Universidad Austral de Chile
Conocimiento y Naturaleza

Engaging Communities Today

Community Health Experts Meeting: Defining Community Health in the 21th Century, Pan-American Health Organization Head Quarters, Washington D.C, 14-16 June 2017

Claudio A. Méndez, MPH

Associate Professor of Health Policy

Instituto de Salud Pública

claudiomendez@uach.cl

Outline

1. Did communities succeeded in shaping our health systems?

2. Are health systems overcoming communities inequalities?

3. Why politics matters more than ever? Communities are evolving faster than social policies.

4. Final remarks and drafting the roadmap.

The convoluted history of Latin American and the Caribbean health systems

- Health Systems from The Americas share –in most cases- similar political, social, and economic trajectories.

- Communities were not necessary the cornerstone behind their foundations.

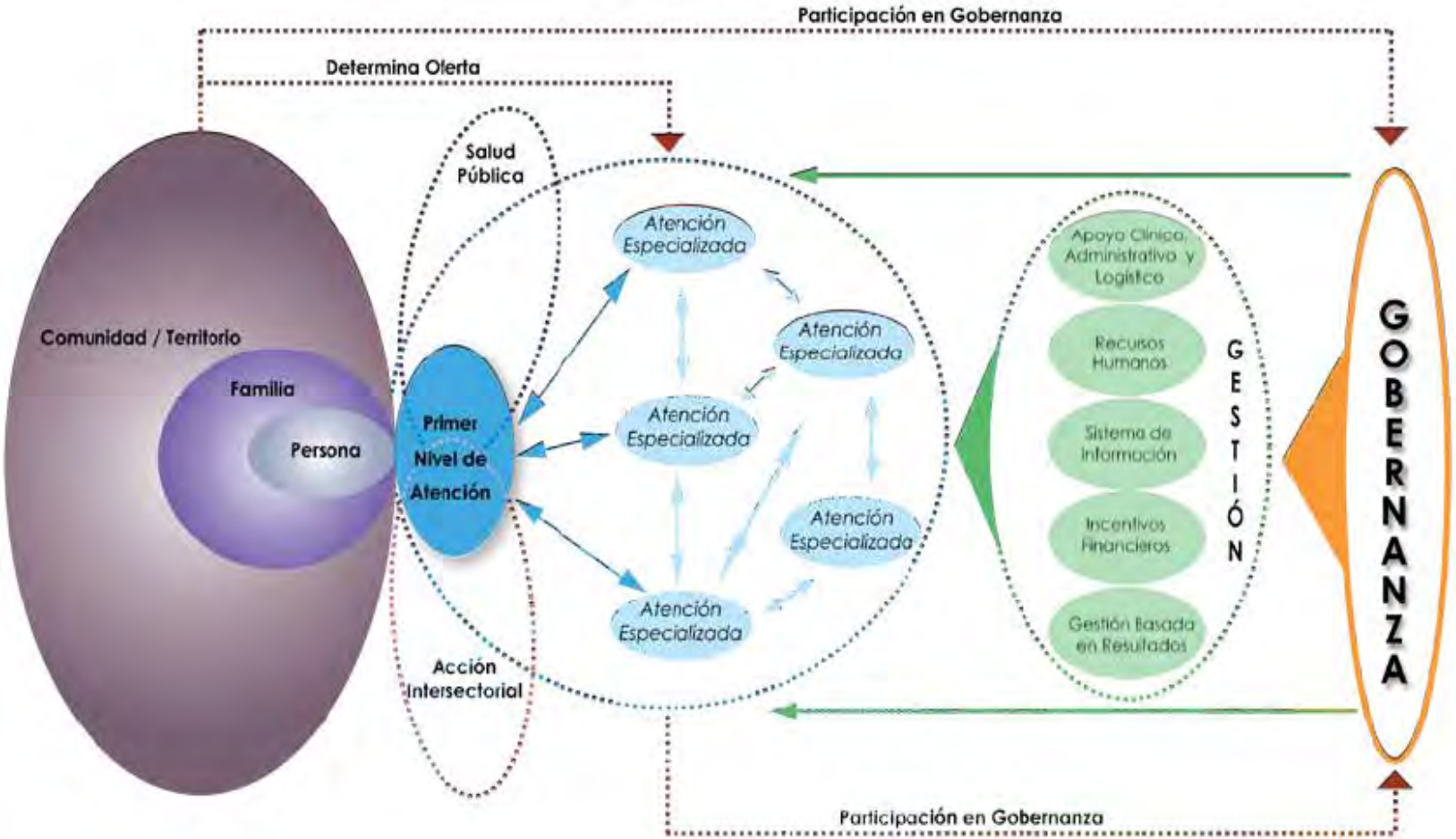
- Communities have been targeted mainly from research as a path to overcome biomedical outcomes.

	What worked?	What did not work?
Common global vision of health for all: universality and equity	Promoted wide involvement of stakeholders in health; problem-focused on the needs of many, reaching scale; pro-poor: overcoming the inverse care law; primary care solutions: health service provision and health promotion (supply and demand); the MDGs have revitalised this common vision with intersectoral development linkages	Health for all and Summit for Children goals not country specific so some countries could achieve easily and others could never achieve; some goals were unreachable as no effective, feasible intervention (eg low birthweight reduction) so pushed the action focus to more specific, achievable interventions; very low investment except for a few specific issues (eg, some vaccine preventable conditions and even for immunisation funding fell during the 1990s); challenge of competing priorities but perhaps case not communicated clearly to the key audiences
Comprehensive action	Conceptual framework of an integrated health system with intersectoral linkages and appropriate technology and essential drugs; successes in some countries persisted with incremental implementation	Conceptual framework of comprehensive health care considered too complex—broken into dichotomies: health or development (intersectoral), vertical or horizontal delivery, coverage or quality, facility vs community, mother vs child, central vs decentralised; management and programme tools lacking
Community participation and ownership	Community diagnosis process, now embedded in some societies and programmes, and revitalised as community action cycle, participatory learning and action leading toward empowerment	Community ownership perceived as slower and less controllable, less measurable; very bottom up, so variable and harder to track and risk that communities may select a priority judged to be inappropriate leading to conflict with professionals rather than partnership
Community workers	Promotion of innovative delivery strategies: not just the status quo (eg, delegation of tasks)	Patchy: lack of consistent supervision and linkages to existing health system, reliance on volunteerism, local cost recovery erratic and mostly for the lowest levels
Collection of data for action	Use of coverage data to drive action, especially for immunisation, leading to the development of coverage data surveys, the precursor of UNICEF's Multiple Indicator Surveys (MICS)	Focus on outputs instead of impact (eg, number of trained community health workers or trained doctors who may not be retained or may not be effective especially without supervision and functional system support)
Innovation for supplies and technology	Developed innovations: cold chain, oral rehydration solution, partogram, vitamin A capsules, salt iodation; essential drug list used in almost every low-income and middle-income country	Technology, even appropriate technology, considered a waste of money compared with other priorities, very low investment in innovative technologies for health in low-resource settings
Environment	Recognition of importance of water and sanitation to health. Some countries placed major emphasis, especially on water.	Sanitation and garbage disposal more complex than clean water and has progressed slowly, especially for the poorest countries and rural areas, so inequity has increased
Intersectoral action	Some countries convinced agriculture to take on a role in food security, occasionally even household nutrition, but this was rare	Education, agriculture, housing, public works often ignored their role in health and were ignored by health planners. The intersectoral concept is good in theory, but in practice each sector has its own agenda and major change is required for effective intersectoral collaboration

