Measuring and analysing community action for health. An indicator-based typology and its application to the case of Barcelona

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Abstract

Social welfare systems face major challenges, particularly in a context of social transformation, austerity and growing inequalities. This process is highly visible in the health sector. In this context, many voices ask for public sector reforms and community action for health as a relevant practice. However, analyses and evaluations of this kind of practices are still limited, particularly beyond the cases of single community health actions or interventions. We still need to identify key indicators for measuring and characterising what community action for health consists of, as well as to what degree this kind of intervention has been developed across a city. Based on a research about 49 neighborhoods in Barcelona, this paper creates an index to measure and characterize community action for health, using different indicators: citizen engagement programs in community health, organizational transformation of the health and social protection systems, stable participatory structures with specific teams, and urban health policies. We apply the index to the case of Barcelona and build a map of community action for health in the city using 4 categories: strong community health development (one neighbourhood), middle (9 neighborhoods), emergent (25 neighborhoods) and without specific community health promotion (14 neighbourhoods). We find that community action for health is extensive within the city of Barcelona, have great potential as a response to the need for change in the relationship between the public (health) sector and the citizenry, but is still implemented unequally across the urban territory in terms of types and methods.

Key words: community action, health, public sector, indicators, Barcelona

1. Introduction

The current context of economic crisis and epochal change (Bauman 2012) is bringing about deep social transformations in daily life and a subsequent questioning of the relationships between the public sector and the citizenry (Bovaird 2007; Subirats 2011; Osborne and Strokosch 2013). This context brings with it complex and multidimensional public problems that are impossible to understand and address from a strictly technocratic logic based on disciplinary segmentation and delimitation. The public policy literature

has described these types of problems as “wicked”, because they involve situations that generate both uncertainty and discrepancies among social actors and groups, therefore requiring solutions that go beyond the usual methods employed by public administrations (Rittel and Webber 1973; Fischer 1993; Koppenjan and Klijn 2004; Weber and Khademian 2008; Brugué, Blanco, and Boada 2014). In the face of such public problems, standard solutions are ineffective, especially in a society that is increasingly diverse, pluralistic, and unequal. The result is a challenge to the legitimacy and sustainability of the Welfare State and, more specifically, the health system. While many important policy responses lie outside the health sector, as fiscal policy and social protection, the health system response is critical (Thompson et al. 2014).

In this context, community action for health has become an intervention strategy that tries to respond to these challenges. Community action for health drives positive change in community health through the implementation of necessary interventions by various actors and with the participation of the community itself (Fuertes et al. 2012). It goes beyond the provision of healthcare, emphasising instead the relational dimensions of health and optimising related opportunities. Based on participation and multi-sectoral cooperation, community action for health considers the members of communities themselves as important players in transferring knowledge and controlling health determinants. This approach links population empowerment to health improvements, but also to the sustainability of the health system, the optimization of resources, improvement in healthcare quality and the transversality of public policies.

Thus, this article explores the concept of community action for health in a context of wicked problems, focusing in the case of Barcelona. In Barcelona, much like in other cities and countries, social inequality in terms of health outcomes is not a new phenomenon (Borrell and Pasarín 2004), with a number of studies highlighting inequalities across gender, social classes, place of origin and geographical residence (Borrell et al. 2004; Borrell et al. 2008; Rodríguez-Sanz et al. 2016). Moreover, in Spain, the economic crisis and passing of austerity measures have had a significant impact on health and related inequalities across the country (Cortés-Franch and González López-Valcárcel 2014; Bartoll et al. 2015; Zapata Moya et al. 2015; Padilla and López Ruiz 2016). In the field of health, such inequalities are accompanied by the emergence of new needs resulting from, on the one hand, an increasingly ageing society with a greater prevalence of chronic conditions (Nuño et al. 2012) and, on the other hand, an increasingly migrant population with specific health needs (Malmusi et al. 2010).

In situations of economic crisis and austerity and related deterioration in living conditions – particularly in more disadvantaged city neighbourhoods – health and social protection systems face grave challenges. The comparative literature on health service management points out the need to strengthen autonomy and promote a healthy life for the population (Loeffler et al. 2013; Parrado et al. 2013; Renedo et al. 2015). The healthcare paradigm must adapt, in terms of both the responsibilities of healthcare workers and the role of social actors and patients. In advanced healthcare systems, comprehensive reforms are being discussed that strategically focus on changing the organization of healthcare

services and empowering the population. It is increasingly necessary to adopt a global perspective on health that incorporates its social, educational and relational components. The emphasis therefore must fall on community dimensions of health and promoting health in the community (EuroHealthNet 2012).

The promotion of community health has a broad history, in which social actors and certain public institutions have played important roles. Although this approach and related interventions have been applied in some cases, critical analysis and evaluations of their impact are still minimal, particularly in contexts of austerity cuts. The limited evidence suggests that community-based health promotion has a positive impact on health problems that cannot be addressed through individual healthcare (Montaner, Foz, and Pasarín 2012). For example, two systematic reviews studied the effect of community action interventions among disadvantaged populations and found positive impacts on health and health inequalities (Cyril et al. 2015; O'Mara-Eves et al. 2015). However, a number of significant difficulties in the evaluation of community health programs persist, and effective instruments are still required in order to advance these efforts (Gervits and Anderson 2014; Barcelona City Council 2014; Renedo et al. 2015; Cahuas, Wakefield and Peng 2015; Wood 2016). One of the main gaps is that most experiences of community engagement have been evaluated as single actions or interventions and not as a whole process of community action for health. We still need to build and apply indicators for measuring and characterize what community action for health consists of and to what degree this kind of intervention has been developed. As a result, public confidence in community health experiences is still limited, despite such experiences representing a potentially transformative and sustainable alternative. Ultimately, the field must generate knowledge that allows for improved scrutiny and transparency of these efforts, while also strengthening their autonomy.

