarding the reduction of socioeconomic gaps.

> "To combat poverty, we must increase the capacities of individuals and not just distribute goods. Of course, the reverse is also true: internalized capacities will hardly flourish if basic commodities are not available for subsistence and labor. Another advantage of internalized resources is that they increase the power of the recipient and reduce their dependence on the provider (Reygadas 2004:8).

It is clear that the imbalances generated by the globalization process and the increased health risk far exceed the established capacities of the various national health systems, even though many of them have undertaken substantial reforms in recent years. Urban governance, according to Díez et al. (2016), is "promoting well-being and health insofar as it provides platforms that enable citizens to improve their social and economic conditions using their own capabilities."

The notion of capacity that welcomes only individual abilities to adapt and self-regulate to deal with social, economic, emotional, and environmental determinants of health, leaving aside the structures and influence of contextual factors, is not only insufficient but also counterproductive because it places all responsibility on individuals, not on issues that the individual is unable to handle alone. The focus on

individuals' ability has to do with their actual ability to perform "valuable work" as part of life. It is necessary to create or strengthen local structures and mechanisms to permanently increase the capacity of different actors in a territory to affects the determinants of health inequities, as well as build synergy at the regional, inter-agency, and social levels.

Monitoring and Evaluation Research as Powerful Tools to Support the Development of Actions

Although the evaluation model and its operational strategy include critical aspects to include in any evaluation exercise, it is recognized that the operation and success of any intervention depend on the conditions of each territory. The evaluation can be considered an intervention itself because it consists of a hypothesis, a theoretical basis, research questions, a goal or goals, assumptions, and a methodological (operational) approach to address the research problem (question). Assessment has several evaluation scopes: process, effectiveness, and impact. These three dimensions of evaluation are complementary but have different purposes, interests, methodological approaches, and audiences (stakeholders and users of information). M&E should become lifelong learning processes using practical experiences. For this, the planning, operational plans, and financing of evaluations must be an inherent part of interventions (Fig. 15.4).

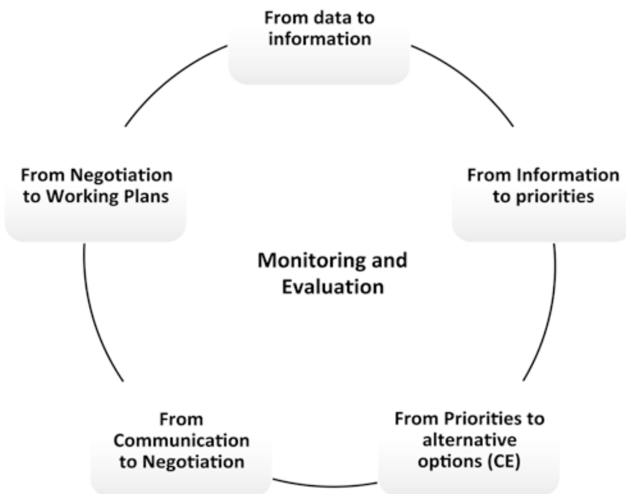


Fig. 15.4 Monitoring, evaluation, and capacity-building circle. Source: Author's elaboration

What Type of Evaluation Is Required to Support Actions to Reduce Health Inequities and Boost Human and Territorial Development?

Evaluative research is conceived in this proposal as inclusive learning processes, to assess and inform about feasibility and impact of complex, multipurpose and dynamic social interventions; in this case, to tackle health inequities and other determinants of health.

The foregoing question is answered by integrating the concept of local development into an operative structure composed of theories of change, values, complex decision-making contexts, and methodological approaches within diverse settings and scenarios. The present evaluation proposal addresses issues and concerns posed in previous sections.

Objective

The objective of this process is to convert the M&E function into a sociopolitical negotiation process, supported by technical tools to address health inequities and to create favorable conditions to improve and maintain population health.

Main Features and Requirements

The proposed strategy to address health inequities has as its focus of action the strengthening of social, institutional, and territorial capacity to deal with conditions related to health equity. To fulfill the previously stated objective, the M&E must meet several requirements: (1) place health equity at the center of the intervention design; (2) sensitize key actors and stakeholders and instill the political will to act; (3) optimize local resources and structures to meet key requirements for success; and, finally, (4) interventions adapted to the context (characteristics) of the territories. The M&E as, was mentioned earlier, are means to achieve this, through which transformation processes in the territory are generated and sustained. The questions are then what approach to M&E is most suitable, and what characteristics the M&E should have.

Complexity Present Throughout the Intervention Cycle: Design, Implementation, and Evaluation

An evaluation must be coherent theoretically and operationally given the complex nature of social interventions. Systemic analysis to understand the phenomenon of complexity from the interaction between key components of the intervention would help. The identification and understanding of the coherence between theory, practice, and results is useful to avoid establishing spurious correlations and associations. To this end, we will start with a study of the challenges and limitations and, at the same time, an understanding of the theory behind the intervention; finally, we will examine the conditions required for the work plan to be successful. Once we have identified and understood the aforementioned three aspects, we need to establish the correlation between them as a system.

Problem Definition

Health inequities, as the main problem, should be placed at the center of the political agenda. To do this, the problem must be appropriately defined, identifying those who are most vulnerable, where they live, who is most affected, and how risks and consequences are distributed, among other issues. These issues are inputs to define the scope of interventions, the indicators of success, the methodological approaches, and the recommendations that result from the evaluation. It is important to be aware that in the course of implementation of the intervention these aspects could be modified taking into account the performance and degree of compliance of the assumptions, among other issues.

One important limitation when assessing interventions aimed at reducing health inequities is that the problems might not have been clearly defined, and it also has not been made explicit in the planning of the intervention what and how these problems will be addressed; therefore, the expected results are not obtained. As the following figure shows, international and global orientations ignore or do not care about the structural conditions and culture of the countries, and therefore, the application of their orientations remains at the level of rhetoric and good intentions. On the other hand, countries are not doing what is necessary to strengthen their capacity to negotiate with representatives of international cooperation and financing agencies.

In other words, it is necessary to balance the power relations between the different actors (municipal, national, and international). Unfortunately, the governments and representatives of the countries often do not know the conditions of the most vulnerable population (around 50–70%) (Fig. 15.5).

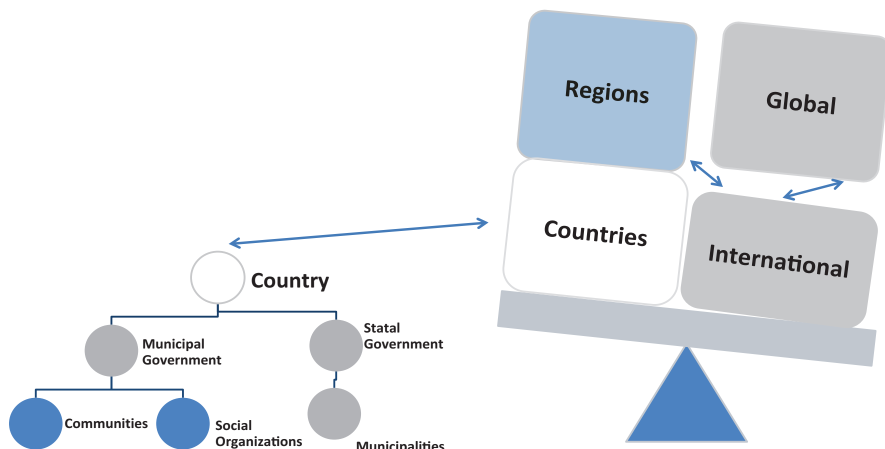


Fig. 15.5 Balance of power relations among stakeholders. Source: Author's elaboration

Intervention Design

Complex interventions are usually described as interventions that contain several interacting components, although there is no sharp boundary between simple and complex interventions. Social interventions are not only complex but are operated in complex environments and contexts, which are permeated by an imbalance of power relations and tensions between key actors. Therefore, it is wise to analyze the consequences of this complexity in the design, implementation, and outcomes of this type of intervention and its evaluation. Various actors have studied theory-based evaluation; a summary can be viewed in Figs. 15.6, 15.9, and 15.13).

Intersectoral initiatives should include a comprehensive equity analysis to identify any populations that are positively or negatively affected and the contexts under which such effects occur. This is important to avoid having the interventions increase population health inequities. Since intersectoral initiatives focusing on downstream determinants are unlikely to eliminate disparities, we recommend the use of "entry points" in order to undertake a multilevel intersectoral initiative by which the intersectoral action is scaled up to other levels.

