Joining Forces to Live Together

Keys to the Intercultural Community Intervention Project

4 Health
"LA CAIXA" FOUNDATION. THE SPIRIT OF "LA CAIXA"
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Increasingly, the whole world and its individual countries (including Spain) are facing the formidable challenge of managing diversity in terms of culture, ethnic groups, origins, languages and religions. This is a challenge that not only affects each country in itself but also regions and towns, additionally implicating their institutions and organisations and each of their citizens.

One of "la Caixa" Foundation’s commitments since it was set up over a hundred years ago was to take a good look at new social realities and develop programmes for people, with a sense of anticipation and social transformation that can be used as a model for future actions. This vocation paved the way for the Intercultural Community Intervention Project.

Since 2010, the ICI Project has been developed in 17 territories with high cultural diversity, proposing a model for social intervention and management of diversity focused on local communities taking centre stage, with an organised, effective and positive way of tackling the crucial challenge of living together and social cohesion. The ICI Project was extended to 40 territories in July 2014.

Without connections, it would be impossible to live together. Consequently, the ICI Project, along with local administrations and entities in the territory, promotes setting up programmes for meetings, connections and positive interaction between people with different cultural and religious origins and belongings, to ease social inclusion, equal opportunities, social cohesion and promote living together.

Joining forces is a basic yet innovative and transforming idea, involving political and institutional leaders, organisations working in the territory and citizens, prioritising joint-responsibility and shared commitment, focussing on living together. The ICI Project is promoting living together from this joint endeavour and aims to improve the standard of living within a territory.

Its work over the last four years has involved over 1800 professionals, including participation from over 280,000 people. The remarkable results and impacts obtained in terms of improving living together* and social policies in the intervention territories have emphasised that it is possible to adapt the ICI Project’s conceptual and methodological model to different types of territories with diverse socio-demographics.

* 2012 survey on local intercultural living together
Joining Forces to Live Together Collection. The Intercultural Community Intervention summarises the work carried out over the first three years of the intervention. Based on feedback between theory and practice, this work stems from building knowledge among the people who have participated actively in the process, making it available to any persons or institutions interested in developing policies to promote living together and social cohesion.

"la Caixa" Foundation is grateful for the collaboration and invaluable contribution of the experience, knowledge and political intention from all persons, entities and institutions that have taken part in the Intercultural Community Intervention Project.
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### 6. Glossary
Presentation

A theoretical-practical collective work, working from a joint project targeting community praxis

This series of books summarises the experience, achievements, limitations and learning obtained during the first stage of the Intercultural Community Intervention Project, meaning the collective work for living together and intercultural citizenship and social cohesion carried out not by hundreds, but thousands of people in 17 local territories in 15 towns in Spain between September 2010 and August 2013. Currently (I am writing this in November 2014), the ICI Project has been extended to 39 locations and this work is, among other things, a key contribution to be able to tackle new and complex challenges with a shared view and collective intelligence.

By presenting the Joining Forces to Live Together Collection, please allow me to begin by highlighting two deficiencies that are seen all too often in plans, policies, programmes and social projects. Much as I do not wish to get off on a negative foot, I consider that it will help to frame the nature and value of what the reader is about to tackle. I will focus on social intervention projects as this is the ICI Project’s main field.

First stumbling block: in social intervention projects, the knowledge dimension does not always play its rightful role. These initiatives suffer all too often from a lack of due scientific and conceptual grounding. From there, the degree of accuracy or success of this initiative will start to decline. When the theoretical and conceptual grounding fails or is lacking, the practical work for the project players does not consist of dynamic and dialectic practice, receiving feedback on creative symbiosis between thought and action, theory and practice, knowing and transforming. Practice, in short, becomes practicism.

Second stumbling block: all too often again in social intervention projects, once the project or some of its stages have been completed, the experience that it has represented (always complex, by definition) is not systematised and published, thereby wasting its accumulated wealth. In other words, the corresponding action is not duly accumulated among everyone involved. In addition, it seriously weakens possible forthcoming stages, even more so when this project is collective, community and public; this lack (when summarising the experience and spreading the word on what was learnt, results and impacts) represents not giving back to the social, professional and institutional players that made the project and the experience possible.
So then, these five volumes that are now being presented to the many different players in the ICI Project, as well as anyone who is interested in these relevant, decisive and pressing matters of living together and local cohesion, demonstrate the enormous relevance of collective and applied knowledge in this project on the one hand whilst representing a responsible exercise in systematising, publishing and giving back what has been done and learnt on the other.