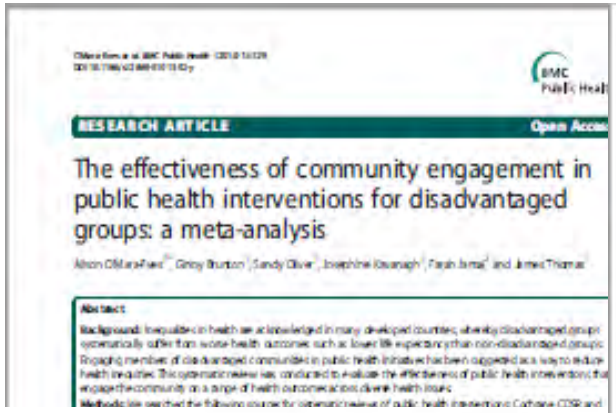
Table 2: 30 years after Alma-Ata, what worked and what did not?

Source: Lawn JE, Rohde J, Rifkin S, Were M, Paul VP, Chopra M. Alma-Ata 30 years on: revolutionary, relevant, and time to revitalise. Lancet 2008; 372: 917–27

Figura 3. Representación gráfica de los atributos esenciales de las RISS.



Contexto: tipo de sistema de salud, nivel de financiamiento, marco legal y regulatorio, capacidad de rectoría de la autoridad sanitaria, disponibilidad de recursos humanos, físicos y tecnológicos, etc.



RESEARCH ARTICLE Open Acces

The effectiveness of community engagement in public health interventions for disadvantaged groups: a meta-analysis

Abstract

© Oxford University Press and Community Development Journal 2011
All rights reserved. For permissions, please email: journals.permissions@oup.com
doi:10.1093/cdj/bsr043
Advance Access publication 23 June 2011

The impact of community engagement on health and social outcomes: a systematic review

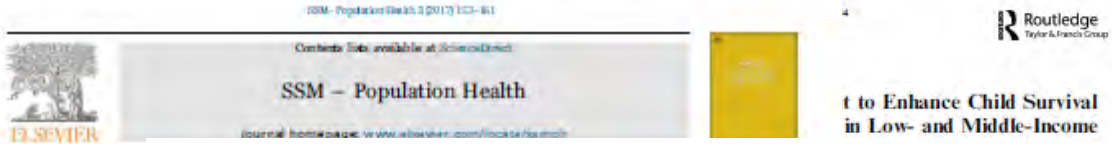
Beth Milton*, Pamela Attree, Beverley French, Sue Povall, Margaret Whitehead and Jennie Popay

Abstract Community engagement is central to national strategies for promoting health, yet there have been few attempts to systematically review the evidence on the impact of initiatives that aim to engage communities. This rapid review fills this gap by exploring the population impact of initiatives which sought to address social determinants of health. It took a novel approach to synthesizing a sample of the enormous UK literature on community engagement. The synthesis found no evidence of positive impacts on population health or the quality of services, but initiatives did have positive impacts on housing, crime, social capital and community empowerment. Methodological developments are needed to enable studies of complex social interventions to provide robust evidence of population impact in relation to community engagement.

Introduction

Engaging communities is central to UK national strategies for promoting health and reducing health inequalities. Policy-makers are seeking to involve communities in addressing a broad range of social determinants of health including initiatives directed at housing improvement, regeneration, transport and health service planning (Department for

*Address for correspondence: Beth Milton, Department of Public Health and Policy, University of Liverpool, Whelan Building, Quadrangle, Liverpool, L69 3GB, UK; email: bmilton@liverpool.ac.uk



SSM – Population Health

Article

Place, health, a
associated with

Sarah A. Lovell[b,*],

ARTICLE INF

1. Introduction

Health Policy

Feasibility of a community action model oriented to reduce inequalities in health

Carmen Fuertes[a], M. Isabel Pasarín[a,b,c,d], Carme Borrell[a,b,c,d,*], Lucía Artazcoz[a,b,c,d], Èlia Díez[a,c,d], the Group of Health in the Neigbourhoods[1]

[a] Agència de Salut Pública de Barcelona, Spain
[b] Universitat Pompeu Fabra, Spain
[c] CIBER Epidemiología y Salud Pública (CIBERESP), Spain
[d] Institut de Recerca Biomèdica (IR Sant Pau), Spain

ARTICLE INFO

Article history:
Received 20 July 2011
Received in revised form 2 May 2012
Accepted 6 June 2012

Keywords:
Community participation
Community action
Health inequalities

ABSTRACT

Objective: To assess the feasibility and achievements of a systematic community action model, *Health in the Neighbourhoods*, in two deprived areas of Barcelona.
Methods: The feasibility of the model implementation in two neighbourhoods was assessed. The model developed three stages aiming: (1) to make alliances with partners and stakeholders, (2) to develop a participatory needs and assets assessment, and (3) to plan, implement and evaluate interventions on the community prioritised needs. The feasibility of the model at each stage was assessed through the percentage of achievement of 18 indicators. It was evaluated between 2007 and 2011.
Results: The achievement of the indicators exceeded an average of 75% in both neighbourhoods. In stage 1 community working groups were set up. In stage 2 a comprehensive assets and health needs assessment was done through quantitative and qualitative methods, as well as participative prioritizations of community health problems. In stage 3, the community working groups defined an action plan and a number of interventions against the prioritised problems, based on evidence and local assets reviews. Interventions were developed, implemented and evaluated.
Conclusion: This structured model, including a small set of indicators, enabled the implementation of a community action model with neighbourhoods' stakeholders. The model showed flexibility to adapt to neighbourhoods' characteristics and the objectives were successfully met. The alliances and partnerships with community and municipal sectors promoted the sustainability of most interventions.

1. Introduction

The determinants of health have to do with the socioeconomic and political context, with individual socioeconomic position and other intermediate factors such as housing, income, psychosocial circumstances, behavioural and biological factors, and the health system [1,2].

Since the 1990s various studies have been conducted in Spain on social inequalities in health and have shown inequalities in morbidity and mortality, in health related behaviours, and in health services utilisation as functions of social class, age and gender, and area of residence [3]. Barcelona city has a long tradition of studying social inequalities in health [4] and in the establishment of some public health intervention programmes [5].