Implementation and Scenarios of Practice

Program evaluations face challenges in real-world contexts, where evaluators and the agencies commissioning evaluations face budget and time constraints and where critical data are not available or are of poor quality. Evaluators must also adapt the evaluation to a range of political pressures and influences and must work within organizational systems that often involve many different agencies and actors and

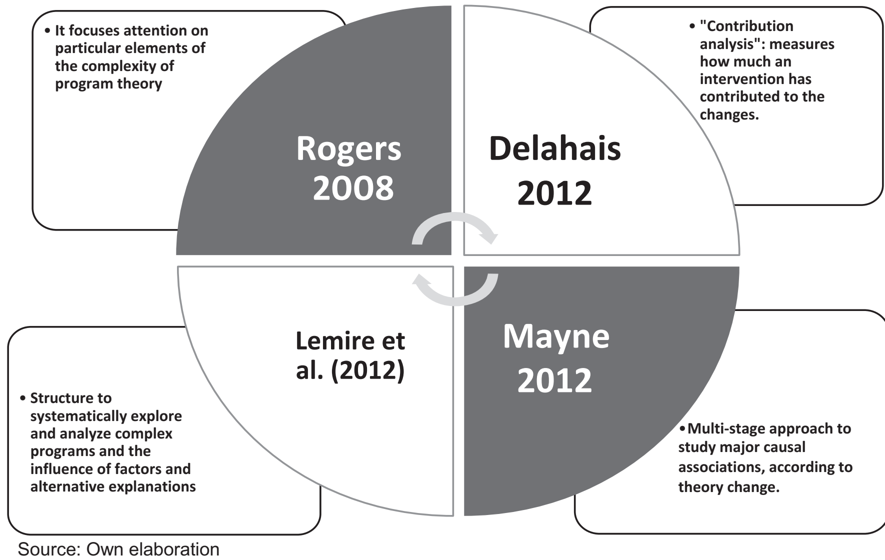


Fig. 15.6 Theory-based evaluation. Source: Author's elaboration

where administrative procedures may not be well suited to conduct a rigorous evaluation. Hawe et al. (2004) propose a critical analysis of the logic of intervention (log frame) to help construct or reconstruct more informed and effective interventions and evaluations.

For Hartz (1997), the analysis of the implementation is oriented toward identifying the procedures involved in the production of the effects of an intervention.

> Process evaluation, which may employ qualitative methods, can offer critical and illuminating evidence of what happens during a programme's life (Macdonald et al. 1996). If we want to find out why a programme has achieved its goals and objectives or not, rather than whether it has, process or illuminative research should provide the answers. Further, evaluation of large-scale health promotion programmes, such as the Healthy Cities movement (Davies and Kelly 1993, cited for Macdonald and Davies) and Heartbeat Wales (Nutbeam et al. 1993, cited for Macdonald and Davies), has proved difficult. This has been mainly due to the difficulty of isolating environmental and multimodal intervention effects and assessing their impact on health status outcomes. It has been suggested that even the processes of dissemination of such programmes through communities should be legitimate outcome targets for health promotion (Nutbeam et al. 1993).

Evaluation

As was previously mentioned, the evaluation should be theoretically and operationally coherent with the complex nature of social interventions. Several authors have associated the concept of complexity of these interventions with that of resilience,

within the so-called eco-health and eco-system approach (Kay et al. 1999), arguing that these interventions produce a large number of interactions and become resilient. Holling and Gunderson (2002), on the other hand, argue that "rapid surprise changes can occur, which often move in cycles, in which structures are repeatedly constructed and then collapse. Understanding these phenomena from the perspective of resilience and complexity provides inputs for the management and sustainability of these initiatives." The opinions of some authors who discuss the complexity of interventions are summarized in Table 15.1.

Table 15.1 How complexity influences the design, implementation, and evaluation of interventions

Author	Recommendations
Kay et al. (1999)	Associates the concept of complexity with the concept of resilience, within the so-called eco-health and ecosystem approach. Understanding these phenomena from the perspective of resilience and complexity provides inputs for the management, operation, and sustainability of these initiatives. For them these interventions produce a large number of interactions and become resilient
Holling and Gunderson (2002)	Argue that rapid surprise changes can occur, which often move in cycles in which structures are repeatedly constructed and then collapse
Craig et al. (2008)	Identified the following characteristics of complex interventions: The number of interacting components within the experimental and control interventions; number and difficulty of behaviors required by those delivering or receiving the intervention; number of groups or organizational levels targeted by the intervention; number and variability of outcomes; degree of flexibility or tailoring of the intervention permitted
Singh (2008)	According to the author there are two recurring themes in the literature, which are closely linked to health inequities: they are poverty and chronic diseases. The first is enunciated as a global issue, but there is no detailed analysis of the causes that explain it; there is no in-depth analysis of variables such as road access, forms of production, marketing, migration, education and training deficits, services deficit, environmental depredation, and lack of water, among others
Bamberger et al. (2012)	Complexity according to Bamberger et al. (2012) refers to the contexts in which actors and institutions interact
Craig et al. (2008)	They recommend the following steps to develop a complex intervention: Identify existing evidence (what is already known about similar interventions and the methods that have been used to evaluate them); also identify and develop theory; the evaluation must be developed at the time a worthwhile effect is expected; keep in mind that the changes to be achieved may not be clear at the outset
	A theoretical understanding of the likely process of change by drawing on existing evidence and theory, supplemented if necessary by new primary research, modeling a complex intervention before a full-scale evaluation, and assessing feasibility. Evaluations are often undermined by problems of acceptability, compliance, delivery of the intervention, recruitment and retention, and smaller-than-expected effect sizes that could have been predicted by thorough piloting. Pilot study results should be interpreted cautiously when making assumptions about the numbers required when the evaluation is scaled up. Effects may be smaller or more variable and response rates lower when the intervention is rolled out across a wider range of settings

Scope: Monitoring and Evaluation as a Political Negotiation Tool

In this section we will present mechanisms and instruments to make M&E a political instrument for learning, negotiation, and strengthening capacity to deal with health inequities.

The components of the evaluative process are closely related; therefore, any evaluation must consider all of them as reaching appropriate conclusions. These components, as was stated earlier, are interdependent and therefore, the approach to study them must be systemic. Any approach adopted will have repercussions for the others: the scope of the intervention, the objective, the questions, the indicators to understand the process and appraise the results, the complexity of the operational strategy, the methodological approach to defining its effectiveness, and the impact (Fig. 15.7).

Mechanisms for Permanent Reflection on Theory and Practice

The relevance, feasibility, sustainability, inclusion, and equitable process of learning is the cornerstone of this strategy. The use of available sources of information could support reflection and action in favor of human and territorial development. To accomplish this task, local resources must be adapted.

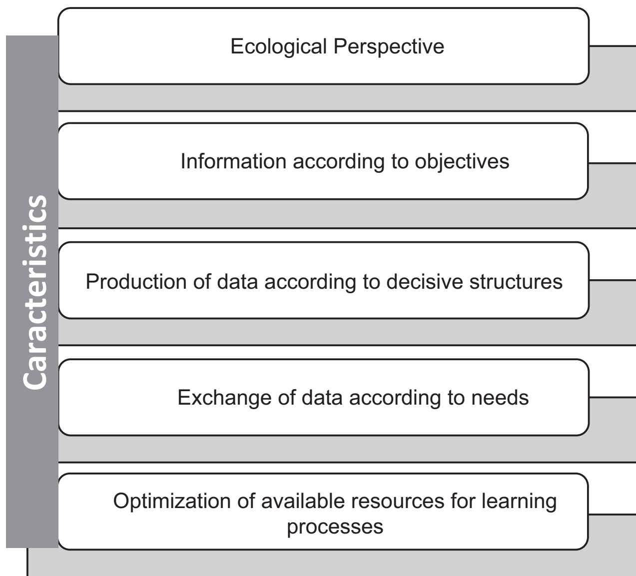


Fig. 15.7 M&E approach: characteristics. Source: Author's elaboration

The political will to modify structures of power (institutions, groups, and social organizations, among others) is very limited. New strategies could serve as an entry point to strengthen the previous one; moreover, it represents a valuable opportunity to integrate all the strategies aimed at reducing inequities and to make more efficient use of available resources. Research, M&E, knowledge sharing, and permanent advocacy are needed in order to understand, interpret, and transform reality, facing challenges imposed by the complexity and multidimensional nature of strategies.

The operational meaning and scope of strategies to reduce health inequities are not always fully understood; one example is related to participation: it has been said that the achievement of health equity depends on the strengthening of community participation in the process of formulating public health policies (WHO 2016:4). Often the definitions of terms such as participation, empowerment, and capacity building are made loosely, so the requirements and resources to implement, evaluate, and assess their success or failure are not clearly defined. Knowledge development is understood as a process that arises not only from the sciences but also by means of ongoing observation of the achievements and changes where interventions are applied.

As was mentioned earlier, capacity building is a key issue, and the design and evaluation of interventions provide a rich source of data and knowledge that are often ignored. De Salazar and Pineda (2015a) reflected on evaluation and its contribution to capacity building.