Actually, these books, devoted respectively to focus, method, education, health and participation (merely using the keyword for each text) were written from knowledge on managing diversity, local development, immigration, minorities, community intervention, conflictology or mediation that were used to design this project, with as strict a grounding as possible, around 2009 to promote living together and validate the hypothesis of community and mediating work. However, and this is important, this reach and collective prior baggage was applied, validated (or not), adjusted and developed, working from the practice of 17 teams in 17 territories and the participation of institutional, professional and technical leaders, tens of organisations and thousands of citizens in these towns.

In this intervention process:

a. A database or control panel was configured to compile a wide variety of weekly, monthly and annual reports.

b. Listening and discussion sessions were organised.

c. Community monographs were drawn up as the key product of shared knowledge.

d. Surveys were run on living together in territories with high diversity in 2010 and 2012.

e. Multiple and constant discussions and contributions were recorded.

Without all of this, without this intensity of applied knowledge and reflection on practice, this work could not have been written.

And, to do the above, it was necessary to draw up (also in this elaboration phase) some systematisation axes that will combine drawing up and writing work for the texts. As the reader might appreciate, the different volumes are structured around four central questions that are the common thread to the corresponding chapters in each work:

1. How we approached the matter in the ICI Project, for example, the methodology from volume 2, the education work in volume 3, etc.

2. How we put it into practice, for example, promoting living together in volume 1, the specific community health line in volume 4, etc.
3. The specific achievements in this field or issue, for example, the results from the specific line of social relationships and participation in volume 5.

4. And finally, what has been learnt and what recommendations can be made for the second stage of the ICI Project, begun in September 2013.

The Joining Forces to Live Together Collection is a collective work both in terms of design and development.

In fact, developing each of the volumes has fallen, jointly, to the ICI Project advisers and the members of the Scientific Management team. However, it can be stated that this collective work has an even greater reach as it would not have been possible without the local experiences developed by the ICI Project intervention teams jointly with professionals, citizens and institutional representatives in each territory.

The general editing work was organised by a technical publication coordinator working closely with the ICI Project scientific director.

It has been far from easy, due to being written up over many months, among other things, when the ICI Project not only continued running with new activities and challenges but it was also being expanded. Nevertheless, we achieved it. We would like to thank everyone for your valuable contributions and also the "la Caixa" Foundation and particularly the Social Area and its team, as it is not only making this wide-ranging and innovative project possible but also distributing this work.

All that remains now is for the Joining Forces to Live Together Collection to serve its purpose: continue creating knowledge for action, giving back the experience to anyone who has made it possible and being useful to whoever we are committed to in the fight against exclusion and discrimination by means of promoting real cohabitation - not only coexistence - in local and diverse communities of citizens.

Carlos Giménez Romero

*Scientific Director of the Intercultural Community Intervention Project*
Translator’s Note

The translation of this work has been quite complex in terms of adaptation of certain concepts from Spanish into English, especially regarding the word 'convivencia'.

The difficulty arises from the general use of ‘pacific coexistence’ in English. However, this project wants to emphasize, as clearly as possible, the difference between the meaning of the concepts of ‘coexistence’ and ‘living together’.

‘Convivencia’ has been translated from the Spanish as ‘living together’ and occasionally more formally as ‘cohabitation’ in an attempt to express the concept of not only living in the same space or alongside each other but actually interacting with each other as well.

Having clarified this key difficulty, we are presenting other examples here of decisions which had to be made in order to adapt certain concepts within this work in the best possible way:

— Convivencia Ciudadana Intercultural: Living Together and Intercultural Citizenship
— Diagnóstico Comunitario: Community Assessment
— Espacios de Relación: Relationship Spaces
— Encuentros Comunitarios: Community Meetings
— Línea de Actuación Global (o Específica): Global (or Specific) Action Line
— Monografía Comunitaria: Community Monograph

We hope this translation is able to give English readers coherent access to the contents of this work and make positive contributions to challenging translations of relevant issues in this field of study: public policies and social intervention.
Introduction

1. Systematisation of an innovative social intervention experience
Joining Forces to Live Together Collection. The Intercultural Community Intervention comprises five volumes that systematise each of the dimensions in which the Intercultural Community Intervention Project experience has taken place during its first stage from 2010 to 2013.

Due to its new social intervention proposal that combines specific action lines (health, education, participation) with an overall backbone line for the whole ICI Project, and the enormous wealth and diversity of the actions carried out in 17 intervention territories, the systematisation of the first stage of the ICI Project was organised into five volumes that match each of its dimensions: living together and social cohesion, methodology, education, health and participation.

The ICI Project is an innovative proposal for social intervention and management of social and cultural diversity that is extending to new neighbourhoods, villages and cities all over Spain, validated by its good results and its impact on improving living together and social policies in the territories where it has been working.

