Chapter 15
A Bet for the Reduction of Health Inequities in Accordance with the Conditions of the Latin American Region

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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.

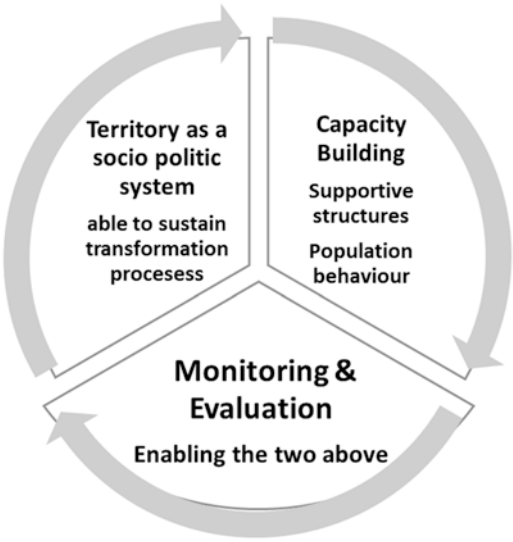


Fig. 15.1 Strategy to cope with health inequities. Source: Author's elaboration

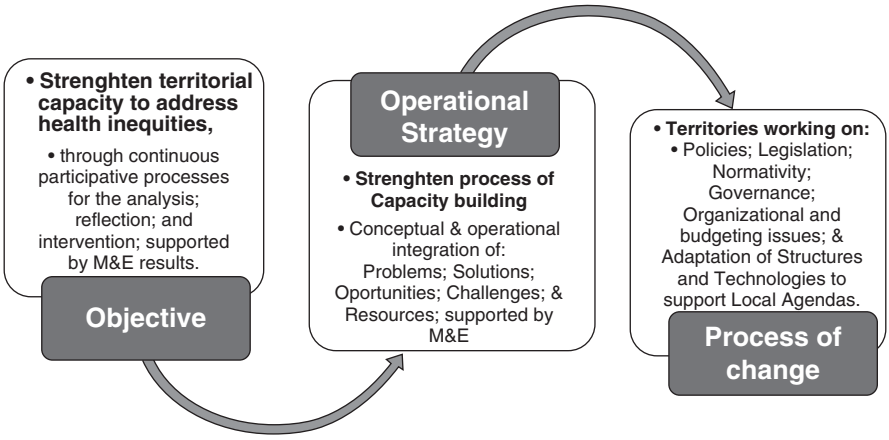
Source: Own elaboration

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).



Source: Own elaboration

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)

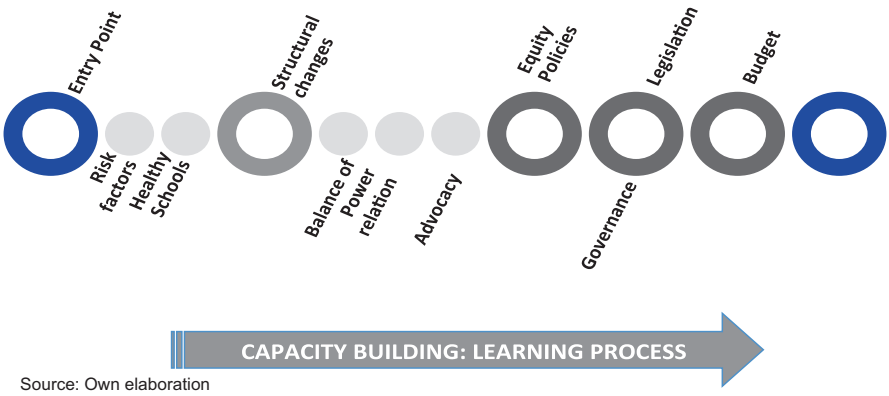


Fig. 15.3 Capacity-building processes. Source: Author's elaboration

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).