Communicational Strategies to Support Learning Processes and Decision Making

The publication and exchange of experiences, challenges, ways to face them, and requirements for success have been recognized as inputs to strengthen the theory, practice, and evaluation of these initiatives. This practice should be inserted into processes of reflection and debate according to each context. *Communication, advocacy, negotiation,* and *agreements:* It is well known that not all population health interventions are necessarily reproducible; however, much can be learned from other experiences. Few rigorous studies of interventions focused on community-wide change are available, and this seems a very promising area of work. Research design and measurement issues are significant in this form of research (Israel et al. 1995 in Clark and Mcleroy 1998:28).

Communication strategies can support this process of collective learning as long as they meet several criteria, one of the most important being the collective production, interchange, and use of reliable, complete, and relevant information in decision-making processes. This information should support any decision related to the adoption, modification, or rejection of an intervention, as well as to identify the mechanisms and requirements responsible for yielding results, either good or bad.

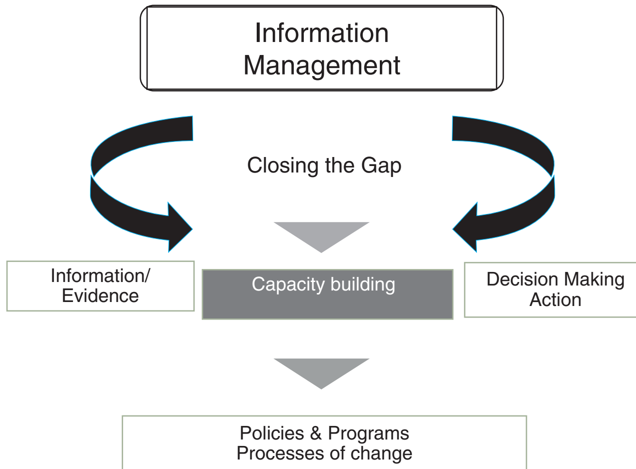


Fig. 15.8 From data to information for decision making and action. Source: Author's elaboration

Unfortunately, most publications contain insufficient information to make this assessment. The main reason for this is that the objective of researchers and promoters of these initiatives is different from that indicated; it is rather oriented to demonstrate the success achieved.

Closing the gap between information, knowledge production, and its utilization demands the establishment of mechanisms to ensure a fluid, inclusive, sustained, and assertive communication. To comply with this objective, it is necessary to have an understanding of the type of information and communication that moves action (Fig. 15.8).

Without a doubt, the opportunity, political situation, windows of opportunity, and way information is presented influence its utilization. Communities, governments, social movements, and international agencies, among others, have excellent opportunities to exchange information, reflect on practices, and develop collective agendas to meet the challenges presented. Unfortunately, this does not happen; on the contrary, the recommendations of these parties do not respond to the needs of the territories and their populations.

Several sources of information are available, which can be strengthened to serve different purposes: (1) to improve practice, (2) to sensitize decision makers**,** (3) to allocate resources, (4) to follow up on policies and programs, (5) to strengthen research and increase and qualify the participation of key actors in development processes, and, finally, (6) to maintain permanent processes of learning and political negotiation. The questions to answer are who defines what information is needed and based on what criteria, who will have access to information, who will require it and for what purposes, and who will finances a project.

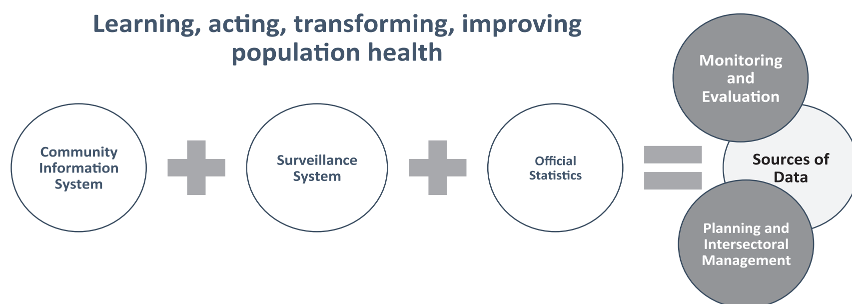
Supporting Structures and Technical Tools: Requirements

Supporting structures are the pillars for creating, driving, strengthening, and sustaining transformation processes. These structures are territorial and can be classified in several ways: by intentionality, scope, governing corps, and resources, among others. We will focus the analysis on the political, physical, and organizational characteristics of structures to undertake and sustain processes of change, transcending the solution to specific problems to address issues related to equity and population health within territories. Also, we will examine the adaptation or transformation of the systems that support those structures to accomplish their functions.

Examples of these structures are the mayoralty with all its subordinate structures, organized social groups, the private sector, and nongovernmental organizations, among others. It is important to recognize that all of these structures have their own way of functioning, tools to carry out their activities, and, finally, rules and legislation that frequently hinder or limit the execution processes of change, which could threaten their power and interests.

Therefore, to close the gap between information, evidence, and political action to reduce health inequities, it is necessary to create or strengthen local structures and mechanisms to permanently increase the capacity of different actors in a territory to build synergy at the regional, interagency, and social levels. Somehow, this type of evaluation is close to what has been called "empowerment evaluation," which is aimed at creating favorable conditions to increase the success of interventions.

> Empowerment evaluation is an evaluation approach that aims to increase the likelihood that programs will achieve results by increasing the capacity of program stakeholders to plan, implement, and evaluate their own programs (Wandersman et al. 2005:27) (Fig. 15.9).



Source: Own elaboration

Fig. 15.9 Technical instruments for planning and management of processes for social change. Source: Author's elaboration

De Salazar (2011), using noncommunicable diseases (NCDs) as a "pretext" to evaluate the effectiveness of social interventions, highlighted the need to establish mechanisms and tools to identify threats and risks and generate collective responses to address them. On the other hand is the need to articulate sectoral plans to territorial development plans, as well as other initiatives, in order to increase sustainability. This action will strengthen the local capacity, moving from the management of activities to the management of policies and programs (De Salazar and Pineda 2015b:21).

Traditional public health functions could be important inputs to undertake processes of change, but unfortunately, this is not the case. They do not meet the requirements that allow them to create and sustain territories for strengthening citizenship and the empowerment and capacity building of its inhabitants and institutions, in other words, territories as promoters of equity and well-being.

Coping with Evaluation Challenges Without Compromising the Validity and Credibility of Evaluation Results

As stated previously, key technical tools need to be created or reinforced to reach the aforementioned objectives. Our plan is to optimize the available tools, such as information and surveillance systems, M&E, and other sources of information, formal or informal, to collect, analyze, interpret, and use data. The optimization of available resources could generate several advantages, among them the institutionalization of changes, the reinforcement of local culture, a reduction in operational costs, the continuous improvement of tools, and, last but not least, the sustainability of procedures to sustain local learning processes of capacity building and resilience.

Existing policies support the initiation and implementation of intersectoral initiatives. There is a need to further integrate policy advocacy into the core functions of these initiatives and to adequately understand the relationships between sectors and the contribution of the public health sector to this work. Collaborations between public health and other sectors show promise in creating supportive environments, as well as in enhancing access to services for marginalized populations. There is a need for more multilevel interventions that address structural determinants of health across entire populations.

Different initiatives have been created, many of them unknown because they represent "pilot projects" that have not been able to permeate political and power structures or they have not been publicized; therefore, their impact does not transcend the borders imposed for being "a social experiment." A deeper analysis of these issues is beyond the scope of this chapter, but what is clear is that our practice follows the guidelines of our governments, which in turn adopt or adapt the orientations set by cooperation and financing agencies. This fact is one of the consequences of the globalization of knowledge in colonized countries, which do not have the power or the opportunity to define and develop their own agendas.

Holistic Health Approach: Not Only Health Inequities But Also Social Inequities

The evaluation strategy must define its scope according to criteria such as the nature of the intervention, theory of change, time horizon, expected outcomes during the implementation phase, required resources, and feasibility of applying the methodological approach (mainstream evaluation). The political nature of health is not sufficiently recognized; while one of the core values of health promotion and public health is the right to health, in practice, often what drives actions are individual needs, especially in times of crisis. Hence, the actions become cyclical and volatile and are applied to individuals rather than to populations. Approaches to health equity in the Latin American region have been conceived based on foreign models, which have different conditions and capacities to undertake the needed changes. Although the complexity of population-based interventions has been acknowledged, often the concept is not materialized in practice, with the notion of simplicity prevailing because it is easier and responds to what countries can do.

