Facilitators and challenges of community action for health. Comparative analysis of four case studies in neighborhoods of Barcelona

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Abstract

In a context of welfare austerity and growing inequalities many voices ask for public sector reforms in the health sector and for community action as a relevant practice. However, analyses of community action for health are still limited to single actions. For this reason, this paper analyzes community action for health as a whole process of a public intervention in the neighbourhood context, including multiple actors and actions. Based on research on four disadvantaged districts in Barcelona, we develop and apply an analytical tool that allows to identify facilitators and challenges of community action for health on three dimensions of policy: symbolic (why), substantive (what) and operational (how). In this regard, several factors emerge as key ones: generating a shared discourse on health and its assets, developing a common and transversal agenda, ensuring institutional recognition and improving participation and involvement at all times of the different agents.

Keywords: Community action, Public policy, Health, Inequalities, Barcelona

Introduction

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 beyond individuals themselves, with elements of our immediate surroundings (family, school, work) and broader environments (macroeconomic conditions, public policies, etc.) playing key roles in determining our health and driving health inequalities (Dalghren and Whitehead 1991; World Health Organization 1998). Consistent with this conception of health, one of the strategies adopted in public policies has been the development of community action programs.

Community action for health (CAH) drives change in community health through the implementation of interventions by various actors and with the participation of the community itself (Fuertes et al. 2012). CAH goes beyond the provision of healthcare, emphasizing instead the relational dimensions of health and optimizing related opportunities. Based on participation and multi-sectoral cooperation, CAH considers the members of communities themselves the important players in transferring knowledge and controlling health determinants. This approach links population participation to health improvements, but also to the sustainability of the health system, the decentralization and optimization of resources, improvement in healthcare quality and the transversality of public policies.

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 analysis of community health programs persist, and effective instruments are still required in order to advance these efforts (Gervits and Anderson 2014; Renedo et al. 2015; Cahuas, Wakefield and Peng 2015; Wood 2016). Most experiences of CAH have been analysed focusing on the results of single actions or activities and less as a broad process with the interventions of multiple actors at the neighbourhood level. That is to say, we consider particularly relevant to analyze the way in which CAH is developed as a collective process, what factors facilitate this process and what factors pose challenges to their implementation at the neighbourhood level. Specifically, the paper aims to answer: How is the CAH developed at the neighbourhood level? What are the main factors that facilitate or hinder the development of CAH?

This article is based on the results of a research project on CAH in the city of Barcelona, where we can see that the need to advance in the analysis of CAH is not only evident in the academic field, but also among public services and community agents (Barcelona City Council 2014). On the one hand, 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). On the other hand, CAH aims to address those social determinants and inequalities, also in Barcelona including particular public policies at the neighbourhood level[1]. Moreover, CAH has a growing importance for comprehensive reforms that are being discussed in advanced healthcare systems. These reforms

[1] See next section for details.

are strategically focused on changing the organization of healthcare services including citizen involvement.

Considering all these reasons, from an analytical point of view, we decided to adopt a public policy analysis approach, which facilitates to stress the link between CAH processes at the neighbourhood level and public programmes. We adopt the analytical approach of Gomà and Subirats (1998) because of several reasons. This multidimensional theoretical model has been widely applied to numerous empirical analyses in diverse policy sectors, providing insights in the explanation of policy formulation and implementation (Leon 2002, Genieys et al 2004, Della Porta 2007, Knoepfel et al 2015 among others). Moreover, the authors define three dimensions for analysing a public policy -symbolic, substantive and operational-, which allows us to develop and apply a tool for the analysis of facilitators and challenges of CAH[2]. Finally, it is important to highlight that we do not focus on outcome measures in terms of health indicators, that is, we do not address the question of the impact of community health action on the population's health, mainly because in the case of Barcelona, the available information on health indicators is insufficient to obtain representativeness at the scale of specific neighbourhoods (Palencia et al 2017).

After this introduction, the paper is structured as follows. We begin by presenting and justifying the methodology of the study on which this article is based. Next, we develop an analytical framework of CAH, to enable the identification of facilitators and challenges of this type of intervention. Then, we present the results of the comparative analysis of four case studies in neighbourhoods of Barcelona, identifying the factors that facilitate or hinder CAH. The article concludes by underlining its key contributions to the literature and raising new research issues.

[2] See the analytical framework section for details.