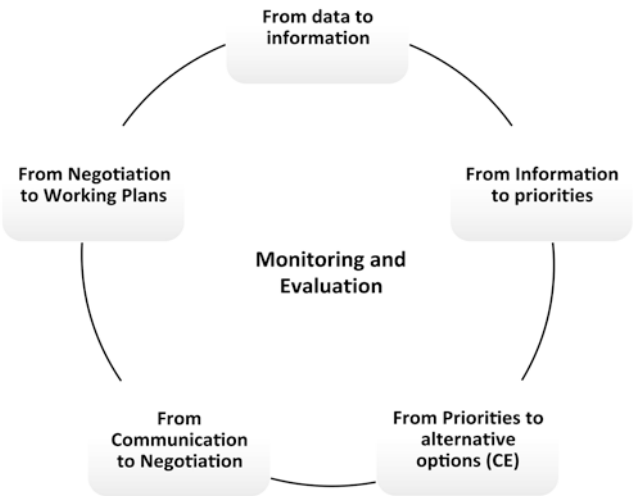


Fig. 15.4 Monitoring, evaluation, and capacity-building circle. Source: Author's elaboration

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).

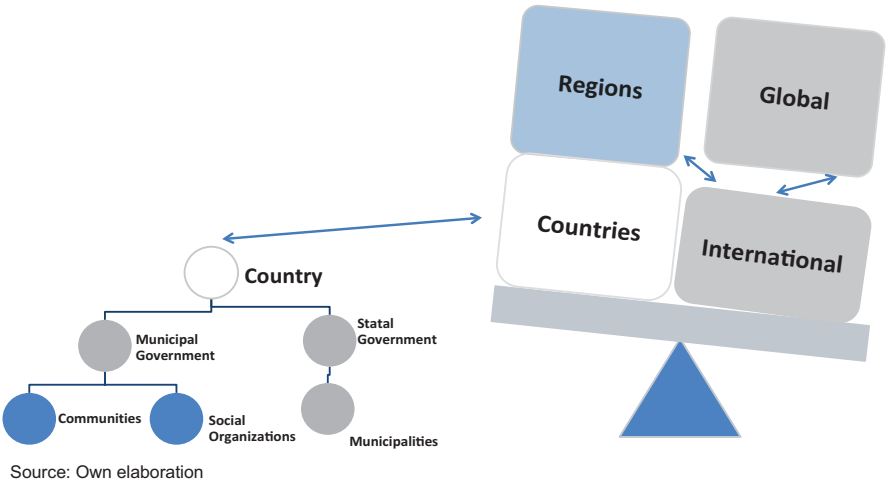


Fig. 15.5 Balance of power relations among stakeholders. Source: Author's elaboration

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

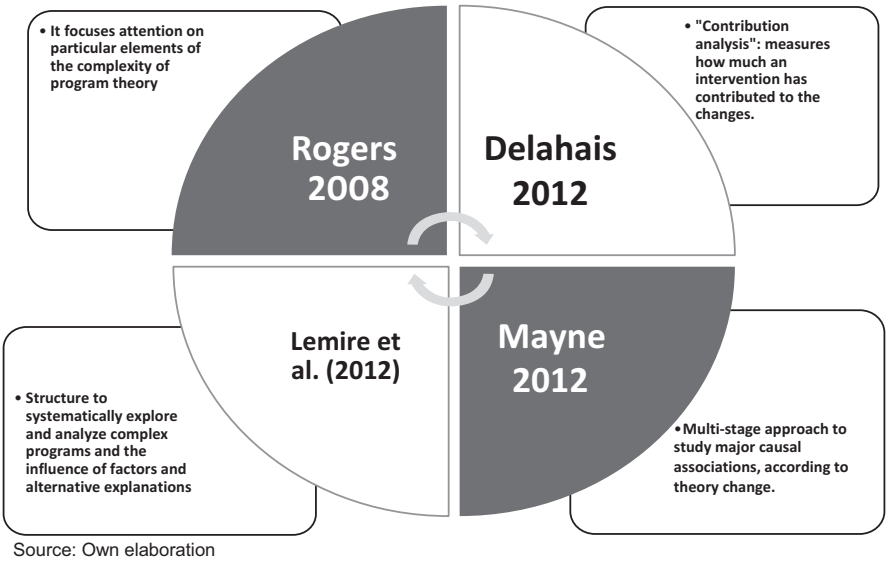


Fig. 15.6 Theory-based evaluation. Source: Author's elaboration

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.