The precision of the evaluation scope, supported in a broader intentionality of the purpose of the evaluation, creates an opportunity to expand awareness and capacity to face threatening situations. In this case, the use of "entry points" as generators and promoters of transformative processes could be a viable and effective alternative for changing the conditions that traditionally have impeded the attainment of health and well-being goals. The definition of the scope of an evaluation, requirements, funding, and roles and responsibilities constitutes a negotiation endeavor; therefore, it is necessary to have clarity about the role of the entry point and a working plan to fulfill it (Fig. 15.10).

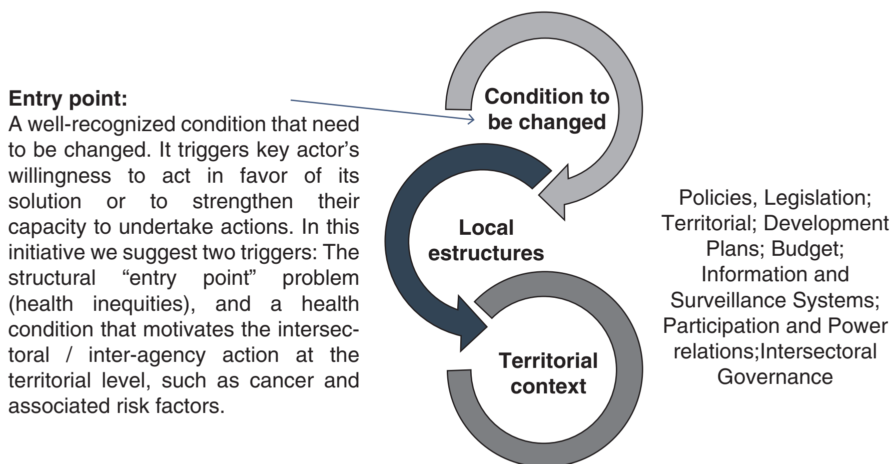


Fig. 15.10 Subjects of action and transformation. Source: Author's elaboration

Evaluation as a System

In this section, process, effectiveness, and impact evaluation are addressed. These three dimensions of evaluation are complementary, although they have differences in their purpose, scope, and interests, as reflected in their objectives and the types of questions they address; in addition, their methodological approaches and audiences (stakeholders and users of information) are diverse. The emphasis of this proposal is on the implementation process, though the importance and necessity of the other types of evaluation are not ignored. On the contrary, we are convinced that without an evaluation of the implementation it would be inefficient and useless to establish evidence of associations/attributions between interventions and results. This decision is made for different reasons, including because an implementation evaluation is closer to the evaluation intentionality, which has already been manifested: it produces permanent data and information to support learning and capacity-building processes; it facilitates the active participation of different stakeholders; it facilitates the opportune identification of the advances, strengths, and limitations on achieving the objectives; and, finally, it is an indispensable input to establish the effectiveness and impact of an intervention. Therefore, it is necessary to insist on the need to analyze in depth the consequences and adjustments to be made to the evaluation process.

We refer to the words of Appadurai (2011), who made the following wise statement:

> A socioeconomic transition toward another model of production and consumption is necessary that will not be found in accords with other countries facing different realities and having their own interests. The only opportunity we have is to direct our research and social and political actions toward strengthening our capacity to "sit at the table" not only as guests but also as agents of change with sufficient information, capacity, and power to reorient international and national inclusive agendas. (2011)

The influence of complexity on social interventions is manifested in the aspects previously mentioned, plus those indicated in graph 9.

Process evaluation**.** The process of carrying out social interventions is usually a so-called black box whose central feature is the lack of information on which to judge the interventions' achievements, the aspects that have influenced the implementation and changes, the adherence to protocols, the degree to which assumptions played out, and how they might have influenced the results. It is important not only to answer questions about what worked, but also for whom, how, and under what circumstances. The process evaluation provides information to identify and understand the interaction among variables in order to establish coherence between the theoretical basis of the intervention and the achievements during implementation. At the same time this information facilitates the reorientation and adjustment of the logical framework and the strengthening of the theory based on concrete realities.

> In our opinion the traditional "Fidelity" concept must be taken with care since the interest is not to force results that do not fit in specific situations, but to understand them to make the necessary adjustments. In other words, fidelity is not a virtue but a variable to be studied and understood.

The most common definition of program implementation is related to the question of how well a program or intervention is put into practice, or fidelity (Durlak 1998). The documentation and systematization of experiences provide information to answer this question.

Effectiveness evaluation**:** This refers to the fulfillment of an intervention's objective(s) as well as the type and magnitude of changes (how they are perceived and how they can be explained) or the capacity of the structures in a territory to produce the expected results with the intervention. Effectiveness evaluation is like a summative evaluation since it is directed at identifying the achievement of the expected goal as an effect of the intervention. To this end, it could establish in some cases a causal relation between intervention and outcomes (theory of change); also, it could identify the factors that hinder or facilitate achievement of the objective (De Salazar 2009).

The results of a systematic review evaluating the impact and effectiveness of intersectoral actions on the social determinants of health and health equity held by the National Collaborating Centre for Determinants of Health (2012) found that:

> The studies focused their interventions on populations experiencing social and/or economic disadvantage; few described evaluating and comparing the impacts of interventions in marginalized groups with the impacts of such interventions in other groups within the population. The majority of studies did not specifically analyze the health equity implications of the interventions in terms of multiple factors of disadvantage. It is possible that some initiatives would improve the health of marginalized populations without changing the gap between marginalized and privileged groups. While the interventions reviewed here were focused on marginalized communities, the majority were downstream and midstream interventions. For example, none of the included studies that focused on racialized communities addressed the issue of institutionalized racism. Previous work has noted the challenge of addressing upstream determinants of health. (2012)

An issue almost absent from published reports is the strengthening of local capacity to create and maintain sustainable, participatory, and equitable transformation processes in favor of health equity and well-being of populations. Evaluating the impact of interventions to reduce inequities in health should establish, according to Mahoney et al. (2004), articulation between the intervention, practice, health, and equity.

Types of Questions and Indicators to Assess Success

> The true measure of success is not how much we promise, but how much we deliver for those who need us most. (Ban Ki- moon 2017)

It has been found that the limitations of formulating evaluation questions are related to many factors such as a misunderstanding of the theory of change, interventions designed not in accordance with their scope and complex nature, limited budget and time horizons to show expected results, conflicting interests among stakeholders, budget, and relevance for decision makers, among others. As a result,

questions usually do not correspond to the objectives and scale of implementation of the interventions; also, they are not related to the principles and values that underlie the interventions and do not take into account intermediate results, only final results, which are often difficult to obtain in the short or medium term. At the same time, usually they do not respond to the interests of primary users of information and decision makers. These assertions are supported by two studies carried out in the Latin American region (De Salazar 2012).

Two additional aspects influence the type of questions to pose: Who is asking them? And what criteria are used to assess the response? Ray and Mayan (2001), referring to the political and ethical issues of evaluation, stated that this is related to the question of who determines what is considered as evidence, what are the appropriate indicators and standards of comparison. One concern here is how to reach a consensus on the criteria for judging evidence when different expectations and rationalities are in place.

There is a tendency to value performance by the activities undertaken to justify budget allocations; less frequently encountered is an interest in answering questions to address the assumptions and hypotheses under which initiatives were designed (theory of change). This implies that the evaluation questions must arise from the consensus of those involved and users of the information. This consensus is a negotiation exercise:

> A key question in evaluating complex interventions is whether they are effective in everyday practice. It is important to understand the whole range of effects and how they vary, for example, among recipients or between sites. A second key question in evaluating complex interventions is how the intervention works: what are the active ingredients and how are they exerting their effect? Answers to this kind of question are needed to design more interventions that are effective and apply them appropriately across group and setting. (Craig et al. 2008:7)

> Best practice is to develop interventions systematically, using the best available evidence and appropriate theory, then to test them using a carefully phased approach, starting with a series of pilot studies targeted at each of the key uncertainties in the design, and moving on to an exploratory and then a definitive evaluation. (Craig et al. 2008:8)

Craig et al. (2008) point out three types of evaluation questions in complex interventions: "Intervention effectiveness under controlled and uncontrolled conditions—whether there is positive or negative impact and whether the benefits are distributed-equitable according to needs; questions about the mechanisms that influenced the results (how these changes occurred and why from the perspective of those involved in the intervention, both service providers and decision makers; and questions on the feasibility of reproducing it or expanding it elsewhere (external validity). The results must be disseminated as widely and persuasively as possible, with further research to assist and monitor the process of implementation" (Craig et al. 2008:8).

Researchers need to consider carefully the tradeoff between the political and social importance of results compared with the value of the evidence obtained under controlled conditions. It is surprising that the indicators to judge interventions' success or failure to tackle health inequities usually do not include the most prominent

factors influencing their success or failure. Therefore, the operational definition of *best practice*, to my knowledge, is that it is not static but context bound; it depends also on the nature and theory of change of the intervention, plus what happened in the "real world." The indicators for assessing the effectiveness of interventions are often ambitious in relation to what was planned or implemented. This fact creates confusion when, considering that the intervention did not work, what was done wrong was the design or the implementation.