* Corresponding author at: Agència de Salut Pública de Barcelona, Plaça Lesseps No. 1, 08023 Barcelona, Spain.
E-mail address: cborrell@aspb.cat (C. Borrell).
[1] Núria Cabrada, Xavier Cortès, Lourdes García, Eva Galobart, Felipe Hermera, Glòria Manzanera, Glòria Pérez, Montse Petit, Susana Núñez, Araceli Rico, Maica Rodríguez-Sanz, Noelia Sotoca.

0168-8510/$ – see front matter © 2012 Elsevier Ireland Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.healthpol.2012.06.001

Health systems have shaped communities

- Communities driven to health systems goals.
- Participation instead shared decision-making.
- Illness-based community health rather promotion-based.
- Community health achievements shifted to managerial outcomes.
- Homogenization regarding what communities are pursuing from health systems.

	Phase 1: pre-national institutions	Phase 2: national institutions	Phase 3: primary health care and consolidation of segmentation	Phase 4: overcoming segregation
Milestone defining the beginning of each phase	Independence.	Creation of Ministry of Public Health.	Consolidation of social security institutions.	Implementation of one of the paths to integration.
Values and assumptions underpinning health care	Public health is acknowledged as a limited state responsibility, mostly linked with trade and economic use of territories. Personal care is initially an object of charity by religious orders and evolves to beneficencias (philanthropic elite-led organisations).	Public health is a state responsibility. Personal services for formal sector workers become a responsibility or right linked to labour status and financial contribution; for poor people, it becomes a form of social assistance.	Two views of public and primary health care: comprehensive (a social right) and selective (an instrument for individual and economic development linked to control of specific health problems and management of what was perceived as the population time-bomb). Personal services for the formal sector perceived as benefits from a truncated welfare state.	Increased consensus around the idea that health care is a social right—linked to general consolidation of democracy. Epidemiological change requires going beyond communicable, maternal, and child health. Recognition that economic growth might not lead to a fully formal economy. Economic growth facilitates expansion of public expenditures in health.
Public health	Public health and sanitation interventions initially aimed at facilitation of trade by focusing on ports and later on increasing the productivity of export-producing areas. Later in this period, all countries create offices in charge of sanitation linked to the ministries in charge of public activities, such as law enforcement.	Public health is the main responsibility of a sectoral ministry. Public health often includes responsibility for improved water and sanitation. Dissemination of scientific measures of control. Countries initiate vertical programmes against malaria, yellow fever, yaws, hookworm, and smallpox.	Expansion of primary health care combining public health with child, maternal, and population services. Immunisation and vertical programmes coexist with broader holistic programmes that aim to improve the living conditions of poor people. Rapid expansion of improved water and sanitation.	Governments slowly owning up to new behavioural risks, including by implementing multisectoral policies linked to tobacco, obesity, violence, and other social determinants of health. Epidemiological surveillance continues to be strengthened.
Institution building at the national level	In the 19th century, development of hospital beneficencias, which become autonomous from religious orders. In the 20th century, state participation in international public health coordinating events; 1924 PAHO conference defines health as a responsibility of the state. Reliance on family and community support, and practitioners of traditional medicine (mainly indigenous and African-American).	Creation of Ministry of Public Health in charge of public health interventions. Implementation of vertical campaigns against communicable diseases. In many countries, the ministry is also in charge of providing social assistance through public hospitals; charity hospitals become state-owned (often attached to medical schools) and health workers become public workers. Some building of public hospitals but provision of care is seen as a transitory responsibility of state, waiting for populations to become incorporated into the formal economy. Separately, social security institutions are created, initially created as financing institutions but gradually moving to the provision of personal health services.	Ministries evolve from the Ministry of Public Health and Assistance into the Ministry of Health. Massive efforts to expand essential child and reproductive services to previously underserved regions and populations through vertical programmes. Extended implementation of user fees for interventions not included in vertical programmes, especially at a hospital level. In many countries, health functions are decentralised, usually as part of a wider political process. Consolidation of social security institutions into fewer larger institutions. Social security benefits are extended to dependants of formal sector workers. Some countries launch market-oriented reforms. Initial development of private insurance. Rapid growth of private hospitals.	Countries that enter phase 4 (seeking equity) aim to reduce inequalities in access and in financial protection. They choose from one of three paths: integration of the financing of social security and public subsectors into a single-payer sector; allowing a choice of insurer to all populations; or maintaining segmentation of financing or provision, but making efforts to increase per person financing of the public sector and to mandate explicit benefits. In a few countries, expansion of comprehensive primary health care through family health strategy.

PAHO=Pan American Health Organization.

Table 1: **An institutional history of health systems in Latin America**

Source: Cotlear D, Gómez-Dantés O, Knaul F, Atun R, Barreto ICHC, Cetrángolo O., et al. Overcoming social segregation in health care in Latin America. The Lancet 2015; 385(9974): 1248-1259.

	Health system types (classified by sources of financing)	Integration of social security and public
Argentina	Tripartite: public, social insurance, and private	Segmented
Bolivia	Tripartite: public, social insurance, and private	Segmented
Brazil	Dual: public (three levels) and private (mainly supplementary)	Integrated
Chile	Dual: public or social insurance and private	Integrated
Colombia	Tripartite: public or subsidised social insurance, contributory social insurance, and private	Integration under implementation
Costa Rica	Dual: social insurance and private (small), public only direction-regulation	Integrated
Cuba	Single: public (there is no private)	Integrated
Dominican Republic	Tripartite: public, social insurance, and private	Integration under implementation
Ecuador	Tripartite: public, social insurance (with peasant insurance), and private	Segmented
El Salvador	Tripartite: public, social insurance, and private	Segmented
Guatemala	Tripartite: public, social insurance, and private (including NGOs)	Segmented
Haiti	Dual: public and private (three types)	Segmented
Honduras	Tripartite: public, social insurance, and private	Segmented
Mexico	Tripartite: public, social insurance, and private	Segmented
Nicaragua	Tripartite: public, social insurance (through private), and private	Segmented
Panama	Tripartite: social insurance, public, and private	Segmented
Paraguay	Tripartite: public, social insurance, and private	Segmented
Peru	Tripartite: public, social insurance, and private	Segmented
Uruguay	Dual: public or social insurance, and private (small)	Integrated
Venezuela	Tripartite: public, social insurance, and private	Segmented

NGOs=non-government organisations. Some data adapted from Mesa-Lago.[9]

***Table 3*: Health system type and segmentation in Latin America**

Source: Cotlear D, Gómez-Dantés O, Knaul F, Atun R, Barreto ICHC, Cetrángolo O., et al. Overcoming social segregation in health care in Latin America. The Lancet 2015; 385(9974): 1248-1259.