This paper develops and applies both an analytical approach and methodological tools to address these needs. It is important to highlight that we do not focus on outcome measure in terms of health indicators, that is, we do not address the question of the impact of community action for health on the population's health. Instead, we focus on different (and previous) aspects. Specifically, the paper aims to answer three research questions: How can we measure the level of development of community action for health? Is community action for health developed homogeneously across the neighbourhoods of a city? Which are the main factors that could explain a different degrees and types of development? The objective of the paper is to build a methodological and analytical tool to assess the degree and type of development of community action for health and apply it to the case of Barcelona and its various neighbourhoods.

To answer these questions, the paper is structured as follows. We begin by outlining the framework regarding the analytical and empirical relevance of community action for health. We also identify key factors that have to be taken into account when measuring the level of development of community action for health. Next, we present and justify the methodology of the study on which this article is based, which assesses community action for health in disadvantaged districts in Barcelona. A series of health-related interventions,

which incorporates the collective and relational dimensions of health determinants, have been applied in Barcelona over the past decade. We dedicate one section of this article to describing and analysing these experiences. Finally, we build and discuss the index of community action for health and we present the results of applying this index to the case of Barcelona. The article concludes by underlining its key contributions to the literature and raising new research questions.

2. Analytical framework

In this section we, first, define key analytical concepts of our paper and, second, we identify key factors for measuring community action for health and building specific indicators.

Health is a state of physical, mental and social wellbeing, rather than simply the absence of illness. It is well known that achieving health is a task that goes far beyond individuals themselves, with elements of our immediate surroundings (family, school, work) and broader environments (unhealthy policies, macroeconomic conditions, etc.) playing key roles in determining our health and driving health inequalities (Dalghren and Whitehead 1991; World Health Organization 1998). The social determinants of health are defined as the complex, comprehensive and overlapping socio-economic and political context and socio-economic structures (structural determinants) that can result in health inequalities. The intermediary determinants of health include material and psychosocial circumstances, behavioural and/or biological factors, and the health system (Commission on Social Determinants of Health 2008). Particularly in urban contexts, these socio-economic determinants include our social and physical environments, which generate healthy or unhealthy settings, with variation between social groups (Borrell et al. 2013).

As previously mentioned, the current economic crisis and austerity measures have had a significant impact on the health of the population and on health inequalities in European populations (Karanikolos et al. 2013). In Spain, such impacts have been particularly notable in the field of mental health (Bartoll et al. 2014), reproductive health (Varea et al. 2016), and in relation to certain causes of death (Borrell et al. 2014b).

In this context, the need for reformulation of the role of the public sector, and particularly of the healthcare system, is evident. Certain attempts at healthcare reform have placed greater emphasis on public health (Baggot 2000). However, such reforms, often focused on organizational aspects of the system (Parker and Galsby 2008) are limited in their capacity to provide comprehensive answers to complex problems in the area of health. It is essential to approach these problems in a transversal manner, recognizing the interdependence between the administration and the citizenry and fostering initiatives developed by citizens themselves in which they play a role in the management of public and community matters.

However, a shift towards community action as an innovative practice requires some initial definition and conceptual rigour. Otherwise, we run the risk of misinterpreting and undervaluing some of the key concepts in these processes. One such concept is that of community. We begin with the definition of community put forward by the World Health Organization (1998), but adjusted to the context of our study. Thus, we understand community as the group of actors that share a territorial space of reference – regardless of whether they reside there or conduct their social and/or professional activities there – and that establish interdependent relationships. These actors can be grouped into organized or non-organized residents, professionals in public service and social organization, and actors that conduct economic activities in the territory in question.

Another key concept is that of community organization. One of the classical definitions of community organization is provided by Murray Ross (1955), who stresses the cooperative process by which a community identifies and orders its needs, finds the resources to deal with these needs and takes action in respect to them. Taking into account that community organization is a living and contested process (Kenny 2016), we focus on the idea of community action, which can be defined as a process of stimulating cooperative social relationships between members of a community (neighbourhood, centre, building, etc.), a human collective that shares a space and a sense of belonging that results in mutual linkages and support, and that motivates members to become protagonists in the improvement of their own reality (Barcelona City Council 2005). The objective of community action is to improve social wellbeing by promoting active participation in actions designed to achieve that wellbeing. It requires the awareness, participation and organization – in short, the empowerment – of citizens to drive change and improvements beyond their own individual spheres. Community action can be led by public administrations and the services they provide (social services, education, healthcare, etc.) as well as by citizens themselves through local efforts, regardless of whether they are formally organized or not.

But if we aim to build a tool for measuring community action for health, we need to indentify and discuss the main factors that could lead to different degrees of development of this kind of interventions. This is a first step for building specific indicators. In this respect, we stress five general issues, referred in academic literature but still understudied as a whole process: *precommunity* interventions, citizen participation in decision making, comprehensive programs, specific institutional arrangements and urban renewal policies.

Firstly, a particularly important aspect of the discussion about community action (in the field of health, but also education or social protection in general) is that involving population is less a starting point than an ending goal. Some public interventions, even if they cannot be considered as community action (in the way we have defined it), may generate opportunities for collective action. Interventions for health prevention or starting awareness-raising within the population could gradually generate interest, organization and implication in community-based interventions (Balcazar et al. 2010, Soler et al. 2016). We can call them *precommunity* interventions.

Secondly, community action for health is strongly related to citizen participation. Without citizen involvement, at least in the design of an intervention, any possible change in community wellbeing will be resulting from others' decisions (Taylor 2007, Sheikh et al. 2010, Marchioni 2014). Thus, members of a community could not be considered protagonists in the improvement of their own reality, but mere recipients of the consequences of those changes. In the field of health (and health systems), this participatory approach is based on the concept of community health – that is, the health of individuals and groups in a defined community, determined by the interaction of personal, familial, socioeconomic, cultural and physical factors (Gofin and Gofin 2010). In this sense, community health emphasises the social dimensions of health and represents a comprehensive approach to processes of health and illness, taking into account the macro- and micro-social levels and the participation of communities, institutions and other sectors in decision making (Restrepo 2003).