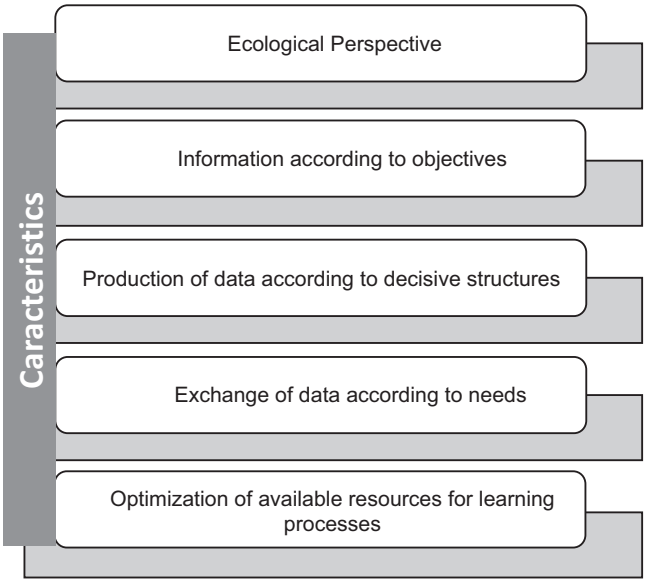


Fig. 15.7 M&E approach: characteristics. Source: Author's elaboration

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.

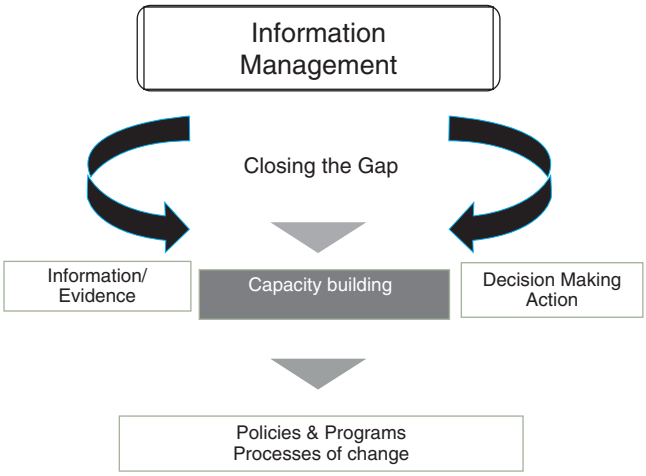


Fig. 15.8 From data to information for decision making and action. Source: Author's elaboration

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.

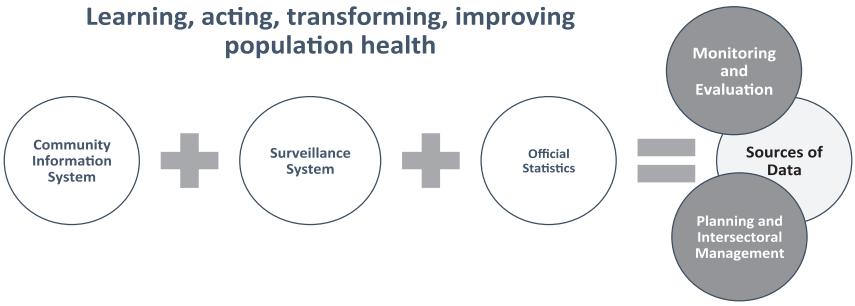
Supporting Structures and Technical Tools: Requirements

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).