One aspect underlies this situation, the time required to produce the expected results, in contrast to the timing in which decision makers and stakeholders require the data; another issue relates to the indicators used to assess whether an intervention is successful. In conclusion, one solution is to produce different types of information, a permanent one, oriented to the leaders and operators of the interventions who need to make adjustments over the course of their implementation, and another, for the government that needs to justify its budgets and investments. These mechanisms of production, exchange, and use of information becomes a process of learning, negotiation, and decision making.

According to the Evaluation Consensus for the Americas (1999), assessment indicators include changes in the amount and adequacy of facilities and equipment, their organization, the administrative structure, relations among actors, the scope of actor and sector participation, intersectoral planning and management, quality of performance, and effective project metrics, among others. Other indicators are absent from most reports, such as those related to capacity building, balance of power relations, influence on policies and programs of greater reach, knowledge sharing, and territorial governance, among others. A clear example of the foregoing statements happens when objectives are achieved despite a poor problem formulation; the intervention was not theoretically related to that formulation or the implementation was not carried out as planned because it did not take into account aspects of the context in which it took place; however, other policies, legislation, and interventions were implemented in the same time horizon.

Figure 15.11 shows the differences in an intersectoral intervention aimed at reducing health inequities when driven by the health sector and when the government drives it. Several aspects are notable, and the initiative's promoters could play the role of mediator (health sector) or regulator (government). In the latter case, the outcomes in terms of the reduction of health inequities are more ambitious and have a greater likelihood of being achieved through a territorial development plan, which is regulated, and when the mayor makes budgetary allocations.

One aspect to be taken into account is the frequent practice of each sector to develop their own plans and try to articulate them to the territorial plan, which is not easy since the sectors do not start from a collective purpose, but sectorial, for which they have a fixed budget. Therefore, territorial and sectoral plans are key tools for encouraging cross-sectoral work, optimize resources and reach agreement on the definition of priorities, additional funding sources, roles and intersectoral work.

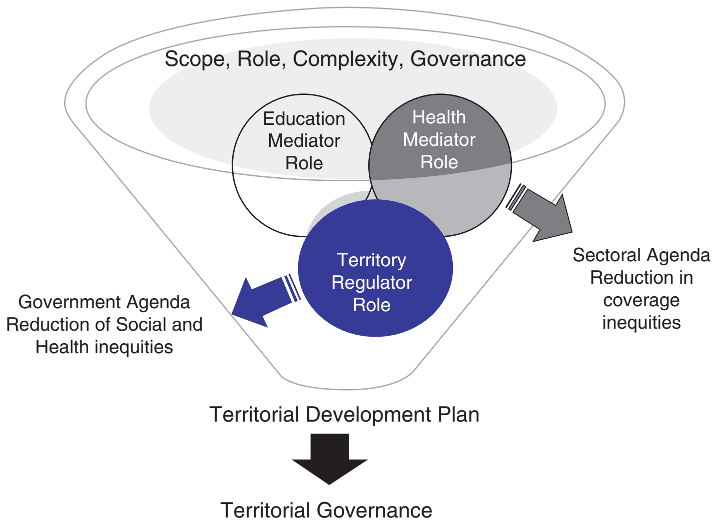


Fig. 15.11 Intersectoral work led by health sector and by government. Source: Author's elaboration

By law, most local governments are responsible for formulating, implementing, and spearheading territorial development plans, which have an allocated budget. This gives local authorities the opportunity to negotiate with the different actors and sectors in the territory.

In short, depending on the aforementioned aspects, as well as the magnitude and feasibility of making necessary adjustments, we cannot be held responsible for changes whose results depend to a great extent on the several sectors over which we have no control or power to reorient their actions toward the improvement of the social and economic conditions of the population.

Otherwise, we can barely effect a reduction in inequities in coverage and access to health services. Therefore, the difference between a reduction of inequities in access to health services and a reduction in health inequities should be clearly established; the former is more within the purview of the health sector, while the second is within that of the government. The indicators should align with this definition.

Evidence, Methodological Approaches, and Methods

The main intention of this section is to present inputs to convert an evaluation into an instrument of social policy, which contributes to undertaking informed participatory negotiations in a territory and strengthening local capacities for making social

changes. There exist a wide variety of methodological tools, so the focus in this section will not be on an in-depth analysis of different methodological options but on criteria for selecting the most appropriate ones according to the scope of the evaluation described.

Evidence and Methodological Approaches

As mentioned previously, we must develop evaluation methodological approaches in accordance with the ontological and epistemological perspectives required by the type of interventions being addressed and with our ability to address the research questions based on the availability of resources, time horizon, and quality of available information, among other factors. This gives the evaluation research special significance, which demands changes in the type of questions, methodological innovations, variety and integration of information sources, diverse rationality for selecting methods and technologies, different criteria for selecting participants, and the types of abilities and capabilities of evaluators (Fig. 15.12).

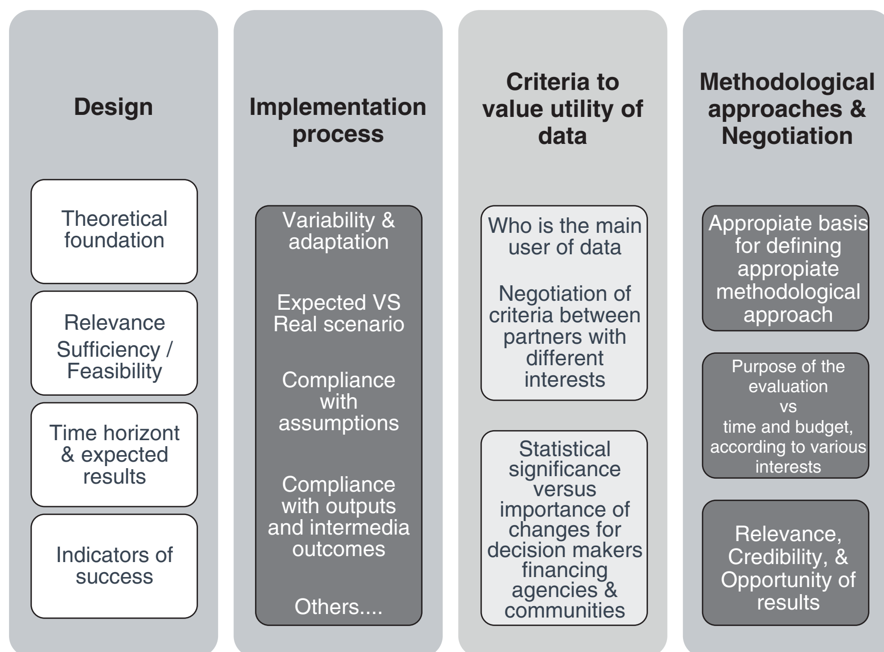


Fig. 15.12 Key aspects to be analyzed in the evaluation of complex interventions. Source: Author's elaboration

Methodological Approaches

The analysis used to identify the most appropriate methodological approach should consider the distinction between the terms *assessment* and *appraisal*. Stevens and Milne (2004) refer to "assessment as the scientific / technical process of gathering and summarizing information on the relevant aspects of a health technology," while appraisal is the "political process of making a decision about health technologies, taking account of assessment information as well as values and other factors." Evaluation research should definitely consider both. The conscientious and judicious use of evidence is only a necessary element, but it is not sufficient to assess whether an initiative is effective and useful, according to Tang et al. (2003). There appears to be a higher probability that decision makers will use evidence when it is reliable, deals with questions they consider relevant, and involves them in the process for its generation; it is believed, apparently, that decision makers use information when it is credible; however, other factors affecting the use of evidence are not scientific but political.

The evidence concept has often been restricted to quantitative facts derived from randomized experimental designs, which do not necessarily capture the inherent complexity of population health interventions. There is a general agreement that intervention outcomes depend highly on the way a large number of agents respond. Their participation is influenced by the institutional arrangements that mediate relationships between them and by their understandings and expectations of how other actors will respond.

Lavis et al. (2008) reported a case study on the use of evidence in policymaking that showed as strengths the existence of an organizational approach to policy formulation based on evidence; at the same time, it was recognized as time consuming and as being mediated by the existence of a close relationship between researchers and policymakers, which could be influenced by conflicts of interest between these two actors. The main weaknesses were the lack of resources and the presence of conflicts of interest.

Other authors argue that when the notion of evidence is broad, it also includes qualitative evidence of lived experiences and case histories (McQueen and Anderson 2000). "This type of evidence is important because it reinforces the understanding of human behavior, promotes holistic thinking, and offers qualitative contextual data that goes beyond what some critics call 'mere opinions'" (Madjar and Walton 2001).