Justification of case selection and methodology

Barcelona is a relevant case when analyzing CAH. A wide range of community health promotion experiences has 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*[3]) (Sierra et al. 2008; Pasarín et al. 2010).

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. It is important to note that community-based health promotion has mainly taken place in neighbourhoods of low socioeconomic status, and has been largely non-existent in neighbourhoods of higher socioeconomic status.

As such, the methodology of the study behind this article was based on a comparison of four neighbourhood cases with disposable household income of less than 70% of the average for the city of Barcelona[4]: Carmel, Roquetes, Zona Nord and Poble Sec. Why particularly these four neighbourhoods? These are neighbourhoods of Barcelona where a high degree of development of CAH is detected. To do this, we rely on the results of the application of a measurement index of the CAH, a methodological and analytical instrument built within the framework of this research project (author 2017).

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

[4] 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.

The information analyzed in the case studies was collected through different techniques: reports of economic and social context of the territory, documentation of the community programs, direct observations of activities in each neighbourhood and 32 semi-structured interviews, covering diverse and complementary profiles of key informants (health, social, educational and cultural professionals, community mobilizers, members of non profit organizations and residents). The selection of interviewees was done following the technique of snowball sampling, where key informants helped to identify others directly involved in CAH processes. We also applied heterogeneity criteria to include neighbours' residents not directly involved in the promotion of CAH among the interviewees. The sample size of interviewees was finally defined by data saturation, regarding the three dimensions and key factors of CAH[5]. How did we proceed with the analysis? The same categories were used in the content analyses we developed, triangulating interviews alongside other data sources previously mentioned.

From the design itself, the research project was developed by a team composed of people dedicated not only to research, but also to the daily deployment of CAH. This team has worked together on the contrast, modification and validation of the methodological tools, in the discussion and interpretation of the results, and, finally, in the communication of these results. This process has proved very useful in ensuring not only methodological and analytical rigor but also adequacy and consistency with community practice.

Analytical framework

This section has two objectives. On the one hand, we define the key concepts of this paper: the social determinants of health, the inequalities in this area and the role of community action. On the other hand, we present the model of analysis of CAH.

[5] See the next section for details on the three dimensions.

Social determinants, inequalities and community action for health

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).

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 (Karanikolos et al. 2013). 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).

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) and decentralization and amalgamation of health and social care (Saltman et al. 2007). However, such reforms often focused on organizational aspects of the system (Parker and Galsby 2008) and a consultative approach, replay divisions between professionals and communities (Martin 2008, Renedo et al 2015). These reforms are limited in their capacity to provide comprehensive answers to complex problems in the area of health. Thus, it is essential to approach these problems in a transversal manner, recognizing the interdependence between the administration and the citizenry and analysing initiatives in which citizens play a role in the management of public and community health matters.

However, the emphasis on 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.

Policy dimensions of community action for health

As we explained above, the CAH may be promoted by public administrations as well as by citizens with activity in the territory, whether in the form of an association or not. In the study of CAH, we can apply the analytic model of the public policy dimensions: symbolic-discursive, substantive-thematic and operational-processual (Gomà and Subirats 1998). We define in detail the aspects that should be taken into account when analyzing these three dimensions of CAH.

Symbolic dimension

In the first place, we refer to the "why" of the CAH (symbolic dimension) as the public problem, values and ideas that would be motivating the intervention. Community is a contested concept in community development and the ubiquity of the concept of community poses challenges for consensus building (Purcell, 2006). That is why, if we analyze CAH facilitators and challenges, it is key to pay attention to the existence or not of a shared discourse in the community.

On the one hand, special attention should be given to the conception of health present in the community. 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). 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 (and determinants) 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, Reijneveld 2017).

On the other hand, a second fundamental aspect in the symbolic dimension of the CAH is the degree of recognition of assets for health within the community. The concept of assets for health refers to those strengths and capacities of the people who form a community (Kretzmann and McKnight 1993) to improve health and reduce inequalities in this field (Morgan and Ziglio 2007, Cofiño et al 2016). The greater or lesser shared recognition of these assets in a community is a key factor for the development of CAH.

Substantive dimension

Secondly, we are talking about the "what" of public policy, that is, of the specific content of CAH (substantive dimension). This dimension allows us to analyze two important aspects.