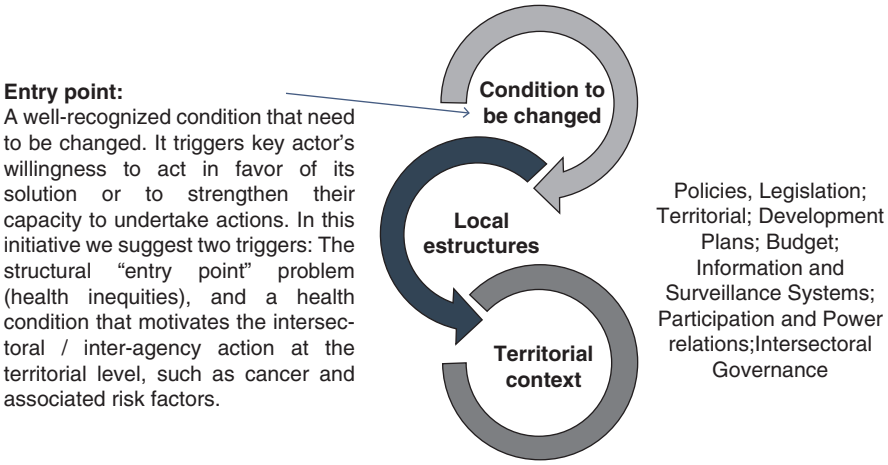


Fig. 15.10 Subjects of action and transformation. Source: Author's elaboration

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

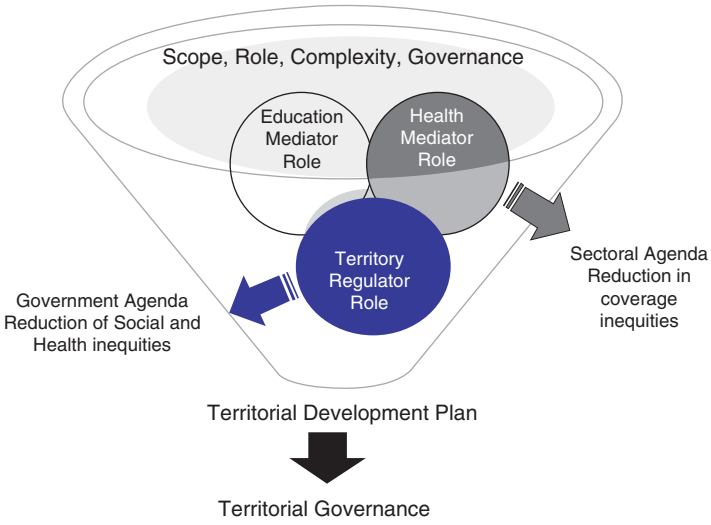
factors influencing their success or failure. Therefore, the operational definition of *best practice*, to my knowledge, is that it is not static but context bound; it depends also on the nature and theory of change of the intervention, plus what happened in the "real world." The indicators for assessing 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.



Source: Own elaboration

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).

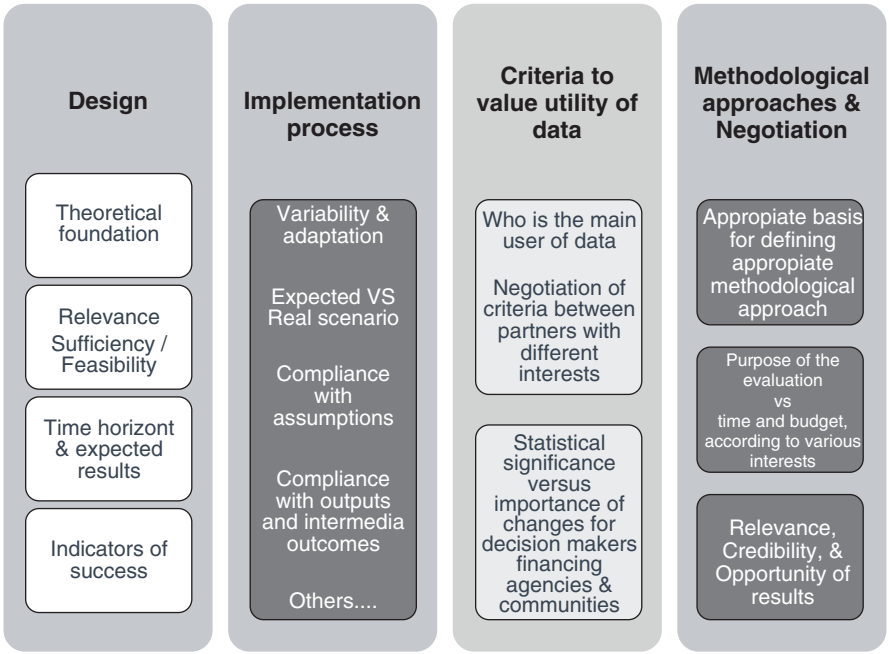


Fig. 15.12 Key aspects to be analyzed in the evaluation of complex interventions. Source: Author's elaboration