The attribution of results to a given intervention is not only due to a statistical association but also to a systematic study of the process and the interaction of variables that affect both the intervention (design and implementation) and the outcomes. For this reason, alternative options have arisen, with the most accessible being the conceptual and technical integration of positivist and constructivist approaches through a mixed-methods approach and so-called real-world evaluations (RWEs). "In contrast to the very large literature on rigorous quantitative experimental research designs, the evaluation literature has had very little to offer to

the majority of funding and implementing agencies and evaluators. This is a 'missing piece' where we hope the real world evaluation (RWE) approach will make a contribution. (Bamberger et al. 2012:29–30).

The generation of evidence serves a purpose beyond mere intellectual curiosity (McQueen and Anderson 2001)

Although the demands for informed decisions based on evidence on the effectiveness and impact of policies and programs are growing, a number of questions have arisen about the relevance and consequences of basing these decisions on a single type of evidence, without taking into account the economic, social, political, and cultural consequences that their use can bring. In practice, evidence is insufficient to support decision making. According to Tang et al. (2003), external evidence can inform, but never replace, the expertise of the initiators of the initiatives.

The evidence according to Potvin is constructed through the relationship between theory, empirical observations and practice; it is context sensitive and not static. She also recommends evaluation research, not to add experiences, but to strengthen the theoretical foundation, to have a more complete and updated knowledge of the phenomena studied. The author emphasizes that "evidence based on practice (where it is produced) does not mean that pure knowledge is being adapted to a real-life situation; rather, it is trying to derive knowledge that is important Potvin (2007).

An exercise that helps define the methodological approaches to evaluating interventions that have the aforementioned intention is to collectively respond to the following questions: Which methodological approaches and methods produce reliable, relevant, and timely information to address health inequities? The answer to this question returns us to the basics of this type of evaluation: strengthen territorial identity and capacity to cope with health inequities, qualify participation in decision making, create conditions to undertake intersectoral management, and others.

There appears to be a higher probability that decision makers will use scientific evidence when it is of high quality, deals with questions that they consider relevant, and involves them in the process of generating it—from the formulation of questions to the presentation of results. In addition, it is necessary to reanalyze the intention and scope of the evaluation, how data will be used, and what kind of decisions will be taken. The information requirement is different when it comes to expanding or strengthening a program than when the intention is to justify a decision that has already been made (Table 15.2).

Table 15.2 Example of criteria to select evaluation approach and methods

Nature of intervention	Evaluation scope	Degree of implementation	Stakeholders interest	Resources available
Social/clinical Simple/ complex	Purpose/objective Feasibility of responding to evaluation questions Type of data expected: accuracy, reliability, precision Available sources of information Time horizon	What results could be obtained at the time of the evaluation, considering: (a) The theoretical basis (b) Completion status of work plan (c) Assumptions met (d) Unforeseen events?	Who is interested in the results? For what? What data do users need? What types of decisions will be taken? The objectives of the evaluation must be agreed to by stakeholders	Human Financial Technological Time horizon to present results

The instruments for the documentation and systematization of experiences is a valuable tool in the process of learning, building, and acting according to results derived from the implementation of policies and programs in diverse contexts (process, mechanisms, and outcomes under specific social, geographic, and political conditions). The case studies featured show that elements for successful intersectoral action are diverse but that they also provide an increasing evidence base for establishing general success factors and common approaches to overcome challenges (De Salazar 2016).

Adaptation of Technologies to Account for New Requirements

It is necessary to point out that in Latin America and in most LMICs, evidence studies are not exhaustive. Latin America still lives with large gaps in relation to production, ownership, and access to knowledge, connectivity, and interconnectivity, and to informational goods and services produced. The reduction among asymmetries and deficiencies of information are part of the challenges that our countries must overcome.

Despite the aforementioned constraints, there are several positive aspects and opportunities in the current situation, one of being the motivation, creativity, and diversity of current interventions to create healthy environments and, within these, the realization of measures to increase service coverage, from which one can envision actions that could affect the determinants of health. Therefore, there is a need

Low Middle Income Countries	Developed Countries
▪ Lack of policies supporting local actions; insufficient political will; lack of aplicability of a regulatory frameworks; fragmentation and divisions for reasons of political ideology; lack of financial resources for intersectoral actions; individualism; low social participation;capacity for planning, of management, of sustainability and of impact for the intersectoral work in the municiplity; low sustainability of processes of change"	▪ Existence of "mecanisms that facilitated intersectoral actions for health such new legislation or enforcing already existing legislation, using intersectoral working groups and promoting working relations with minimal bureaucracy. A variety of financial mechanisms and funding sources. ▪ Establishing common goals, engaging sectors and implementing mechanisms for intersectoral work, building up personal relations, identifying sectoral champions using a key to successful relationships

Source: Own elaboration

Fig. 15.13 Are the challenges similar in developed and LMICs? Are they just as complex? Source: Author's elaboration

to raise awareness of this potential and strengthen the capacity of the promoters of these initiatives for technology innovation, according to our needs. Otherwise, the strategies to reduce inequities and promote health are at risk of becoming a matter of mere rhetoric and a noble intention, with little chance of success, if realistic strategies and mechanisms are not created to influence the structural factors that impede or limit an intervention's implementation and results (Fig. 15.13).

Type of Evaluation Designs

There is a need to establish evaluation designs that cope with the following situation. First, the evaluation of most social interventions do not meet the criteria of traditional research design, which is aimed at establishing causal relationships between intervention and outcomes. The central objective of evaluation is to produce information that will allow one to make informed decisions; evaluators must start by accepting that there is not a single truth and a single answer to their questions and, therefore, not a single method. The context is dynamic and could produce frequent changes in the initial intervention protocol. Finally, the type of evaluation proposed has a social and political objective, which transcends the mere establishment of associations.

In complex interventions, diverse factors interact, most of them unknown by the drivers of these initiatives and for which it is difficult to foresee all the changes and resulting effects. The intentionality of the evaluation should go beyond etiological explanations obtained in the presence of "ideal" or controlled situations to produce information about the feasibility and sustainability of processes of social and political change. This reaffirms what was said previously, that there is no single method that can be identified as superior without being analyzed in light of each specific situation.

This fact has been recognized by Stake and Abma (2005), who advocate for the inclusion of approaches that give weight to the term *contribution* rather than *attribution*,

which implies conditionality or contextualization. On the other hand, Pawson (2001, 2002, 2003) recommends the total study of the system of relationships between the variables and suggests dividing the intervention into its components: mechanisms, context, and outcomes. Mechanisms refer to the ways in which one component causes changes, and the process is defined in terms of how individuals interpret and act on the intervention strategy, known as program mechanisms, and context refers to the place and system of interpersonal and social relations.

To decide how to deal with current methodological challenges to undertake evaluation research in an effective and sustainable way, we must think about questions regarding the following aspects: What exists? What is useful for our purpose? What can be improved? What is needed and how can it be obtained?

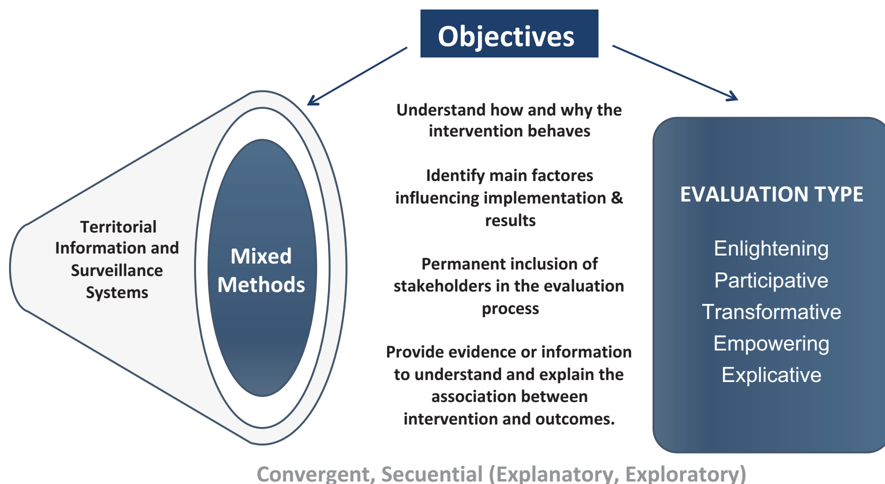
Two public health tools fit these requirements: information and surveillance systems. They have traditionally been among the main constraints on making well-informed decisions. On the other hand, the problem is not only about the accessibility of information but its sufficiency and relevance, which affect its reliability.