On the one hand, this dimension refers to the agenda of CAH, that is, the type of actions that are developed, which we classify according to their nature and to the type of issues addressed (Poland, Krupa and McCall 2009, Reijneveld 2017). Regarding the nature of actions developed, the classification is based on the agreements of the Alma ATA Conference of 1978, which allowed progress beyond biomedical and curative (rehabilitation oriented) models by defining two other models of care: promotion and prevention. With regard to the issues addressed, we pay particular attention to the fact that the participation of the population in the structures for promoting community action is understood as a key issue in the intervention agenda. In addition, we consider aspects such as healthy habits and protective factors of health, and welfare promoters as vitally important.

In short, a common agenda is critical for engagement and intentional collective impact. Creating a community agenda, including a theory of program change, serves as a uniting force (Wood 2016).

On the other hand, the substantive dimension is also related to the resources devoted to CAH (Poland, Krupa and McCall 2009, Cahuas, Wakefield and Peng 2015). We analysed three key issues in this regard: the type of resources available (monetary, in kind, human), their recognition by the institutions involved (as well as the degree of specific dedication to CAH) and, finally, the stability and continuity over time of these resources.

Operational dimension

We refer to the "how" dimension of public policies as to how interventions are managed (processes dimension), on the bases of the interaction between the different agents when doing CAH. Some CAH 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). In this regard, it is necessary to pay particular attention to three key aspects.

First, the kind of participatory structures in the field of health that foster collaborative interaction between population and public services (Rydin et al. 2012, Rebollo 2012). These CAH structures can be integrated into other structures of a wider territorial character (for the whole neighbourhood) or can work separately. This is key to understanding the integration of healthcare with areas such as social care or education (Reijnevald 2014, Humphries 2015).

Secondly, it is necessary to analyze diversity in relation to the participation of community agents in the structures of promotion and organization of the CAH (Poland, Krupa and McCall 2009, Renedo et al 2015). We propose three possibilities to take into account in the analysis.

The first, with the presence of three types of agents: public services, non profit organizations and users or non-associated residents. The second, with the presence of two of the actors (public services and non profit organizations) in a similar number. And the third, with the exclusive or almost majority presence of a typology of agents (mostly, public services). In this regard, one of the key issues for the analysis of the whole public participation mechanism is political inequality (Fiorina 1999, Fung 2006, Martin 2008 among others). In our research, we decided to address this issue by prioritizing the analysis of the diversity of community agents involved in the structures of promotion and organization of the CAH.

Finally, a third key element is the level of participation and involvement of community agents in the activities that drive the CAH (Sharek et al. 2013, Franklin et al 2015). In our research, we defined two scenarios, which establish two extremes between which it is possible to locate the initiatives. The first is a low level of participation, where leadership relies chiefly on those agents (mostly professionals) who promote specific community health activities. The second, of high participation, where leadership and decision making incorporates numerous and diverse agents, beyond those that drive specific activities and beyond professional agents.

After introducing the key factors of the three dimensions of CAH (symbolic, substantive and operational), we synthesize these factors in Table 1.

Table 1. Key factors of the symbolic, substantive and operational dimensions of the CAH

Dimensions	Key Factors
Symbolic dimension	Conception of the health status that the community has and the role given to the different agents and factors in the promotion of health (assets)
Substantive dimension	Agenda of the CAH: types of action developed, according to their nature (promotional, preventive or rehabilitating) and issues addressed
	Resources available to CAH: type (monetary, in kind, human), degree of institutional recognition and sustainability
Operative dimension	Structure and leadership of the CAH: type of participatory structure that drives the interaction between public services and population
	Diversity of community agents involved in the structures that drive the CAH
	Level of involvement of community agents in the activities that drive the CAH

Case analysis

This section is divided into two sub-sections. In the first, the general characteristics of the studied districts and of the CAH developed in each of them are presented. In the second, the key aspects of this type of intervention in the four districts are analyzed comparatively, identifying strengths and challenges of the CAH.

General presentation of neighbourhoods and community action for health

The set of districts analyzed here have, as a general characteristic, a social composition by popular classes, a rate of migratory flows from inside and outside the Spanish state higher than the average in Barcelona, indices of higher education levels inferior to the average of the city

and worse health indicators than the city average. We present below the main indicators that reflect these aspects, comparing them with the average of the city of Barcelona.