Outline

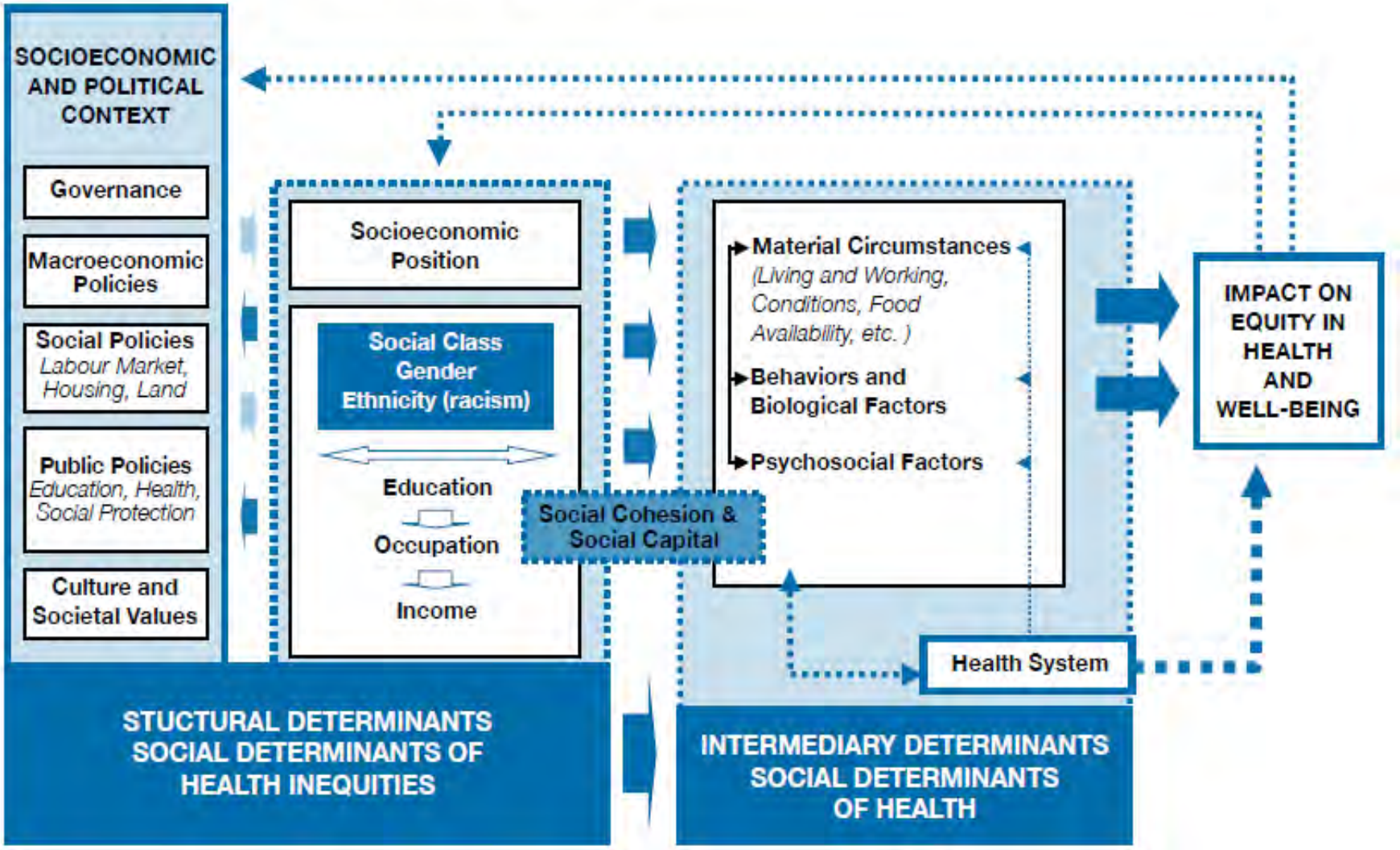
1. Did communities succeeded in shaping our health systems?

2. Are health systems overcoming communities inequalities?

3. Why politics matters more than ever? Communities are evolving faster than social policies.

4. Final remarks and drafting the roadmap.

Figure A. Final form of the CSDH conceptual framework



Source: Solar O, Irwin A. A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2 (Policy and Practice).