Thirdly, another particularly important aspect is that community action for health is an expression of the need to transform the public sector, mainly in terms of its relationship with citizens. Some community action for health interventions can be defined as comprehensive programs. They mobilize a significant number of public services, social networks and/or the population of the territory (organized or non-organized), and they evolve into important strategies for the health and other public services of the territory (Cyril et al. 2015, O'Mara-Eves et al. 2015). We are talking about a particular kind of transformation, related to what Hall (1993) called second-order change and third-order change. Second-order change means transforming form, content, and repertoire of goods, services, and organizational routines, and third-order change means transforming the underlying problem understanding and policy objective.

Fourthly, we need to specify which kind of institutional arrangements could strengthen community action for health. We also need to find measurable arrangements. Frameworks of analysis of participatory arrangements (such as Fung 2006) identify three important dimensions: scope of participation, mode of communication and decision and extent of authority. Regarding these three dimensions, and focusing on community action for health, a clear measurable institutional arrangement are participatory structures in the field of health that foster collaborative interaction between population and public services (Rydin et al. 2012, Rebollo 2012). This kind of structures needs stability for consolidating, so time in the implementation will be a key factor (Sheikh et al. 2010, O'Mara-Eves et al. 2015). Another related institutional arrangement is the so called community teams –people specifically in charge of leading community action for health. The existence of specific professionalized teams has been identified as a key factor for the consolidation of community action for health and, particularly, the population needs assessment (Barcelona City Council 2012, Franklin et al 2015).

Lastly, there is significant evidence that community action for health is related to urban renewal policies. Renewal projects usually include construction or reform of community centres and public spaces, as well as specific community programs that inspire or

strengthen health interventions (Rydin et al. 2012; Mehdipanah et al. 2015). Thus, measuring community action for health needs to consider whether urban renewal policies offer opportunities for the residents to learn new skills, while integrating and meeting other residents and public services.

3. Methodology and case study justification

Barcelona is a relevant case when analysing community action for health. A wide range of community health promotion experiences have been seen in the city, in which social actors and certain public institutions have played key roles. Such experiences have for a long time been driven by community entities with the broad participation of residents and professionals. In addition, specific public policies have been developed, such as the Neighbourhood Health program (*Salut als barris*) (Sierra et al. 2008; Pasarín et al. 2010), implemented in a number of neighbourhoods in Barcelona and Catalonia since 2008.

Why do we focus our analysis on neighbourhoods of a low socioeconomic status? The research on public health has widely corroborated the evidence of a marked relationship between socioeconomic status and health, demonstrating that those in more disadvantaged socioeconomic situations perform worse on multiple health indicators (Borrell and Pasarín 2004). The reduction of health inequalities therefore depends on going beyond population-level strategies to establish intervention strategies specifically for the most vulnerable groups, whose distribution usually follows a geographical pattern, and community-based health promotion initiatives are aimed at improving welfare of those groups. Moreover, it is important to note that, in Barcelona, community-based health promotion initiatives have mainly been developed in neighbourhoods of low socioeconomic status, while they have been largely non-existent in neighbourhoods of higher socioeconomic status (see Diez et al. 2012 for the case of the Barcelona Neighbourhood Health Programme). Another reason to limit the study to the neighbourhoods of homogeneous socioeconomic level was to reduce the confounding effect that other important determinants of health could have on the results obtained.

Therefore, it is both empirically and analytically relevant to study the key indicators of community-based health promotion in the most disadvantaged neighbourhoods. As such, the methodology of the study behind this article was based on a comparison of 49 neighbourhood cases[1] that, on the one hand, are similar in terms of their socioeconomic status. These are neighbourhoods with disposable household income of less than 90% of the average for the city of Barcelona[2]. This threshold is higher than the standard definition of poverty (60% of average income as used by the Eurostat), but it allows us to cover a wider number of neighbourhoods and, thus, expand our analysis to make it analytically and empirically richer. On the other hand, these neighbourhoods differ in terms of

[1] Barcelona is divided into 73 neighbourhoods.

[2] The household income index is prepared by the Barcelona City Council. It is a theoretical measure of the income of residents in neighbourhoods of the city, compared to the city average which is set at 100 (see http://bit.ly/2559E4U for details). In our study, we consider only neighbourhoods below 90.

whether or not community-based health promotion has advanced within them or not. Community-based health promotion in neighbourhoods of Barcelona is usually framed as part of community development plans (*planes de desarrollo comunitario*, PDCs), community social service programs, the Neighbourhood Health program (*Salut als barris*) or in the activities of Primary Healthcare Teams (*Equipos de Atención Primaria*, EAPs), which are explained in detail in the results section.

How did we proceed with the analysis? Firstly, we constructed an index for measuring the level of community action for health in neighbourhoods in Barcelona. To do that, we carried out a review and critical analysis of the relevant literature in the field (see prior section), as well as in the context of the city of Barcelona. On that basis, we determined four key indicators and sub-indicators (see section 5 for details and justification). Subsequently, we applied the index to the 49 neighbourhood aforementioned, based on a documentary review of existing/past community-based interventions (plans, reports and budgets) and 12 structured interviews: 7 with members of community teams, people specifically in charge of leading community action in the field, and 5 with health professionals involved in community-based interventions. As a result of the application of the index, the neighbourhoods were classified into four groups: "strong", "medium", "emerging" and "non-existent specific" community action for health.