Table 2: key indicators of the neighbourhoods studied

Indicators by neighbourhoods	Poble Sec	Carmel	Roquetes	Zona Nord			Barcelona
				Torre Baro	Vall Bona	Ciutat Meridiana	
Population	40,217	31,498	15,523	2,828	1,351	10,156	1,609,550
Density (hab / Km2)	8,881	33,437	24,179	1,600	2,259	28,608	15,755
Population born in the rest of Spain (%)	15	29.9	24.7	20.8	23.4	22.9	18.2
Population born abroad	37.5	18.2	25.7	20.8	15.9	37.3	22.3
Higher education graduates (%)	23.5	11.0	7.3	23.0	7.7	5.7	29.4
Available family income (average = 100)	66.3	56.6	50.8	45.6	39.9	39.2	100
Unemployment rate (%)	11.1	11.7	13.2	18.8	13.8	17.3	9.7
Life expectancy at birth (2009-2013)	82.6	83.4	81.4	75.2	83.0	83.0	83.4
Ratio of potential years of life lost (2009-2013) *	106.9	122.7	138.8	326.3	134.0	131.0	100
Adolescent fertility rate (2010-2014)	12.8	16	37.4	44.4	66.0	29.20	8.6
Prevalence underweight at birth (2010-2014)	6.6	9.2	8.7	15.6	7.8	7.6	7.4

* Ratio between premature mortality rates (dead between 1 and 70 years), standardized by age, the neighbourhood and the whole of Barcelona. With index 100 for Barcelona as a whole.

Source: *Own elaboration based on Barcelona Public Health Agency (2015)*

The neighbourhood of Carmel

The district of Carmel is located in the north-central part of Barcelona, on the hill of the same name. Its orography is complex and its urbanism disordered, with significant gradients and slopes, and with considerable difficulties of internal mobility. Like many other neighbourhoods

on the periphery of Barcelona, many of its public services and facilities are the fruit of neighbourhood struggles and demands.

In relation to the evolution of the CAH we can speak of a double process of construction that converges towards the first decade of this century. On the one hand, in the early 1990s the Carmel Primary Health Care Center (CAP) was built. Its professionals had training in family and community medicine, and from the beginning they had the intention of collaborating with the actors of the neighbourhood. Initially, this will was unsuccessful, but progressively the professionals were applying the APOC (Community Oriented Primary Care) orientation, proposed by Gofín i Gofín (2010).

In parallel, since 1997, a group of associations that worked with vulnerable groups in the neighbourhood, promoted a Community Development Plan (CDP)[6]. A participatory diagnosis was made and training oriented to professionals of public services of the territory was promoted. Thus, prevention actions and promotion of health involving the community began to be put together, also in the promotion of actions.

The neighbourhood of Poble Sec

The district of Poble Sec is located between the Montjuïc mountain and the Raval district of Barcelona, and combines a highly populated area with a protected forest area.

Poble Sec was a welcoming neighbourhood of working-class people. Nowadays, due to its centrality, it is a neighbourhood that attracts tourism and restaurants and leisure facilities. The typology of housing and urban planning in Poble Sec is diverse, with areas where buildings are concentrated, most have no lift and have deficient accessibility.

[6] Plan of action in one or several neighbourhoods that propose a process of dynamization and organization of the community (residents, organized neighbours, public services). Its aim is to address the problems identified jointly and to promote actions that search improvement of the quality of life of the population. It is financed by the Government of Catalonia and by the different municipalities.

Poble Sec has been, and is, a neighbourhood with a rich associative fabric. CAH are developed centrally from the Health Commission of the CDP of Poble Sec, started in 2005 by one of these platforms of non profit organizations with the support of public administration. Subsequently, as of 2009, the CDP is one of the main engines for the deployment of the *Health in the Neighbourhoods* program.

The neighbourhood of Roquetes

The neighbourhood of Roquetes is located in the Northeast end of the city of Barcelona, delimited by two big avenues and by the mountain. In relation to its historical, urban and housing characteristics, it is very similar to the Carmel neighbourhood: a neighbourhood built on the mountain, with a history of neighbourhood struggles, with internal mobility difficulties and with a significant quantity of self-built housing.

The social and community fabric of the neighbourhood has a solid foundation. It has a consolidated CDP since 2003 and a model of community management of public facilities, which is a benchmark for the whole city.