It is these two tools that are critical when applying the mixed-methods approach in order to provide information to the community, providers, managers, and researchers. The process of producing and using this information could be become a permanent learning activity as long as it fulfills some requirements, such as the articulation of different sources of information in the territory in the planning of intersectoral actions and the establishment of administrative mechanisms to use the information, including that produced by unofficial means, for example, colloquial information, photography, theater, and games. There are several examples in the region in the development of these activities, but they do not go beyond the status of pilot projects; most of the time they are not institutionalized.

Even if there is no installed capacity to carry out evaluation research, stakeholders and especially the community will have information that facilitates their effective participation and engagement in activities related to their health and well-being (Fig. 15.14).

The empowerment evaluation concept is consistent with what is expressed in graph 13. In our opinion, it is a key activity for addressing many of the challenges encountered in reducing health inequities and creating favorable conditions for a population's well-being that have been mentioned throughout this book.

Empowerment is most commonly associated with political action for decision making. Empowerment evaluation is the use of evaluation concepts, techniques, and findings to foster improvement and self-determination (Fetterman 1994, cited for Fetterman 2005). Significant contributions have been made to differentiating among collaborative, participatory, and empowerment evaluation (Alkin 2004; Christie 2003; Cousins 2003; Cousins and Whitmore 1998; Fetterman 2001, cited by Fetterman 2005:7) and decision makers. It is a liberating or emancipatory experience. More precisely, empowerment evaluation places decision making in the hands of community members. However, there is another important level, psychological power, in which the ability of members of a group to achieve their goals as members of a learning community, improving their lives and the lives of those around them, produces an extraordinary sense of well-being and positive growth. People empower



Source: Own elaboration

Fig. 15.14 Information and surveillance systems serving evaluation purposes. Source: Author's elaboration

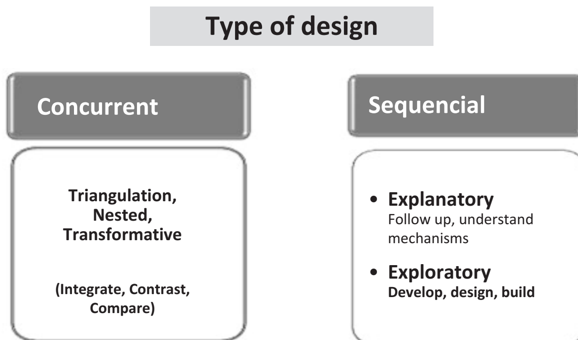


Fig. 15.15 Mixed-method design

themselves as they become more independent and group problem solvers (Vanderplaat 1995, 1997, cited for Fetterman 2005:10).

In this evaluation proposal, it is highly recommended to use a mixed method, which consists in not only combining quantitative and qualitative data but also following a rationale according to the needs of those interested in the results of the evaluation. As shown in the following figure, the two types of methods, convergent and systematic, provide information to respond to different interests and research questions (Fig. 15.15).

Mixed-method designs account for many factors traditionally hidden or unexplored in evaluations, such as context, experiences and mechanisms, or explanations of the associations among variables. Moreover, mixed methods respond to the dynamism of change, which influences these experiences, since they are linked to the

context; therefore, there is no need to wait until the end of an intervention to judge the methods' performance and achievements and to learn from the practice.

To decide which design is more appropriate, it is necessary to take into account the fulfillment of certain criteria related to the questions of which approach sees the evaluation as a tool for learning purposes, not only for measuring achievements, which method would facilitate the learning and capacity building to intervene among a territory's members, which method contributes in greater proportion to generating information for consensual decision making, and which method contributes to strengthening the implementation of interventions aimed at reducing social and health inequities.[1]

Mixed methods researchers use and often make explicit diverse philosophical positions. These positions often are referred to as dialectal stances that bridge post-positivist and social constructivist worldviews, pragmatic perspectives, and transformative perspectives (Greene 2007). For example, researchers who hold different philosophical positions may find mixed methods research to be challenging because of the tensions created by their different beliefs (Greene 2007, cited by Creswell et al. 2010). However, mixed methods research also represents an opportunity to transform these tensions into new knowledge through a dialectical discovery. A pragmatic perspective draws on employing "what works," using diverse approaches, giving primacy to the importance of the research problem and question, and valuing both objective and subjective knowledge (see Morgan 2007, cited by Creswell et al. 2010). A transformative perspective suggests an orienting framework for a mixed methods study based on creating a more just and democratic society that permeates the entire research process, from the problem to the conclusions, and the use of results (Mertens 2009, cited by Creswell, 2010:4).

According to Russell Schutt, the application of mixed methods has left several lessons, among which are (1) the research questions must correspond in complexity to the social world—thus research is not limited to a specific methodological approach; (2) on the other hand, mixed methods transform and enrich the understanding of the measures and causal processes, constituting an iterative process, both in the design and in the analysis and interpretation of data—allowing the exploration and confirmation of emerging patterns (Creswell 2013).

We believe that these lessons do indeed respond to the requirements to perform an evaluation with the characteristics indicated, in addition to the arguments mentioned earlier. Despite these advances, we must continue to work on how to integrate, complement, or reinforce information produced under different logics. This

[1] See Burke Johnson and Onwuegbuzie (2004); Mayoh and Onwuegbuzie (2013); Hamui-Sutton (2013); Morgan (2014); Williams and Shepherd (2015); Hesse-Biber (2015), among other items. Likewise the following presentations: Telling a Complete Story with Qualitative and Mixed Methods Research—John W. Creswell (2013) (https://www.youtube.com/watch?v=l5e7kVzMIfs); Advances in Mixed Methods Research—John W. Creswell—Keynote at the 2016 CAQD conference (2016) (https://www.youtube.com/watch?v=dR2QU2pZcLU); Planning a Mixed Methods Research by Philip Adu (2015) (https://www.youtube.com/watch?v=iqCFIivhHE0); and How to support Research with Theoretical and Conceptual Frameworks (2014) (https://www.youtube.com/watch?v=j2c8G0bBfHk).

proposal does not pretend to deepen the differences between the approaches; there is a vast literature on the subject. In addition, we recognize that the selection of method responds to each particular situation rather than to the hierarchy established to judge its validity.

Final Remarks

The central characteristics of the present evaluation are the integration of public health functions and tools around a common purpose: to create local capacity to improve population health and welfare conditions. The evaluation has several purposes, among the most important are to contribute to (1) the provision of information and contextualized evidence on the merit and value of interventions, (2) strengthening local capacity to respond to changing needs and contexts, and (3) producing knowledge, incorporating alternative mechanisms and methodologies to produce data and information.

We intend to achieve the aforementioned purpose using the results of the evaluation process to transform mechanisms and instruments for the management of policies and programs at the territorial level, adapt technical an methodological tools according to normativity, functionality, acceptance, and feasibility to carry out the aforementioned actions, increase and qualify social and community participation, and balance out power relations between people and power structures in the territory.

> Although Globalization and Colonization are two closely related phenomena, which have strong roots and social consequences in our countries; our governments and populations are not well prepared to deal with both, challenges and consequences.

Although not all problems will be solved, we have the certainty based on concrete experiences that the rescue and strengthening of territorial potential and identity will bring promising results with respect to equalizing power among actors so that they can all be part of decisions affecting population health, inside and outside the countries. The fragmentation of strategies (PHC, HP, and HiAP) has been considered as a critical factor leading to the weak results obtained in terms of reducing health inequities; therefore, it is expected that this strategy will contribute to the integration of policies, programs, and local resources.

A common assumption is to think that if an intervention has a strong theoretical foundation, it can be implemented anywhere, regardless of degree of development, time, and complexity of context. One concern that arises from this idea has to do with what changes will then take place. This is one of the main problems responsible, in part, for the poor performance of interventions; hence, know-how should not be standardized; it must respond to the characteristics of each territorial environment and context in general.

Therefore, the wrong thing is not that we use theories produced outside; this is inevitable in an increasingly globalized world, where LMICs depend on external financing to do research and to implement actions proposed by international organizations, as in the case of Latin America. In other words, governments, populations, and cooperation and funding agencies, among others, play an important role in supporting the capacity building of territories by strengthening them as social spaces capable of responding to challenges by reinforcing their identity and potential for action, without giving up their own principles, culture, potentialities, and historical processes.

A critical analysis should be undertaken of the feasibility and effectiveness of current tools and methodological approaches used to monitor and evaluate policies and programs and long-range sustainable processes. The central problem consists in changing or expanding the applicable concepts but leaving intact the structures and methodological tools to implement them, as well as providing guidelines ignoring the diversity and complexity of contexts. Regrettably, governments and funding agencies invest nothing or very little in process evaluation, contributing to a widening gap between theory and practice and, at the same time, the perpetuation of backwardness.