Following this classification, we conducted two processes of revision and validation. First, we validated the number of points awarded to each neighbourhood. For this, the results of the index were sent to six known professionals in the field of community health projects in Barcelona (including doctors, nurses and project managers), with the aim of assessing the extent of their agreement with the classification results. After receiving their comments, the index was recalculated for cases in which new information had been received. Second, a statistical process of validation of the internal consistency of the index and a cluster analysis of the creation of the four groups were conducted.

Finally, a map of Barcelona indicating the neighbourhoods and their level of development of community action for health was prepared.

4. Community action for health in Barcelona

Before presenting and applying the index of community action for health, it is important to shortly describe and analyse the general background of community action for health interventions in Barcelona. Our index is based on the relevant literature in the field and also in the context of the city of Barcelona.

At the international level, the adoption of a community approach to health by public institutions goes back to the 1970s. The first government document, in the West, to question the traditional emphasis of health policies on healthcare and to propose an approach that goes beyond curing illness for the overall improvement of health was published in 1974 (the *Lalonde* report, prepared by the Government of Canada) (Barcelona Public Health Agency 2012).

In the case of Barcelona, characterising this shift towards illness prevention and community health promotion requires a consideration of the roles played by various actors over the last 30 years. Community health promotion interventions first emerged in the 1980s with the work initiated by the Municipal Institute of Health (*Instituto Municipal de la Salud*, IMS), currently known as the Barcelona Public Health Agency (*Agencia de Salud Pública de Barcelona*, ASPB). Since the 1980s, the Agency, then the IMS, has developed and continues to develop community projects for the promotion of health and/or the prevention of illness. One notable example was the maternal and infant health program of the Ciutat Vella district in Barcelona, initiated in 1986 and 1987 after it was discovered that the infant mortality rate was significantly higher in the district than in the rest of the city (Diez et al. 1995). Since 2010, the ASPB has a specific budget for community health action, taking responsibility for all the phases of the process (alliances, needs assessment, assets detection, health action plan and surveillance and evaluation)

From the 1990s onwards, primary healthcare teams were increasingly adopting the approach of 'primary healthcare for the community' (*Atención Primaria Orientada a la Comunidad*, APOC), with the support of the APOC Group of the Catalan Society of Family and Community Medicine (CAMFiC). While this methodology still did not involve the community's participation in the diagnosis, planning and/or evaluation of community health programs, it did represent a first step towards the study of the community and the elaboration of a strategy for approaching health problems beyond those that could be detected during medical consultations (Gofin and Foz 2008; Gervits and Anderson 2014).

Towards the end of the 1990s, some primary healthcare teams began to form networks for community work that were driven by community development plans[3]. These plans are territorial action plans for one or more neighbourhoods, consisting of a process of mobilising and organising the community (residents, organized neighbourhood groups, organizations, public services) with the objective of addressing identified problems in a coordinated manner, implementing interventions to resolve them, and promoting improvements in quality of life.

In Barcelona (and Catalonia), community development plans started contributing to institutionalizing community-based intervention in disadvantaged neighbourhoods almost two decades ago, funded by the Government of Catalonia and by corresponding city councils. In Barcelona, community development plans are currently being developed in 14 neighbourhoods, although each is at a very different stage of development and implementation. They also differ in the form and content of the interventions they define to achieve improvements in community health[4]. One relevant example of a community health intervention driven by a community development plan is the *A Roquetes fem salut* program, developed under the framework of the community development plan of the Roquetes neighbourhood. This case demonstrates how, occasionally, the process of

[3] For example, the case of the Xafarines Primary Healthcare Centre in the Trinitat neighbourhood since 1997.

[4] These differences are analysed in the next section of the article.

preparing a community development plan can allow for the incorporation of other innovative territorial policies (Rebollo and Morales 2013), in the education, labour and health spheres.

One such territorial health policy is the Barcelona Neighbourhood Health program (*Salut als Barris de Barcelona*[5]), which since 2008 has explicitly promoted the development of community-based interventions for improving community health and reducing inequalities. The program is built upon community work consisting of two fundamental components: inter-sectoral cooperation and participation. This program targets territories covered by the Neighbourhood Law (*Ley de Barrios*), approved by the Catalonian Parliament in 2004 as a policy for comprehensive rehabilitation of disadvantaged neighbourhoods. The Neighbourhood Health program has allowed existing community initiatives and interventions that were most often isolated from each other to come together in a coordinated manner within neighbourhoods. In Barcelona, the program has maintained a continuous and uninterrupted development since it began in 2008.

Recently, the work of primary healthcare teams has been increasingly tending towards the community health approach. A network called United Action for Health (*Actuando Unidos por la Salud*, AUPA) was established in 2004, consisting of various institutions and associations. Similarly, in 2010 the main primary healthcare provider in the city of Barcelona, the Catalan Institute of Health, formally adopted community-based health promotion as a strategic direction for the city (Nebot et al. 2016). Even so, the weight of the community-based approach in the work of different primary healthcare teams and primary healthcare providers varies significantly. Up until the late 2000s, only certain teams with strong leadership focusing on this approach had strategically developed these types of intervention, with teams in the Roquetes and Carmel neighbourhoods serving as examples.

It is also important to highlight that since 2010 the Catalan Health Service (*CatSalut*), a public entity that buys primary healthcare services, has been leading in Barcelona the establishment of Operational Committees for Prevention and Community Health (COPISC), with the goal of sharing lines of work, objectives and methodologies across different healthcare actors involved in community projects in the city. In this sense, for the first time, the need for action beginning with community health was being recognised at levels of the health system that were higher than primary healthcare teams (management levels of service providers and Catsalut).