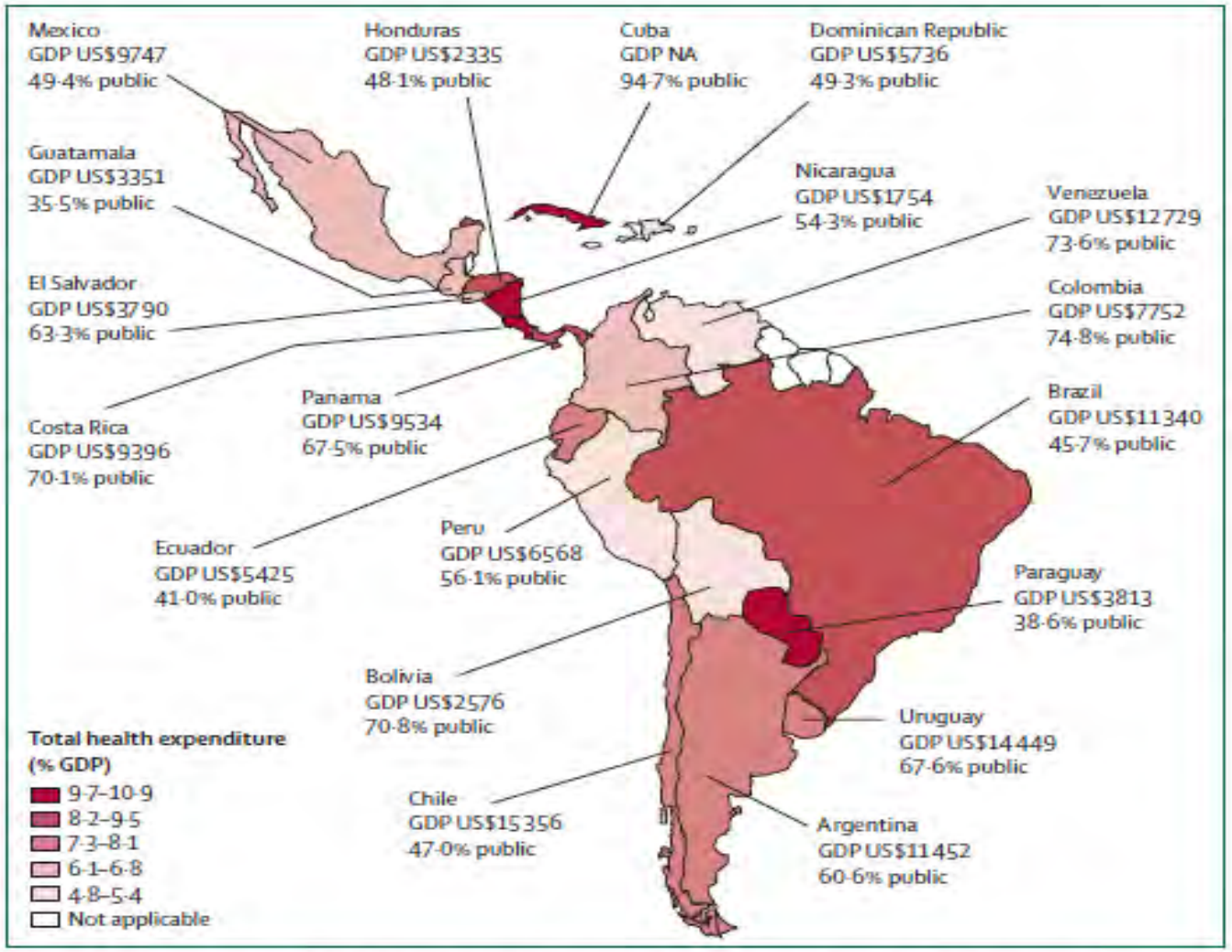


Figure 1: **Per-person income, total health expenditure, and health expenditure from public sources**
Health expenditure from public sources is shown as a percentage of total health expenditure. Data from The World Bank.[9] GDP=gross domestic product. NA=not applicable.

Source: Atun R, Monteiro de Andrade LO, Almeida G, Cotlear D, Dmytraczenko T, Frenz P, et al. Health-system reform and universal health coverage in Latin America. The Lancet 2015; 385(9974): 1230-1247

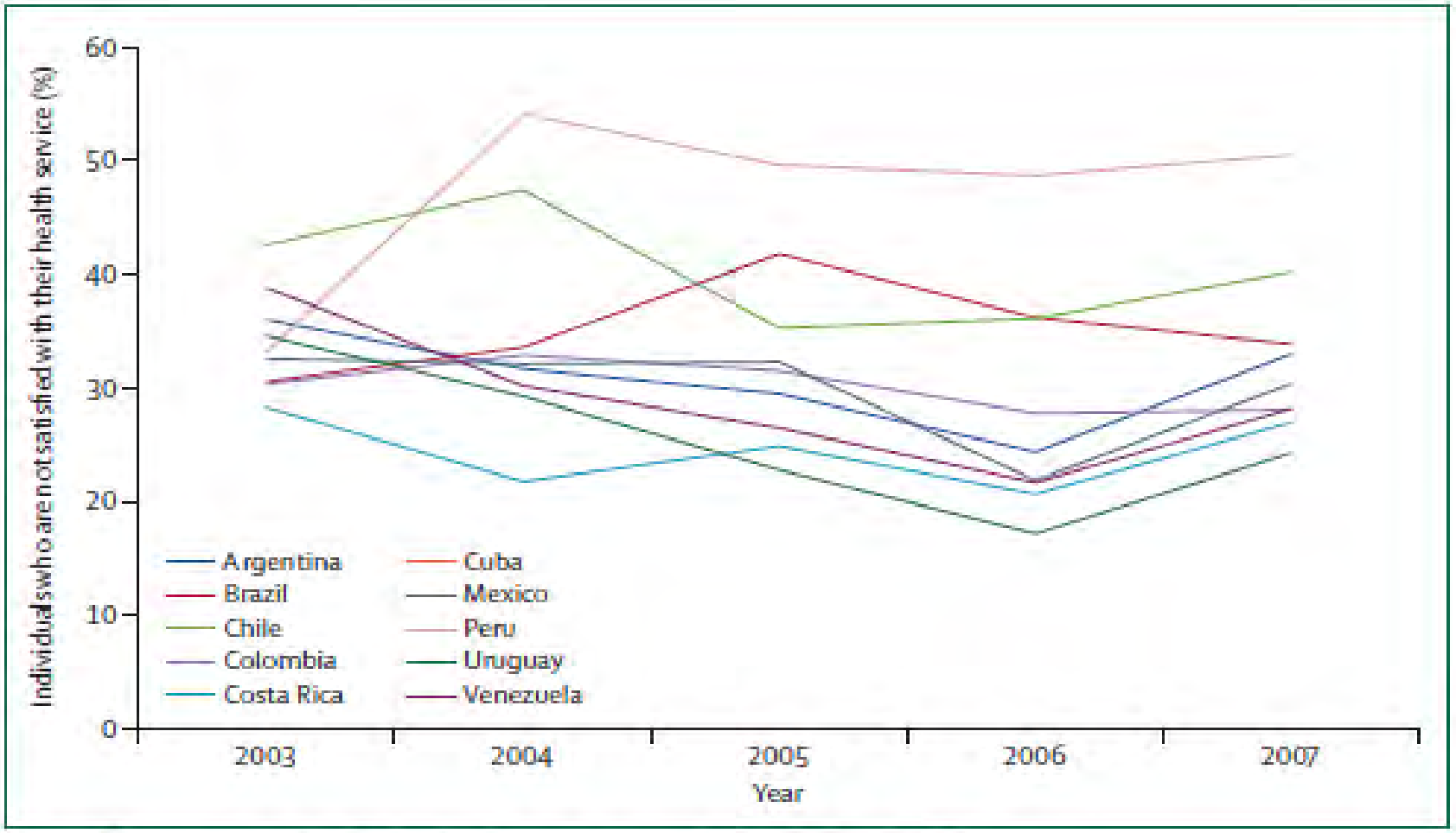


Figure 8: Proportion of individuals who are not satisfied with their health service
Data from Latinobarómetro.[141]

Source: Atun R, Monteiro de Andrade LO, Almeida G, Cotlear D, Dmytraczenko T, Frenz P, et al. Health-system reform and universal health coverage in Latin America. The Lancet 2015; 385(9974): 1230-1247

Table 3
Conceptualisations of 'community' and their construction in the texts reviewed.