The origin of the CAH in Roquetes comes from the 1980s, when a neighbourhood group demanded the construction of the Primary Care Center (CAP). In 2003, the beginning of the CDP and the elaboration of the health diagnosis of the neighbourhood by the CAP coincided in Roquetes, starting with the creation of an APOC professional commission. From this moment, the CDP is the backbone of CAH, including the deployment of the *Health in the Neighbourhoods* program.

The neighbourhoods of the Zona Nord

There are three neighbourhoods in the Zona Nord: Ciutat Meridiana, Torre Baró and Vallbona. It is a territory with a complex location at one end of the city marked by the slopes of the

Collserola mountain, the access motorways to Barcelona and railway infrastructures. In relation to their housing stock, Ciutat Meridiana is a neighbourhood of low-quality high-rise buildings, 60% without a lift: while Torre Baró and Vallbona are neighbourhoods where self-construction and some social housing predominate.

The Zona Nord, like other parts of the city, has had a historical deficit of services and infrastructures. Although improvements have been made in recent years, there is a sense among the neighbourhood of abandonment by the administration. In terms of social relations, the identity of the neighbourhood is marked by these historical deficits linked to the urban peripheries, but also by the feeling of protest.

The mobility of the population and its impact on coexistence is one of the characteristics. Particularly in Ciutat Meridiana, real estate speculation prior to the economic crisis of 2008 led to a process of population substitution. In the context of the crisis, as of 2008, many of low-socio-economic families, largely from non-EU countries, were unable to pay their mortgages and suffered eviction proceedings.

In the Zona Nord, since 2000, there have been different attempts to promote community development plans. Many of these failed because of disagreements between organizations in the territory and with the administration. A CDP and an Intercultural Community Intervention Program are currently active and are working with difficulties in involving the population of the neighbourhoods. In spite of the existence of some specific actions in the field of community health, the most stable articulation in this area is given as of 2009 with the implementation of the *Health in the Neighbourhoods* program.

Comparative analysis of the key aspects of CAH in the four districts

To begin with, we summarize in Table 3 the general results about how the CAH is developed in each of the four districts analyzed. We apply the analytic model of three dimensions of policy (symbolic, substantive and operational) that we built for the study of CAH interventions.

SEE TABLE 3 IN THE ANNEX

Next, we compare the four case studies through the lenses of the same question: what are the main factors that facilitate or hinder the development of CAH? We follow the three policy dimensions model to provide an answer.

Symbolic dimension

As we have explained in the analytical framework, the symbolic dimension refers to the conception of health and the role that is assigned to the different agents in its promotion. A central aspect in this regard is the degree of recognition of health assets within the community. In the first place, it should be mentioned that most (but not all) of the neighbourhoods share a conception of health that incorporates the community dimension. The relational elements, linked to a great extent to the territory and the social agents, are considered assets in health.

However, the degree to which the districts incorporate this discourse is different. In Carmel and Roquetes, the social determinants of health are at the core of the discourse. In Roquetes, there is a common discourse of all the actors: "Clearly, we move from the assistance healthcare vision to a community vision of health, where all agents must be participants through non-hierarchical forms of work" (interview to a community plan member). In Carmel, the construction of this shared discourse is an explicit goal: "Unconsciously, people know that everything affects health in some way or another. Now, uncovering it and making everyone

aware of it is something else. Through the projects we do, people have been relating this" (interview to a community plan member).

In Poble Sec, the accent falls on the idea of responsibility for health of both individuals and structural factors: "There is a historical change happening, the appearance in the media of the social dimension of health, of the inequalities. This makes it easier for the people in the territory to care about it" (interview to a community health professional).

Finally, in the Zona Nord, the discourse of community health is not fully developed, with important differences depending on the profile of the interviewees. Thus, professionals express an appreciation of community action as a strategy that adapts to new conceptions of health and the influence of social determinants. In contrast, neighbourhood organizations and residents consulted, although they value community action, perceive the field of health as an area of expertise and responsibility of the public sector. In this discourse, the community would have little to contribute: "Health is something that has to be resolved by the administration, because the neighbours do not know about these issues and cannot help to solve them" (interview to a member of a Zona Nord organization).