Currently, in Barcelona, a variety of community-based activities for community health improvement are being developed on a territorial basis, with institutional support. Examples include community development plans, Intercultural Community Intervention Plans, community-based programs implemented by municipal social services, interventions under the Neighbourhood Health program, interventions under the

[5] http://www.aspb.cat/quefem/salut-als-barris.htm

COMSALUT program[6], interventions developed directly by structures fostered by primary healthcare teams themselves and intercultural community intervention plans. As such, the study behind this article aimed to detect and measure the varying levels of development of these interventions in the more disadvantaged neighbourhoods of the city. We therefore constructed an index and typology for such interventions and a map that allows us to analyse their reach across the city of Barcelona. The next section presents the results of this process.

5. Index and map of community action for health in Barcelona

As mentioned in the methodology section, this article presents the results of a study that analysed existing information about community-based health interventions that were implemented up until 2014 in a number of neighbourhoods of the city of Barcelona with an average disposable household income of less than 90% of the city average.

Before conducting the study it was necessary to first conceptualise and establish indicators of community-based health promotion that would allow us to operationalize and measure this type of intervention. Based on a review and critical analysis of the relevant literature in the field (see prior section) as well as in the context of the city of Barcelona, we determined four key indicators. Indicator 1 allows us to determine the existence or lack of community-based health promotion interventions. The other three indicators measure the strength of such interventions. In the following, we explain each of these indicators in detail, justifying why the particular indicator and sub-indicators were selected.

Indicator 1 – Health projects and community-based interventions implemented in the territory

Firstly, this indicator specifies whether community-based health programs exist or not. Furthermore, the final score for the indicator reflects the total of the three dimensions and levels of development of community action for health that we describe below. For this indicator, each territory's score can be equal to the total score on the three sub-indicators presented below, since these are not mutually exclusive. The minimum score for this indicator is 0 and the maximum score is 9, achieved if the neighbourhood scores the maximum on the following three sub-indicators:

1.1. Interventions for prevention or the promotion of health targeted to the population. Value: 1 point. As we have discussed in the analytical framework, despite the fact that they are sometimes classified as community-based interventions, such interventions are not community-based in the strictest sense, given that they are not formed through

[6] The COMSALUT (*comunitat* and *salut*, community and health) is a program developed by the Catalan Government including different Primary Healthcare Teams (EAPs), under the logic of the Catalonia Health Plan (*Plan de Salud de Catalunya*).

collective work or in direct collaboration with the population. This does not preclude, however, interaction and exchange with the population as a result of the interventions. Examples of such interventions might include: discussions and informative and preventative campaigns, such as physical activity groups or healthy cooking workshops organized by primary healthcare teams. We consider it important to measure such interventions and include them in the study given that they constitute a first step in collective action towards an intervention model that can, in the future, involve the population in the design and implementation of interventions (community-based interventions).

1.2. Community-based interventions co-developed through the social network of the neighbourhood. Value: 3 points. These activities are, at a minimum, designed or verified in collaboration with the population before being implemented. For this reason they are considered in a strict sense as community-based interventions. This indicator determines the existence of interventions that are normally developed in a consistent and regular manner over time. As we have pointed out in the analytical framework, and also in the analysis of the general background of community action for health interventions in Barcelona, this indicators is related to the participatory approach based on the concept of community health. Examples of such interventions include periodic and regular physical activity groups organized by primary healthcare teams, parental training programs, or the exercise of conducting community health diagnosis. The development and implementation of these interventions in a prolonged manner over time can mean that the coordination and organization strategies employed by the participating actors evolve towards a model that can make the intervention more autonomous, without having to depend entirely on external funding and incorporating – in a consistent manner – the territory's public resources and the active participation of the population (see indicator 1.3). In order to confirm or verify that the experience under analysis belongs to this category, we developed a control question: In the event that the subsidies or economic resources that fund the intervention were to disappear, would the intervention be able to continue? The response for this category should be that the intervention would not be able to continue. If the response were affirmative, the intervention in question would most likely fall under indicator 1.3 (see below).

1.3. Community-based interventions of institutional and organizational transformation. Value: 5 points. This indicator determines the existence of what we have identified in the analytical framework, and specifically in the case of Barcelona, as comprehensive interventions. They foster collaboration between population of the territory, civil organisations and public services in the formulation and implementation of community-based health interventions. Interventions focusing on health promotion and illness prevention that involve strong public participation benefit from greater continuity as they are embedded in the approach and methods employed by the involved health teams and services. Examples of such interventions include certain school health projects[7], or

[7]For example, the health school in the Carmel neighbourhood (see http://bit.ly/2bQj0ho)..

comprehensive programs falling under community development plans[8]. In the case of this sub-indicator, applying the same control question as before would generate an affirmative answer. That is to say, if the external financing of the intervention ended, the services and resources of the intervention would be able to continue with a similar level of success.

All of the territories that receive a minimum score of 1 are subsequently scored on indicators 2, 3 and 4, which we define below. We view these indicators as elements that stimulate community-based health promotion interventions.

Indicator 2 - Existence of stable participatory structures for the implementation of community-based interventions (e.g., community development plans)

In order to identify relevant and measurable institutional arrangements supporting community action for health, we have pointed out the importance of participatory structures. The so called community development plans have been a key structure in the case of Barcelona. These structures establish links with the population and the public services of the territory with the objective of driving community-based interventions. Such structures have a multiplier effect on health promotion and illness prevention interventions that may be implemented in the territory. Thus, we decided to prioritize the measure oh this kind of structures over the scope of individual participation (e.g. number of people). Moreover, unfortunately, none of the experiences of community action for health analyzed in this paper have kept quantitative, reliable records of participation, which conditions and limits this particular dimension of the analysis. For this reason, more extensive, in-depth case studies should be carried out in order to gather this type of data.

Regarding the score, if a neighbourhood has no structures in place, it receives no points on this indicator. If structures are in place, the indicator allows three possible categories of scores, according to how long the structure has been consolidated (in this respect, we have previously discussed the relevance of the issue of time)

- 5 years or less (1 point).
- Between 6 and 9 years (3 points).
- 10 or more years (5 points).