How constructed in Texts	Conceptualisations of 'Community'	Conceptualisations of (In)equality
Explicitly defined	• Group of people with shared ethnic or cultural heritage; shared experiences of harm; or historical connections to land or physical resources. • Group of people 'affected' by a development or project, defined geographically or otherwise.	Relative marginalisation or vulnerability of the 'community' linked to their shared characteristics. Inequality embedded in historically-situated relations, or more contingent, in relation to new developments.
Through descriptions of rationale for money	• *Compensation*: the 'community' as victim of loss of benefits or resources, impacted upon, requiring and deserving of remuneration; the 'community' as having a distinct set of interests. • *Reparations*: the 'community' as victim of systemic discrimination or harms, subjugated; identity of 'community' ratified through reparations process; emphasis on historically situated, shared ethnic or cultural heritage.	Assumed potential for money to address inequalities experienced as a result of harms or injustices faced or anticipated by nature of 'community' identity, but embeddedness of inequalities undermines this.
	• *Land claims agreements*: the 'community' as minority, with historically-situated ethnic/cultural origins; defined through historical claims over physical resources; the 'community' as having a distinct organisation and set of knowledges that must be assimilated with dominant state.	Ownership of resources (e.g. land) is disempowering in face of goals of more powerful corporate/state entities, indicating unequal status afforded to different sets of values.
Through descriptions of the flow of money	• The 'community' as a passive recipient in a flow of money dictated by more dominant entities, such as compensation.	Lacking equality of power, voice or capacity to participate in discussions about money.
	• The 'community' as having a distinct set of interests to be reconciled with those of a corporate entity through the profit sharing from a development.	Attempts to reduce the inequality of status between the entities, but through mechanisms which protect the status of the more powerful entity.
	• The 'community', or some of its members, as agentic, making claims to money through the acquisition of particular skills or resources.	Unequal distribution of skills, but which can be overcome to help 'community' address other inequalities of resources.
Through framing problematics of giving money to communities	• *Negotiating relationships between the 'community' and others*: the 'community' as an entity requiring modification or accumulation of resources to negotiate with more powerful groups; the 'community' as an entity with political or commercial value for external groups.	Marginalised communities must be more closely aligned with values of dominant entities to be able to influence the inequalities they face.
	• *Calculating the amount of money*: the 'community' as an entity with worth that may be viewed differently by different groups.	Power relations around negotiations of money reflect – and may perpetuate – existing inequalities.
	• *Lack of impact of money on the 'community'*: the 'community' as marginalised and disproportionately disadvantaged; as entrenched in persisting structures of inequality, despite receipt of money.	Existing structural context of inequalities faced by 'community' cannot be overcome by transference of money.

Source: Reynolds J, Egan M, Renedo A, Petticrew M. Conceptualising the 'community' as a recipient of money e A critical literature review, and implications for health and inequalities. Social Science & Medicine 2015; 143: 88-97.

Outline

1. Did communities succeeded in shaping our health systems?

2. Are health systems overcoming communities inequalities?

3. Why politics matters more than ever? Communities are evolving faster than social policies.

4. Final remarks and drafting the roadmap.

Communities and political process

- Communities are evolving faster than governments.
- Social policies are arriving to late for communities unmet needs.
- Communities are engaging in the political process as a whole.
- Demanding access to healthcare is not isolated to other social policies.

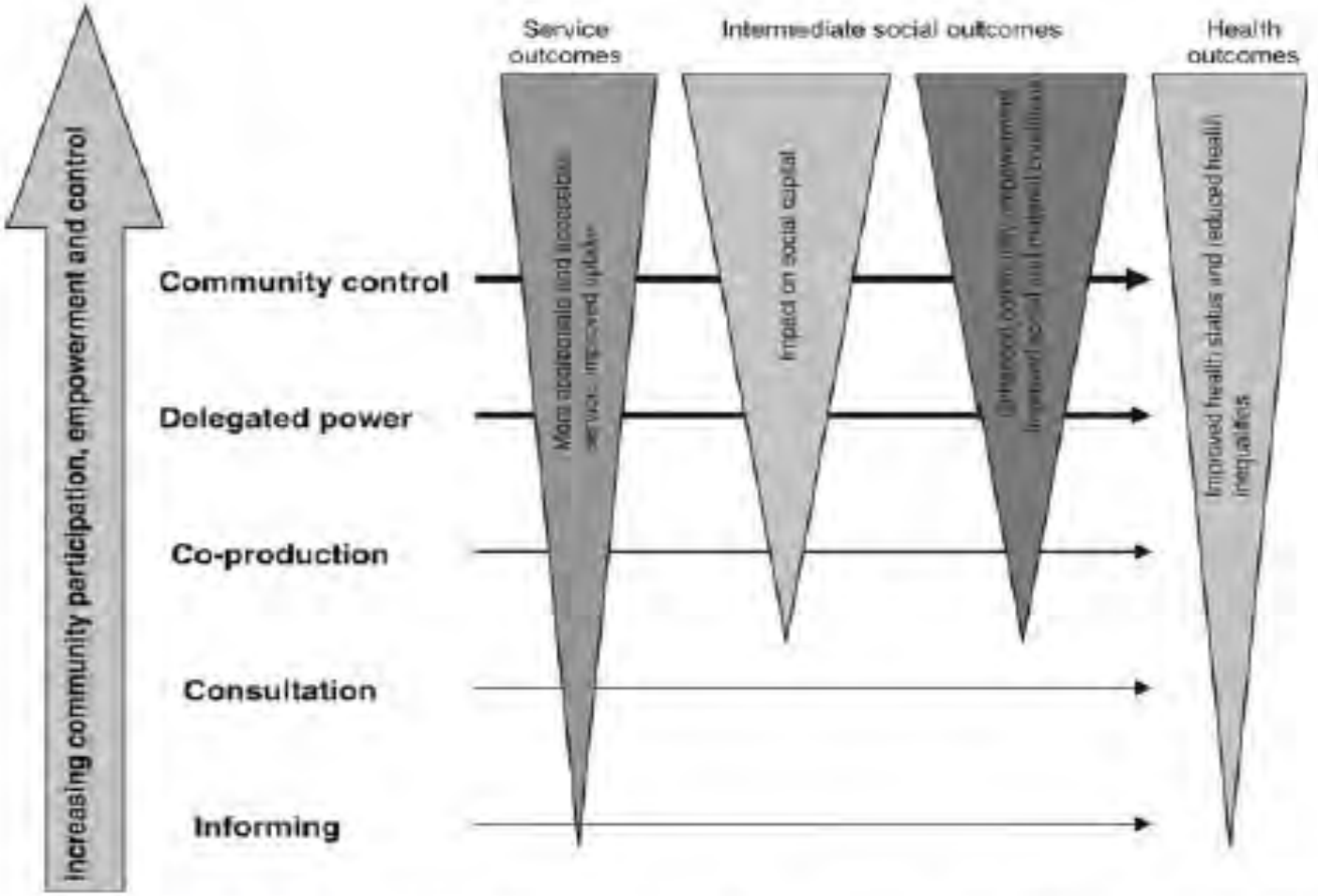


Figure 1 Pathways from community participation, empowerment and control to health improvement (Popay, 2006)

Source: Milton B, Attree P, French B, Povall S, Whitehead M, Popay J. The impact of community engagement on health and social outcomes: a systematic review. Community Development Journal 2012; 47(3): 316–334.

Figure 1. Community Engagement Continuum, developed by the Clinical and Translational Science Awards Consortium (2011).

Source: Farnsworth SK, Böse K, Fajobi O, Souzac PP, Peniston A, Davidson LL, et al. Community Engagement to Enhance Child Survival and Early Development in Low- and Middle-Income Countries: An Evidence Review. Journal of Health Communication 2014; 19:67–88.