In short, the analysis of the symbolic dimension shows that CAH seeks to intervene upon the social determinants of health, but not always to the same degree. In this regard, the concepts of health and community adopted in each territory are key factors. In those territories where the conception of health includes the community dimension, and where the discourse of social determinants of health and asset-based health is more widespread, CAH is found to be consolidated. On the other hand, in those territories where the discourse on the capacities of the community to improve health and reduce social inequalities is still beginning, there are more difficulties for the development of CAH (see Table 4 at the end of this section).

Substantive dimension

This dimension refers to the agenda of CAH, that is, the type of action that is developed (promotional, preventive or rehabilitative) and the type of issue addressed. On the other hand, this dimension is also related to the resources devoted to CAH.

Thus, as far as the agenda is concerned, all neighbourhoods show consistency between community diagnoses and deployed actions. There are shared themes, such as the promotion of healthy habits and the autonomy of individuals and groups. Another key factor is the capacity to integrate different levels of intervention on the same agenda (promotion, prevention and, in some cases, treatment). Beyond these aspects, it is necessary to analyze the extent to which citizen participation is included in the CAH agenda for each territory, and is therefore considered a key factor in the promotion of health. The evidence gathered indicates that participation is an element that is found differently in the CAH agenda of the neighbourhoods studied.

In the neighbourhood of Roquetes, the construction of a care network supported by the collective work of different agents of the neighbourhood is an explicit element in the CAH agenda: "The issue of participation is vital in all the actions we do, so we may transcend formal institutions, because our social fabric nourishes and nourishes itself with CAH" (interview to a community plan member).

In the case of Zona Nord, the actions that are developed are more focused on health-disease issues and not on participation as a relevant component. From the perspective of the actors consulted, this situation is seen as a weakness, which demonstrates the critical capacity of their own work: "We are clear that participation should be part of the work agenda, but it has not been easy because most of the actors do not bear in mind the idea that participation is also a protective factor in health" (interview to a community health professional).

For its part, both the CAH of the neighbourhood of Poble Sec and of Carmel include in their agenda the promotion of the autonomy of people and communities. In Carmel, an in-house digital communication medium (called Lita News) has been created with the aim of generating a health asset for the community: "The good thing we see in the Lita News is that it can be a platform to begin to raise awareness of health from a broader perspective and that it can function autonomously" (interview to a community plan member).

With regard to the origin and sustainability of resources, all neighbourhoods have a variety of sources, although most of these come from public administrations. While economic sustainability seems to stand out as a strength, diversity of sources is still a challenge. Beyond this, all neighbourhoods have hours of professionals and volunteers and/or activists explicitly dedicated to CAH. Although public institutions formally recognize the dedication to the CAH, there still exists, among some professionals, the perception that community health work has a voluntary component.

To sum up, regarding the substantive dimension of CAH, on the one hand, coherence is detected between diagnostics and deployed actions, but again with some differences between territories. We confirm the importance of a common agenda to drive collective action and to multiply its impact. A key element in this regard is the different space that citizen participation occupies on the agenda of the CAH of each territory. Participation could be a mere tool to address sanitary issues, or could also be a goal in a broader strategy for building a healthy neighbourhood.

On the other hand, our work confirms and broadens the knowledge about the importance of resources devoted to CAH. In this regard, flexibility to make the most of each neighbourhood resources and institutional recognition are key elements to facilitate CAH. Moreover, economic resources are not only a necessary factor for the development of CAH, but also a challenge if they come mainly from public administrations (see Table 4 at the end of this section).

Operational dimension

This dimension, which allows us to analyze the "how" of community action, refers to three key elements: the type of structure promoted by the CAH, the diversity of agents involved in these structures and, finally, the level of involvement of these agents.

With regard to the structure of the CAH, all the neighbourhoods have a specific space to promote this type of intervention. But we detected two types of structure. In the districts of Carmel, Poble Sec and Roquetes, the CAH is integrated into a broad territorial structure (generally within the framework of the Community Development Plan). In the Zona Nord, the CAH is developed through a structure (motor group) created by the same public administrations that drive health activities. Each of these models presents challenges. In neighbourhoods like Roquetes, a key challenge is to make the structure of the CAH impulse more visible among the residents. In the Zona Nord, the most important challenge is to improve participatory planning and evaluation tools.

In relation to the degree of diversity of the agents that drive the CAH, the districts agree on incorporating, above all, professionals from public administrations and community development plans. Members of neighbourhood and third sector organizations also participate, although not in all neighbourhoods. A shared challenge between Carmel, Zona Nord and Poble Sec is the incorporation (in leadership structures) of neighbours not associated with entities.