Bearing in mind that all community processes can have their ups and downs, it is sometimes necessary to adjust scores across the three categories. For example, in the neighbourhood of Trinitat Nova, the community development plan was launched in 1997

[8]For example, the activities encompassed in the program *A Roquetes fem salut* in the Roquetes neighbourhood (see http://bit.ly/2c2tNUd). Another example is the *Els divendres al Pou* project, which aims to offer new spaces for healthy leisure activities and training for first work experiences (see http://bit.ly/2bLvuoo).

but its activity was interrupted for some time, during which the public service providers involved were close to exiting the structure. For this reason, its period of consolidation is more accurately reflected by the 6-9 year category than the 10+ year category.

Indicator 3 – Existence of a community team that jointly approaches work with public resources and that works specifically on health

As we have discussed in the analytical framework, and also in the analysis of the general background of community action for health interventions in Barcelona, specific teams on community action for health are a key element for the consolidation of this kind of intervention. That is why, in order to score points on this item, the mobilizer or mobilizing team must work specifically on health issues. The scores can vary as follows:

- Existence of one single community mobilizer: 1 point
- Existence of a mobilizing team (minimum 2 people): 3 points.

Indicator 4 – Existence of the Neighbourhood Health (Salut als Barris) program

As we have explained in the section 4, the Neighbourhood Health Program forms part of a general rehabilitation policy that involves a strategy for community-based interventions in the field of health. In this sense, it can also be seen as a program that inspires or strengthens other community-based health interventions. Thus, this indicator is connected to what we have explained in the analytical framework: the link between community action for health and urban rehabilitation policies.

Bearing in mind that the extent of program implementation in each territory depends on how long ago implementation was initiated, the scores can vary as follows:

- Incipient Neighbourhood Health program (experiences that began in or after 2012): 3 points
- Consolidated Neighbourhood Health program (experiences that began prior to 2012): 5 points.

In short, the aggregation of the four indicators allows us to construct an index of the level of development of community action for health interventions. Table 1 summarizes the indicators described above, which form this index.

Table 1. Indicators of community action for health

	Indicator scales	Points
1 .- Specific health projects and interventions implemented *(total points)*	1.1. Interventions targeting the population which, without being considered community-based interventions, have the objective of preventing illness and promoting health	1
	1.2. Continuous and/or periodic interventions	3
	1.3. Interventions of institutional and organizational transformation	5
Total points for indicator 1 (if equal to or greater than 1, territory is assessed against the subsequent indicators)		
2.- Existence of stable participatory structures for the implementation of community-based interventions (e.g., community development plans, etc.)	Less than 5 years	1
	Between 6 and 9 years	3
	10 years or more	5
3.- Existence of a mobilizing community team that works on health together with public services	Existence of a community mobilizer	1
	Existence of a mobilizing community team (minimum 2 people)	3
4.- Existence of a comprehensive rehabilitation policy with a community health program (Neighbourhood Health program)	Incipient (Implemented from 2012 onwards)	3
	Consolidated (experiences that began before 2012)	5
Total points awarded		Minimum 0 Maximum 22

Based on the construction of the index, we establish a typology of four levels of development of community action for health interventions, according to the extent of implementation and weight of the intervention(s) in each territory. Table 2 summarizes this typology.

Table 2. Neighbourhood classification according to level of community action for health interventions

Levels of community action for health		Points on index
LEVEL A	Strong community-based health promotion	18 - 22
LEVEL B	Medium community-based health promotion	13 - 17
LEVEL C	Emerging community-based health promotion	2 - 12
LEVEL D	Non-existent (specific) community-based health promotion[9]	0 - 1

Here we should restate that the objective of this classification tool is to establish categories relating to community-based health promotion, and not to generate a ranking of experiences. This tool is just one of the possible classification instruments, based on a dataset that places the territories in four large groups according to the strength of their community-based interventions. The classification covers the level of development of community action for health interventions up until mid-2014. Community-based projects and other programs focusing on related services implemented in the territories, which up until mid-2014 had not included interventions for community health, were not analysed.

In Table 3 below we present the results of the analysis and the application of the index in the neighbourhoods of Barcelona included in our study. We reiterate that these are neighbourhoods with a level of disposable household income that is less than 90% of the average for the city.

[9] Although preventative community-based interventions implemented by primary care teams are included, we do not view these as community-based interventions given that they do not establish stable linkages with the population (for the design, launch, implementation and evaluation of interventions) as detailed in the explanation of indicator 1.

Table 3. Classification of community action for health interventions. Neighbourhoods in Barcelona with disposable household income of less than 90% of the average in 2013.

District	*Neighbourhood*	*Population*	*Household disposable income index*	Community action for health classification
	BARCELONA	1,614,090	100.0	
1	3. la Barceloneta	15,571	82.1	B
1	4. Sant Pere, Santa Caterina i la Ribera[10]	22,821	91.2	C
1	1. el Raval	49,225	60.3	B
3	11. el Poble Sec - AEI Parc de Montjuïc	41,060	71.0	B
3	14. la Font de la Guatlla	10,307	77.8	D
3	16. la Bordeta	18,449	71.4	D
3	15. Hostafrancs	15,894	77.2	D
3	17. Sants - Badal	24,344	76.6	D
3	18. Sants	41,104	82.6	D
3	12. la Marina del Prat Vermell - AEI Zona Franca	1,117	59.1	D
3	13. la Marina de Port	30,099	70.9	D
6	29. el Coll	7,170	83.1	D
7	34. Can Baró	8,916	74.2	D
7	33. el Baix Guinardó	25,676	83.6	D
7	37. el Carmel	32,181	54.4	B
7	38. la Teixonera	11,257	69.0	C
7	40. Montbau	5,134	71.5	C
7	39. Sant Genís dels Agudells	6,918	74.8	C
7	41. la Vall d'Hebron	5,543	87.7	C
7	42. la Clota	504	85.1	C
7	35. el Guinardó	35,790	86.4	D
7	43. Horta	26,543	83.1	C
8	46. el Turó de la Peira	15,307	51.6	C

[10] Despite having disposable household income in 2013 that was greater than 90% of the average, this neighbourhood has been selected given its slightly lower rate in the previous years. The disposable household income for previous years was (2008: 81.8), (2009: 91.2), (2010: 91.2), (2011: 81.6), (2012: 89.3).