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

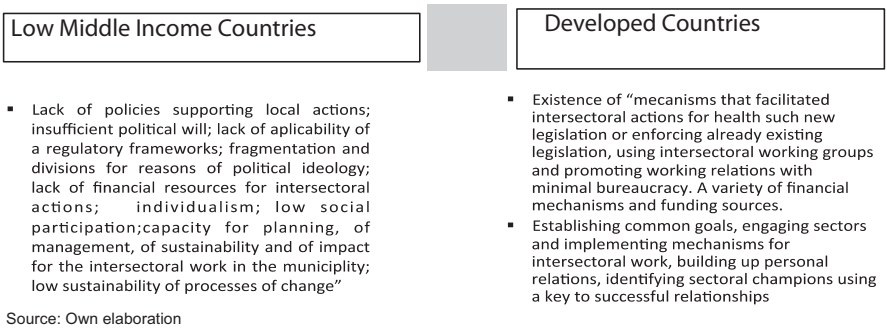


Fig. 15.13 Are the challenges similar in developed and LMICs? Are they just as complex? Source: Author's elaboration

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?

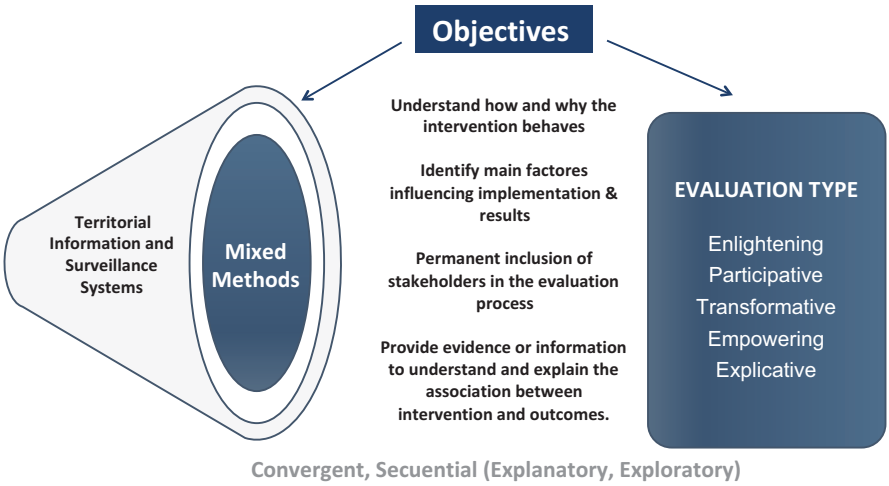
Two public health tools fit these requirements: information and surveillance systems. They have traditionally been among the main constraints on making well-informed decisions. On the other hand, the problem is not only about the accessibility of information but its sufficiency and relevance, which affect 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.

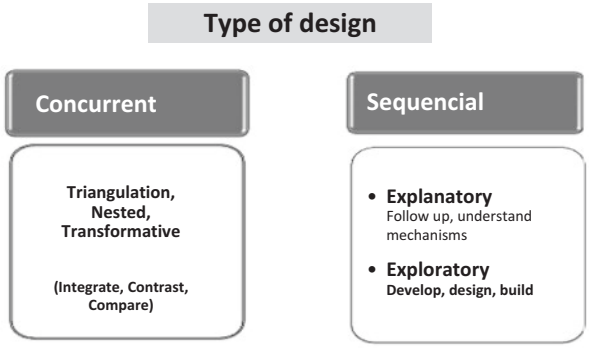
Empowerment is most commonly associated with political action for decision making. Empowerment evaluation is the use of evaluation concepts, techniques, and findings to foster improvement and self-determination (Fetterman 1994, cited for Fetterman 2005). Significant contributions have been made to differentiating 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 postpositivist 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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