In relation to the levels of participation of the different agents, each neighbourhood presents particularities. In the case of Roquetes, there is participation of agents of the public administration, non profit organizations and neighbours in the design, execution and evaluation of the activities. This operational strength is consistent with the symbolic and substantive dimensions of the CAH in the neighbourhood of Roquetes.

In the case of Zona Nord, those who participate in the promotion of the CAH are the professionals of the health motor group. Residents in the neighbourhood participate as beneficiaries of the activities, and to a lesser extent consultatively in the preparation of the health diagnosis and satisfaction assessment. There is however recognition that the participation of residents is a challenge to work on: "We need to retake the essence of the community, not as it is happening at the moment, where we drive everything from the technical field" (interview to a community health professional).

In the neighbourhood of Poble Sec, a powerful leadership is identified by the community mobilizer, a key figure in the CDP. This figure represents one of the main challenges of the CAH methodology, since it is at the same time a member of the community and an expert professional with a technical position: "The relational dimension is basic. I am a person with a first name and last name, but I am also the institution, the public administration" (interview to a community health professional and member of the community plan).

Finally, in the neighbourhood of Carmel, an important leadership of the team of the CDP is detected, which is managed by the citizen organization Carmel Amunt. The CDP is the joint work space between public service professionals and non profit organizations, but also has spaces for deliberation and decision open to the rest of the community. For its part, the role of the primary health care centre is complementary to the activity of the CDP, since it promotes and generates health assets with its own users, and then transfers them to the rest of the community through the CDP.

In short, the analysis of the operational dimension of CAH identified three key factors related to institutional organization and participation. First, CAH is favoured by the development of specific promotion structures, especially when they are integrated into broader territorial initiatives. The visibility of these structures in the neighbourhood, as well as the reduction of CAH to an institutional service offer, stand out as challenges.

Also, in terms of the operational dimension, our work confirms the importance of the diversity of agents participating in the promotion of CAH. The CAH is favoured in those neighbourhoods where we find three types of agents (public administrations, non profit organizations and neighbourhood), including different sectors (health, social, educational, cultural). The most important challenge is to improve equity in these CAH momentum structures, reinforcing the participation of non-associated residents.

A third key element of the operational dimension of CAH is the level of participation and involvement of community agents. The participation in the design, execution and evaluation of the activities facilitates the consolidation of CAH. The existence of strong leadership is compatible with the distribution of complementary roles among different agents involved in CAH. However, one element that hinders the development of CAH is the imbalance between the tasks of agents, even more so when the role of citizenship is limited to that of users of services.

To conclude this section and to help understanding, Table 4 summarizes the main findings of the article: elements that strengthen the CAH and those that pose challenges for its development.

Table 4. Strengths and challenges of CAH.

	Variables	STRENGTHS	CHALLENGES
Symbolic dimension	**Conception of health and its assets**	Shared discourse on health: Community dimension, social determinants of health and asset-based health	Discourse that does not recognize community capacity to improve health and reduce inequalities
Substantive dimension	**Agenda (type of action and issue)**	- Diagnostic-activity coherence - Common agenda, which includes active role of citizenship	-Absence of concrete measures to address health inequalities - Secondary place of citizen participation
	Resources (origin, sustainability)	Specific hours of professionals and volunteers/activists	Little diversity in the origin of resources
Operational dimension	**Structure of the initiative**	Specific structures for CAH (generally integrated into broad territorial structures)	- Little visibility of structures for CAH in the neighbourhood - Reduction of the CAH to institutional supply
	Diversity of participating agents	Presence of three types of agents (public administrations, citizen organizations and neighbourhood) and of different sectors (health, social, educational, cultural)	Low presence of residents not associated with any organization
	Levels of involvement of agents	- Cross-cutting: design, implementation and evaluation of activities - Strong but complementary leadership	-Unbalance of tasks between agents -Participation of citizenship only as users of services

Conclusions

This article creates relevant knowledge to reduce the gap in existing literature on CAH. The results of the analysis identify factors that facilitate and hinder the CAH, by applying the analytic categories of symbolic, substantive and operational policy dimensions.