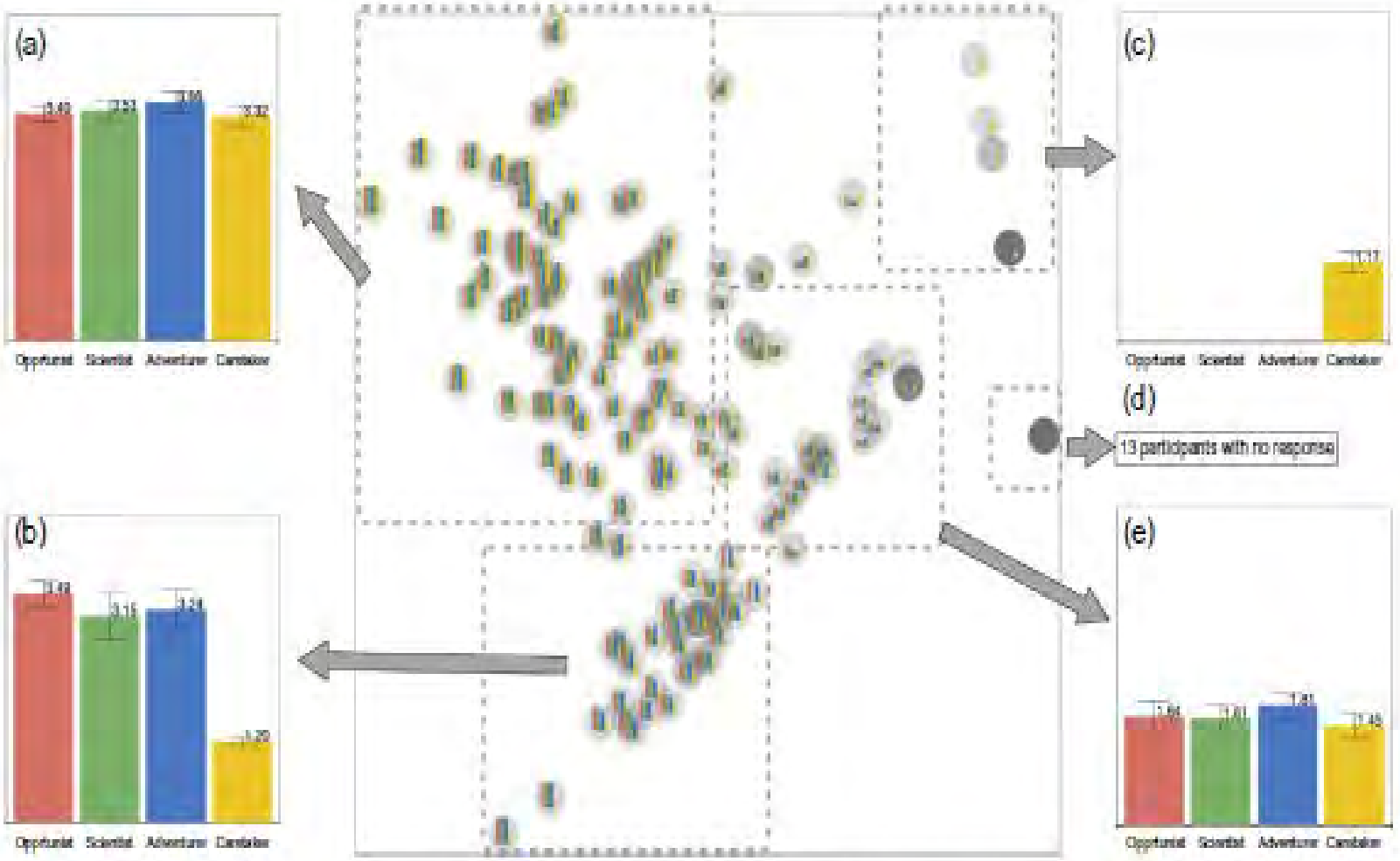


Fig. 4. Clusters of survey participants based on the four persona scores. (a) participants with high scores in all personas; (b) participants with high scores in Opportunist and Scientist groups and low scores on Adventurer and Caretaker; (c) participants with low scores on Adventurer and Caretaker and no responses towards Opportunist and Scientist question groups; (d) participants with no response to any of the four persona questions; and (e) participants with overall low scores in all four personas.

Source: Huh J, Chul Kwon B, Kim S-H, Lee S, Choo J, Kim J., et al. Journal of Biomedical Informatics 63 (2016) 212–225