In our view, priority should be given to so-called implementation research, which focuses on problem solving and the strengthening of capacity, to take part in changes according to evaluation results, rather than creating new theoretical proposals and frameworks, without having solved basic requirements responsible for the poor functioning of previous interventions. This does not mean delaying knowledge production, research growth, and propositional capacity; rather, it means that these actions must be context-bound and emerge from a critical analysis of one's own reality. In this way, LMICs are able to be part of the international agenda, with theoretically founded proposals that are also operationally relevant and feasible.

The issues related to the process of implementation of interventions have been the most challenging and the most neglected. We hope that evaluation research as conceived in this publication will contribute to closing the enormous gap between theory and practice, which have functioned as two opposing and contradictory poles.

This type of evaluation allows for the articulation of different functions of public health and the methodological approaches to carry them out in order to create or strengthen a permanent dialogue between them, favoring integration and avoiding segmentation; the associated model is a kind of knowledge-driven model: new knowledge will lead to new applications, and thus new policies.

We hope this publication will serve to shed light on key issues to consider in undertaking a critical analysis of the suitability and effectiveness of interventions addressing health inequities. This task is not only needed but also urgent and political. Evaluation research is without a doubt a hopeful response.

I wish to emphasize a previously mentioned statement highlighting the words of Appadurai (2011), made at the UN Summit on Climate Change held in Durban in 2011. This statement clearly reflects what we have experienced so far:

I speak for more than half of the world's population. We are the silent majority. We have been given a seat in this room, but our interests are not on the table. What is needed to participate in this game? Bring lobbyists? Have corporate influence? Money? Commitments have not been met; actions have deviated from objectives and promises have been broken. However, all this has already been heard before. (2011)

Appendix

Table 15.3 Meanings and scope of capacity[a] to intervene in social determinants of health

Capacities' scope	Goal to tackle and prevent health inequities
To promote structural transformations	Sustainable development, according to Novo (2006), retains in its conception the following guidelines: a systemic approach, ecological viability, and equity. It may be added that the social and institutional feasibility (identification of strengths and opportunities) of a set of interrelated areas of development is linked to the notion of population welfare. All of the aforementioned structures from a perspective of integral development require a systemic approach (relational, circular, procedural) by institutions, managers, and actors that guide, mobilize, and act according to the proposed social change actions
Institutional	Regarding the strengthening of the institutional capacity of the health sector, other sectors, and citizens, according to Díez et al. (2016:78), reference should be made to the experience and competence of professional teams, as well as political commitments, availability of funds, information and databases for planning, monitoring and evaluation, and organizational structure
	Meanwhile, the capacity refers to "the set of rules and norms that govern the operation and operation of a public health system; that is, it determines the capacity of the system to respond to public health challenges" WHO (2007:8)
Organizational	The capacity of organizations to strengthen their functions is guided by the efficient and sustainable manner in which they operate in order to contribute to the institutional mission and vision and to the organization's strategic policies and objectives (PAHO 2007:8)
	The capacity of organizations is also related to their internal structure, associated with the acquisition of resources (financial, acquisition, use and management of available resources) and physical, which has to do with the so-called installed capacity, which includes the endowment of equipment and facilities
	According to McLean et al. (2005:121), "the capacity of organizations is largely shaped by the capacity of people whose actions and relationships define that organization"
Financing	The capacity for intersectoral work can be structured based on the construction of micro and macro strategies. These strategies involve training and technical assistance to build the basic knowledge with which to strengthen the skills and competences of the various actors. Strategies at the micro level are fundamental in the support of organizational resources required by key actors in the territory. Macro-level strategies correspond to those associated with intersectoral governance (power relationships), which requires the development of a political action approach at different levels (local, departmental, and national) (Luján 2017)

Capacities' scope	Goal to tackle and prevent health inequities
Capacity of the system	Capacity building by health promotion workers to enhance the capacity of the system to prolong and multiply health effects thus represents a value-added dimension to the health outcomes offered by any particular health promotion program. The value of this activity will become apparent in the long term, with methods to detect multiple types of health outcomes. But in the short term its value will be difficult to assess, unless we devise specific measures to detect it. At present, the term *capacity building* is conceptualized and assessed in different ways in the health promotion literature. Development of reliable indicators of capacity building that could be used both in program planning and in program evaluation will need to take this into account. Such work will provide health decision makers with information about program potential at the conclusion of the funding period, which could be factored into resource allocation decisions, in addition to the usual information about a program's impact on health outcomes (Hawe et al. 1997)
Community capacity building	Community capacity building is the interaction of human capital, organizational resources, and social capital existing within a given community that can be leveraged to solve collective problems and improve or maintain the well-being of the community. Hawe et al. (2000) have defined three operational levels of capacity building in the health promotion literature. First, capacity building in public health promotion programs requires that professionals have the knowledge, skills, and resources to conduct programs and that their organizations demonstrate support for these approaches through appropriate policies and expectations. Second is the need to build partnership and organizational structures that can sustain programs (along with their health effects), whether or not the original initiating organization continues to support the effort (Gantner and Christine 2012)
The capacity of health systems	The capacity of health systems in Latin American countries to reliably provide primary care for the identification and treatment of chronic conditions is compromised. Factors such as an insufficiently skilled workforce, inadequate numbers of healthcare providers unevenly distributed geographically, and inadequate facilities limit this capacity (World Health Organization, 2012; O'Brien and Gostin, 2011, in Geissler and Leatherman 2015). High rates of elevated blood pressure and blood glucose (risk factors for diabetes and cardiovascular disease) and obesity persist, and NCDs such as diabetes, cancer, and cardiovascular disease are becoming increasingly common (World Health Organization 2009, 2012, in Geissler and Leatherman 2015)
Dimensions of community	Building on the earlier work of Iscoe and Cottrell, Eng and Parker identified the key dimensions of a so-called competent community in a quantitative assessment tool. These include (Hawe et al. 1997):
	1. participation in community affairs,
	2. commitment to the community,
	3. awareness of each part of the community's identity and contribution,
	4. ability to express collective views and exchange information,
	5. ability to contain conflict and accommodate differing views,
	6. ability to use resources and manage relations with the wider society,
	7. ability to establish more formal means to ensure representative input in decision making, and
	8. social support

Capacities' scope	Goal to tackle and prevent health inequities
Levels of capacity-building	We identify levels and possible dimensions of capacity building as currently addressed in the health promotion literature and highlight the need for more systematic research on indicators of quality and outcome in this hitherto neglected but promising field. We argue that capacity building is instrumental in multiplying health gains. In addition to measuring health gains, we need to be able to measure capacity building (Hawe et al. 1997)
Capacity for public health promotion	Capacity for public health promotion can, therefore, be developed in a number of issue areas, but because skills and resources are transferable to other problems, many public health professionals may already have some of the skills needed to work on emergent public health initiatives like environmental or policy approaches to obesity prevention, while others may require more efforts at capacity building (Gantner and Olson 2012)
Adaptive capacity	Adaptive capacity is defined as the capacity of actors (collectively or individually) to respond to, create, and shape variability and change in the state of a system (Adger et al. 2005; Chapin et al. 2009, cited for Clarvis and Allan 2013). It can be characterized as the preconditions needed to enable adaptation, both proactive and reactive, including social and physical elements, and the ability to mobilize these elements (Nelson et al. 2007, cited for Clarvis and Allan 2013). Adaptive capacity is also closely related to concepts of robustness, adaptability, flexibility, resilience, and coping ability (Smit and Wandel 2006, cited for Clarvis and Allan 2013). Adaptive capacity can be seen as contributing to these aspects of a system, that is, the presence of adaptive capacity leads to a greater ability to cope with climate risks. Building and mobilizing adaptive capacity requires that actors be able to adapt reactively to and cope with hydro-climatic shocks (e.g., floods and drought, interannual variability, predictable uncertainty) but also plan for longer-term indeterminate shocks (climate change impacts, increasingly unpredictable uncertainty), as well as proactively placing resilience-enhancing processes in motion at different scales (Matthews et al. 2011; Tompkins and Adger 2005; Clarvis and Allan 2013, cited for Clarvis and Allan 2013)

[a]Typology of technological capabilities (García and Navas 2007); organizational skills (market orientation, technology, and innovation) (Heward et al. 2007); institutional capacities (Krishnaveni and Sujatha 2013); development of conceptual and methodological capabilities; deliberative abilities or criticism of subjects; building the capacity of the Health Impact Assessment (HIS) (Schutt 2015); structural capacity (Liberato et al. 2011); capacity for the evaluation of strengthened capacities—empowerment (Khaiklenga et al. 2015); research capabilities (ability to generate and disseminate knowledge); general capacity of public health systems; models and approaches to problems of health capacity allocation and consequences (Zhou et al. 2017); and strengthening of local and community capacities, among others

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L. Malagón de Salazar, R.C. Luján (eds.), *Globalization and Health Inequities in Latin America*, https://doi.org/10.1007/978-3-319-67292-2

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