All these previously analysed elements (see table 4) are conditioned by the characteristics of the environment or context where CAH is developed. The type of community we find is an element that determines how CAH is done. In certain territories, the community is active and cohesive, but in others we find a community weakened or practically nonexistent in CAH. In addition, communities are not permanent or stable, but diverse and changing. In this regard, a key aspect is the historical trajectory of the relationship between public administration and organized citizenship in each territory.

Thus, in answer to our research question, there is no single way to develop CAH as a recipe applicable to any case or context. On the contrary: the most appropriate type of CAH intervention will differ depending on the characteristics of each context and community. Therefore, we understand that our paper contributes to generate relevant knowledge about this process, since it develops and applies an analysis tool that allows to detect key factors ordered in three dimensions. There are several factors that will be relevant in defining the most appropriate form of CAH in each case (generation of a shared discourse on health and its assets, definition and selection of the type and content of the actions, leadership and involvement at all times of the different agents, etc.), and this framework for reflection and action is a useful transversal tool applicable to all cases. When it comes to developing a CAH public policy, recognizing these factors, and knowing the intervention environment, are key elements - especially, if we want to avoid healthcare reforms which replay divisions between professionals and communities.

Finally, a key aspect that has been a limitation for our research, but which also determines the practice of CAH, is the type of information available on these processes. The information available on CAH is conditioned by a health sector bias, prioritizing the information linked to the scope of the disease and much less to that of health (community).

This reduction from the field of health to that of healthcare sector is not limited to the generation of information. We have also seen this in certain interpretations of community health. The healthcare sector can undoubtedly be an engine of CAH (in fact, it is in some territories), but we understand that it should not be the only agent (nor the main agent) that drives these initiatives. The very conception of both community action and health indicates the contradiction that the health sector could be the leader of CAH. This does not imply the lack of recognition of the importance of the healthcare sector, nor the strict compartmentalization between health and disease. Rather, it points to the need to continue advancing in intersectorality and transversality when CAH is undertaken.

As a consequence of these elements, the need to systematically produce information and indicators that respond to the intersectoral and transversal logic of CAH is also evident. We speak of indicators, which we call "intermediaries", such as the development of networks or social capital of individuals and groups, collaboration between agents from different sectors, or aspects related to the physical/urban environment.

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ANNEX

Table 3. Characteristics of the CAH in the case studies.

	Variables	POBLE SEC	CARMEL	ZONA NORD	ROQUETES
Symbolic dimension	**Conception of health and its assets**	Community dimension: participation, responsibility, importance of relationships as a health asset	Broad vision: importance of social determinants, participation, empowerment, responsibility	The idea of community health and health assets still under development coexists with a traditional view of health	Shared vision on community health: social determinants, neighbourhood as an asset in health
Substantive dimension	**Agenda (type of action and issue)**	Actions aimed at raising awareness, promoting, preventing and supporting Promoting the autonomy of individuals and the community	Actions aimed at raising awareness, promoting, preventing and supporting Generation of groups as health assets (with autonomy)	Actions are oriented towards raising awareness, promotion, accompaniment and prevention Participation as a challenge, pending work	Raising awareness, promotion, prevention, treatment and rehabilitation actions. Participation as a transversal axis: reinforce a care network
	Resources (origin, sustainability)	Varied, but mainly originating in public administrations Specific hours of professionals and volunteers	Varied, but mainly originating in public administrations	Varied, but mainly originating in public administrations Specific hours of professionals	Varied, but mainly originating in public administrations and certain social organizations.

			Specific hours of professionals and volunteers		Specific hours of professionals and volunteers
Operational dimension	**Structure of the initiative**	CAH integrated in broad territorial structure (CDP)	CAH integrated in a broad territorial structure (CDP) and specifically in the CAP	CAH with sectoral structure (motor group) created by the public administration	CAH integrated into a broad territorial structure (Health Table led by the CDP)
	Diversity of participating agents	Above all public administrations and certain social organizations.	Above all public administrations and certain social organizations.	Mainly public administrations	Three types of agents (administrations, social organizations and neighbourhood)
	Levels of involvement of agents	Strong leadership of the community mobilizer, with diverse participation in diagnosis and evaluation	Strong leadership of the CDP team, complementary role of the CAP and diverse participation in diagnosis and evaluation	Leadership and development by the technical teams of the public administration (neighbourhood as users of services)	Active participation of administration and neighbourhood in the diagnosis, execution and evaluation.