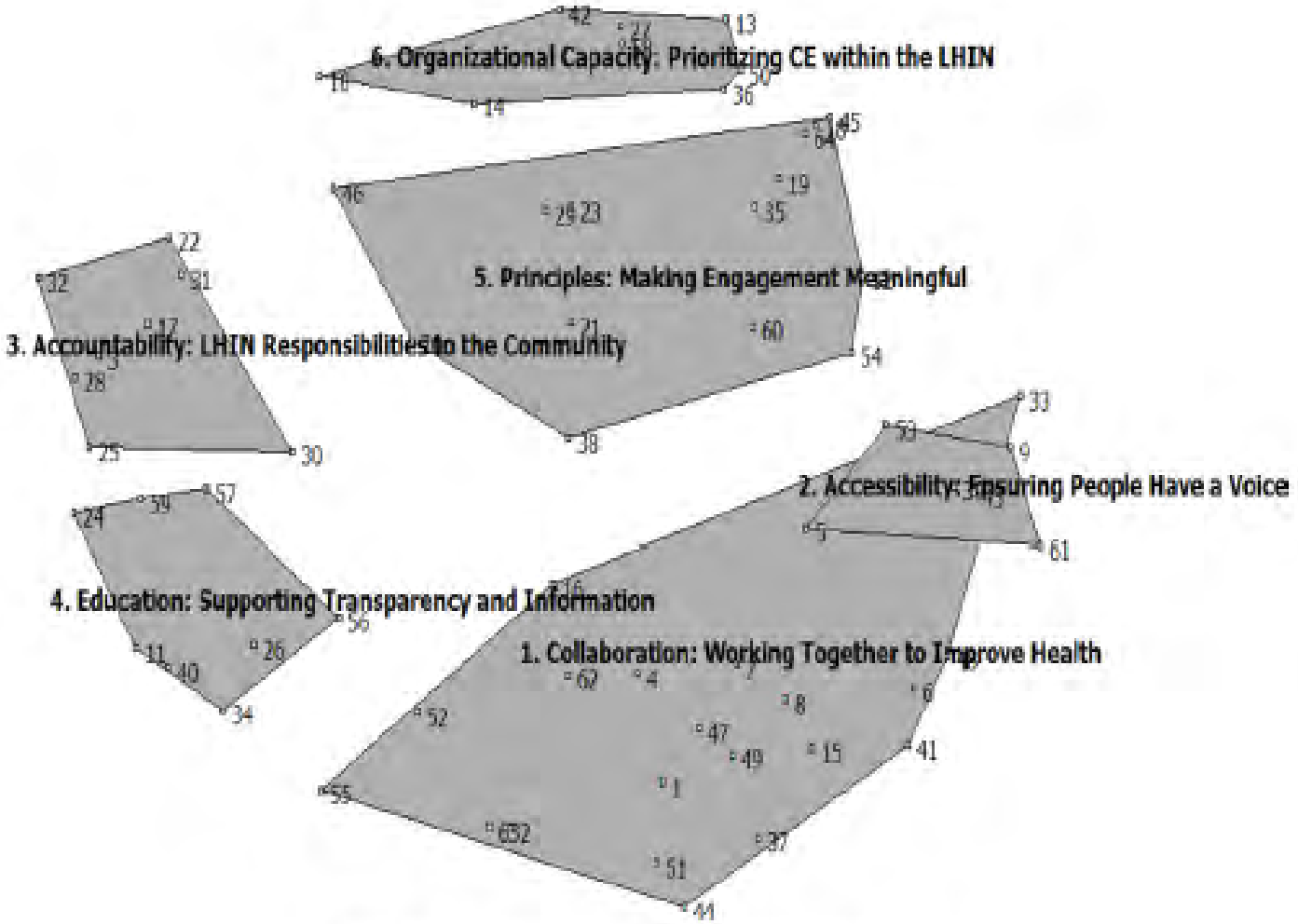


Fig. 3. Final framework for effective community engagement.

Source: Jabbar AM, Abelson J. Development of a framework for effective community engagement in Ontario, Canada. Health Policy 2011; 101: 59–69

Evaluating community engagement as part of the public health system

Jane South,[1] Gemma Phillips[2]

[1]Institute for Health & Wellbeing, Leeds Metropolitan University, Leeds, UK
[2]Faculty of Public Health and Policy, London School of Hygiene and Tropical Medicine, London, UK

Correspondence to
Professor Jane South, Centre for Health Promotion Research, Institute for Health & Wellbeing, Leeds Metropolitan University, Queen Square House, Leeds LS2 8NU, UK; j.south@leedsmet.ac.uk

Received 12 December 2013
Revised 25 February 2014
Accepted 1 March 2014
Published Online First
26 March 2014

ABSTRACT

Community participation and leadership is a central tenet of public health policy and practice. Community engagement approaches are used in a variety of ways to facilitate participation, ranging from the more utilitarian, involving lay delivery of established health programmes, to more empowerment-oriented approaches. Evaluation methods within public health, adapted from clinical medicine, are most suited to evaluating community engagement as an 'intervention', in the utilitarian sense, focusing on the health impacts of professionally determined programmes. However, as communities are empowered and professional control is relinquished, it is likely to be harder to capture the full effects of an intervention and so the current evidence base is skewed away from knowledge about the utility of these approaches. The aim of this paper is to stimulate debate on the evaluation of community engagement. Building on current understandings of evaluation within complex systems, the paper argues that what is needed is a paradigm shift from viewing the involvement of communities as an errant form of public health action, to seeing communities as an essential part of the public health system. This means moving from evaluation being exclusively focused on the linear causal chain between the intervention and the target population, to seeking to build understanding of whether and how the lay contribution has impacted on the social determinants of health, including the system through which the intervention is delivered. The paper proposes some alternative principles for the evaluation of community engagement that reflect a broader conceptualisation of the lay contribution to public health.

INTRODUCTION

The Rio Political Declaration on Social Determinants of Health establishes public participation as one of five areas of global health action.[1] Within this paradigm, community engagement is used as an inclusive term to cover the breadth and complexity of participatory approaches, from minimal involvement in consultation through to approaches where communities take control. The UK's National Institute for Health and Care Excellence refers to community engagement as 'the process of getting communities involved in decisions that affect them' including 'the planning, development and management of services, as well as activities which aim to improve health or reduce health inequalities' (ref. 2, p. 5). Despite a consensus that community engagement should be integral to public health, there is often a failure to make the leap from vertical programmes targeted at changing specific health behaviours to approaches working in partnership with communities. Public health associates itself with an evidence-based approach to commissioning and design of interventions.[3] However, the limitations of the current evidence base on community engagement, which reflect the difficulties of attributing long-term changes in individual and population health to participation,[4–7] may cause those tasked with resource allocation to favour professionally led interventions that pose fewer challenges for demonstrating effectiveness. We need, therefore, to discriminate between programme failure and evaluation failure.[8] Otherwise we risk condemning effective community engagement interventions as 'nice but essentially fluffy' because of a failure to capture their full effects. This is a particular problem where community engagement leads to independent social action by communities and therefore outcomes are not limited to those determined by public health professionals and researchers.[9]

The aim of this paper is to stimulate debate on the evaluation of community engagement where it is a major component of public health programmes. While debates about public health evidence traditionally focus on methodology, we contend that the central problem here is a conceptual one, concerning the link between community engagement and health improvement. Building on contemporary understandings of evaluation within complex systems,[10 11] we argue that a paradigm shift is needed from viewing the participation of communities as an errant form of public health action, one that is poorly defined, highly adaptable, unbounded, and ultimately out of professional control, to seeing communities as an essential part of the public health system. We critique a reductionist approach to evaluating community engagement and propose some alternative principles that recognise the potential for communities to play an active role in addressing the social determinants of health.

THE PROBLEM OF EVIDENCE

There has been much debate about the differences between evaluating public health, with its context-dependent programmes and cross-sectoral working, and evaluating clinical interventions.[12] Smith and Petticrew argue that the complex, non-linear systems of public health interventions are frequently evaluated as if they are 'short, straight and narrow', with a dependence on micro-level evaluation methods and individual-level outcomes (ref. 13 p. 5). Hawe and colleagues propose an 'ecological systems' approach to evaluation, based on an understanding of the dynamic interaction between the intervention and the system into which it is introduced.[11] This has particular relevance for interventions that seek active community engagement. The 2009 Chicago-

To cite: South J, Phillips G. J Epidemiol Community Health 2014;68:692–696.

Outline

1. Did communities succeeded in shaping our health systems?

2. Are health systems overcoming communities inequalities?

3. Why politics matters more than ever? Communities are evolving faster than social policies.

4. Final remarks and drafting the roadmap.

Communities out of the box

- Communities are seeking solutions beyond health systems.
- Health workforce are not necessary the pathway for further community engagement nowadays.
- Health sector is no longer the main entrance for community seeking wellbeing and health.
- From Latin American and The Caribbean health systems, community engagement hinder the challenge of their own democratization within health systems.

What should be the road map?

- Do we understand the politics of community health? A new road project can be the pathway for engage community in health issues.

- How to manage different community setting without fragmentation and segmentation?

- Would we still try to persuading to engage others stakeholders? Political commitment doesn't mean a positive outcome in the politics of health policies.

Universidad Austral de Chile
Conocimiento y Naturaleza

Engaging Communities Today

Community Health Experts Meeting: Defining Community Health in the 21th Century, Pan-American Health Organization Head Quarters, Washington D.C, 14-16 June 2017

Claudio A. Méndez, MPH

Associate Professor of Health Policy

Instituto de Salud Pública

claudiomendez@uach.cl