District	*Neighbourhood*	*Population*	*Household disposable income index*	Community action for health classification
	BARCELONA	1,614,090	100.0	
8	47. Can Peguera	2,261	53.1	C
8	52. la Prosperitat	26,320	56.3	C
8	51. Verdun	12,296	55.6	C
8	45. Porta	24,442	61.3	C
8	48. la Guineueta	15,152	54.5	C
8	49. Canyelles	7,097	57.0	C
8	50. les Roquetes	15,836	50.4	A
8	56. Vallbona	1,330	41.7	B
8	55. Ciutat Meridiana	10,537	43.2	B
8	54. Torre Baró	2,201	44.7	B
8	53. la Trinitat Nova	7,533	38.5	B
8	44. Vilapicina i la Torre Llobeta	25,530	71.1	D
9	61. la Sagrera	28,827	74.3	C
9	63. Navas	21,792	75.4	C
9	62. el Congrés i els Indians	14,015	73.7	D
9	60. Sant Andreu	56,280	79.3	C
9	58. Baró de Viver	2,438	61.9	C
9	59. el Bon Pastor	12,734	71.8	C
9	57. la Trinitat Vella	10,418	53.5	C
10	68. el Poblenou	33,176	89.6	C
10	71. Provençals del Poblenou	20,158	76.1	D
10	70. el Besòs i el Maresme	23,202	53.0	B
10	64. el Camp de l'Arpa del Clot	38,035	76.5	C
10	65. el Clot	27,154	76.9	C
10	73. la Verneda i la Pau	29,103	56.1	C
10	72. Sant Martí de Provençals	26,040	66.2	C

Going beyond the immediate implications of the data, it is interesting to consider the distribution of the 49 neighbourhoods across the four different classification categories. Only one neighbourhood – Roquetes – classifies for the *strong community-based health promotion* category. This is a territory in which residents, organized entities and professionals build interventions that score on each of the indicators constructed for our study. Nine neighbourhoods classify for the *medium community-based health promotion* category, some of which (such as El Carmel) have also implemented some rich and meaningful interventions, such that they score on the majority of the indicators.

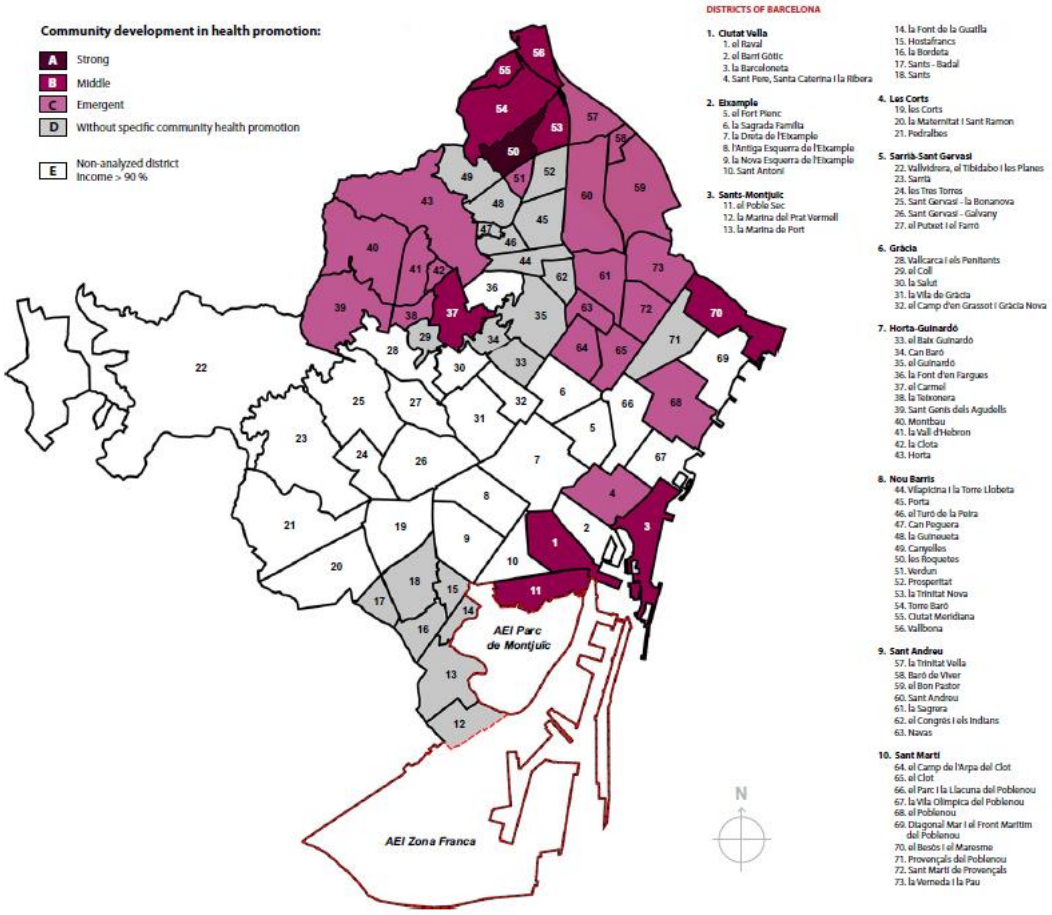
A little over 50% of the neighbourhoods under study have developed what we term *emerging community-based health promotion*. In total, 25 neighbourhoods adopt the community health approach in their professional interventions and projects. However, either these interventions have not resulted in significant changes at the institutional level, they do not involve participatory structures or a stable community health team, or they are not supported by comprehensive public policies in this area.

Finally, 14 neighbourhoods have implemented no specific community-based interventions in the field of health. This does not mean that these neighbourhoods do not conduct any community-based interventions in other fields, such as education or labour. Nor does it mean that they do not implement prevention or health promotion programs for their populations. It simply means that these activities and programs do not fall under the definition of community-based intervention that we establish for our study. In this sense, we do not view such activities as community-based interventions because they were not built through direct collaboration with the population. Here we reiterate that this does not necessarily mean that they do not promote interaction and exchange with the population or that these interventions cannot be considered a first step towards a community perspective that could, at some point in the future, become a community-based health program.

In short, although neighbourhoods with highly relevant community action for health represent less than 20% of the total, these are cases that demonstrate (at least partially) the consolidation of this type of intervention in the city of Barcelona. This perspective has great potential for growth if we consider that, in addition, more than half of the neighbourhoods show some incipient shift towards community health.

In order to visually analyse the territorial distribution of community action for health, we have prepared the following map of the city of Barcelona showing the results of our study.

Fig. 1 Map of community action for health



The map allows us to analyse the territorial nature of these types of intervention. Three zones can be identified where a community health approach is more notably present. First, we see the neighbourhoods in the far north of the city, which belong to the Nou Barris district. In this group we could also include El Carmel, which shares certain characteristics with the neighbourhoods of this area. A second zone with a significant presence of community action for health includes the neighbourhoods of the historical centre of the city, which belong to the Ciutat Vella district.

Finally, we highlight the zone that reaches the Besos River, where one neighbourhood with significant experiences of community-based health promotions is located (Besòs-Maresme), but above all where neighbourhoods with emerging community action for health are concentrated. This suggests that this particular zone is one with significant potential for the development of these types of intervention.

Together, these same neighbourhoods have recently been singled out as those with some of the worst performance on health indicators and health determinants following the application of the Urban Heart Equity Assessment and Response Tool (Urban HEART),

developed by the World Health Organization and used in the annual report on the health of the city (Barcelona Public Health Agency 2015)

6. Conclusion

Social welfare systems face major challenges, particularly in contexts of social transformation, austerity and growing inequalities. In such contexts, calls for public sector reforms are multiple and community action for health is presented as an innovative practice. While such practices have been developed to a certain extent, critical analysis and evaluations of their outcomes are limited. Research in this field is still scarce, as are instruments for measuring the development of community action for health and analysing its effectiveness in city neighbourhoods. This paper contributes to fill this gap in two ways. On the one hand, it contributes to theory by developing and applying an analytical approach and methodological tool, and it does so following a replicable design. On the other hand, it generates knowledge useful for policymaking.

First, this article proposes an analytical conceptualization of community action for health, which contributes to avoiding the acritical reproduction of concepts such as community action or community health. This is methodologically useful at a time in which calls for citizen participation and community action as innovative practices abound.

Second, this article creates and applies an index of community action for health. This contribution is, on the one hand, methodologically valuable as the concept of community-based health intervention is operationalized through four indicators based on a replicable design. These indicators are linked to the type of activities conducted in areas of community health, citizen participation, professional health structures and public urban health policies.

Third, after constructing this index, the article applies it to the case of Barcelona. This exercise allows us to build a typology indicating the level of development of community action for health interventions in the neighbourhoods of the city and, therefore, generating new and important knowledge. The analysis of the Barcelona case illustrates that community-based health interventions are extensive within the city, but are developed unequally across the neighbours of the city. Isolated neighbourhood interventions converge in their content and form, creating zones where (i) community health interventions are strong, (ii) the potential for community health interventions is strong, and (iii) the community health approach has not yet been developed.

These contributions provide an understanding and determination of the differences between standard prevention and/or health promotion activities and community-based interventions in this sphere (including venues for joint work and activities that directly collaborate with the population in the definition and implementation of interventions). It also allows us to identify factors that promote the spread of community health interventions. On the one hand, we see the co-development of interventions with the

social network of the neighbourhood, resulting in activities designed or verified with the population that are implemented in a stable and regular manner over time. On the other hand, we see interventions that involve organizational and institutional transformation of the health and social protection systems, and that benefit from greater continuity in terms of their community action as they are embedded in the approach and methods employed by the health teams and service providers involved. Simultaneously, other factors play a role in stimulating community-based health promotion, including the existence of stable participatory structures (such as community development plans) that drive community-based interventions with teams who work specifically on community health. Finally, we must mention the importance of rehabilitation policies in disadvantaged neighbourhoods that incorporate the community health approach and favour the confluence of community initiatives and activities that already exist in those neighbourhoods.

Ultimately, we conclude that community action for health has great potential as a response to the need for change in terms of the relationship between the public sector (health) and the citizenry, especially in a context of social transformation, inequality and challenges to the legitimacy and sustainability of the health system and social protection in general.

Undoubtedly, the limitations of this article's findings are many, given that it analyses the development of community action for health in a general manner across a wide range of neighbourhoods without detailing the impact on the neighbourhoods' interventional models or the health of their residents. However, at the same time, these limitations allow us to identify new research questions for the field of community action, health and public policy. We must consider, firstly, what impact community development has on the evolution of certain health indicators in the various territories or neighbourhoods. Evaluations of such impacts are still lacking. In addition, it becomes clear that in-depth case studies of the neighbourhoods are required, which would allow us to explain the different ways in which community action for health has developed in each, as well as the key factors that facilitate or hinder that development and the related institutional changes that are possible.

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