For these reasons, after over three years of praxis, feedback between the theory and the practice and construction of shared knowledge by all people who have actively participated, the time has come to bring this knowledge to society to make it easier to transfer to other people, organisations and institutions that might be interested in setting up intercultural community processes for living together and social cohesion. Drawing up these five volumes is one way, among others, to make this transmission easier.

— Volume 1, *Living together and social cohesion*, tackles the theoretical focus and the purpose of the intercultural community intervention.
— Volume 2, *Methodology*, focuses on methodological development followed by implementation of intercultural community processes.
— Volume 3, *Education*, systematises what has been done from the specific line of education within the framework of the intercultural community process.
— Volume 4, *Health*, also tackles the specific line of health within the framework of the intercultural community process.
— Volume 5, *Participation*, finally, focuses its systematisation on citizen participation and how it relates to other players.
2. The first stage of the Intercultural Community Intervention Project

In 2010, on the initiative of “la Caixa” Foundation, the ICI Project adventure began in 17 local territories with intense social and cultural diversity, located in 8 regions. These territories varied in their sociodemographic features and locations: countryside, major cities, historical old towns, suburban areas, coastal zones or metropolitan areas.

A wide range of situations and contexts where the ICI Project has emphasised its flexibility and capacity for adaptation, being capable of obtaining considerable results in practically all territories thanks to active involvement from all players: public administrations, professional resources and citizens.

Developing the first stage (September 2010 - August 2013) made it possible to validate the working hypothesis in practice. Much of the success behind its implementation is due to combining the flexibility required by diversity in local contexts with the intervention’s unique focus and methodology, common to all 17 territories.

This combination of a unique focus and method with local action diversity was strengthened by the synergies established between the social entities responsible for implementation in each territory, working there for a long time, and the ICI Project Scientific Management (DECAF) from the Autonomous University of Madrid that trained, provided skills and carried out continuous monitoring of the intervention teams concerning the focus and methods for the intercultural community processes, using expert consultancy both in the general methodological approach and in specific action lines for health and education.

Another factor that has helped to explain the experience’s good results in its early stage was due to the combination of specific actions, in fields such as health and education, with the development of a global action line that provides a backbone and gives consistency to the intercultural community process.

These good results provide the basis for expanding this innovative, joint intervention model to another 23 territories in the second stage of the ICI Project, begun in September 2013. We understand a “model” not just as an something exemplary or untainted, but as a dynamic set of hypotheses validated by means of the articulating praxis of theory and practice. So then, in the second stage and as a consequence of validating the intervention model, the ICI Project has been extended to other local contexts, now spread over 11 regions plus Ceuta and increasing up to 32 engaged towns, all of which noticeably increases both the diversity and complexity of the ICI Project. The Joining Forces to Live Together Collection will constitute a useful instru-
ment to encourage transmission of learning extracted into new territories, as well as organisations and institutions interested in implementing similar processes.

3. The Intercultural Community Intervention Project proposal

The ICI Project proposal has consisted and consists of a really basic and yet innovative and transforming idea: joining forces (political and institutional leaders, professionals and technicians, organisations and citizens) on living together and social development of local communities (neighbourhoods, villages and cities) as joint-players in the community who share responsibility.

It’s that simple and, at the same time, that complicated. It seems like common sense to everyone and yet it does not usually happen in practice. Whilst the territories seem to have a wide variety of professional resources, NGOs, public services and associations working to solve the problems that affect the population, their enormous complexity and putting public and private resources into sectors make it extremely difficult to articulate them into common projects for living together and social development.

This is what the ICI Project proposal is all about, making it easier and supporting articulation of common projects where everyone fits in: administrations, technical-professional resources from the territory and citizens. All of them, taking centre stage in their own social development process to improve living together locally.

The intercultural community intervention has involved a transformation process in the local communities, facilitating a type of positive interaction between players that did not exist before. This process has generated relationship spaces which have mainly served to strengthen the local communities’ capabilities and opportunities to face challenges stemming from the economic recession and social and cultural diversity.

The intercultural community process has also eased communication, dialogue, collaboration and positive interaction between neighbours from different origins (foreign populations, gypsy populations, native populations), improving positive interactions, foreseeing conflicts and promoting living together in streets, squares and public spaces.

Joint work among so many people, groups, professionals and representatives from the different administrations is helping services and institutions adapt more successfully to the real needs of the population and its growing social and cultural diversity. This is particularly seen in two of the basic pillars of social welfare: health and education.
Maybe the most important achievement will be the qualitative leap involved in assuming that local issues should be dealt with fully and shared among all players. Naturally, that cannot always happen or cover all issues/problems that affect community life, but the process allows this to happen on major common and general matters that are directly related to effective living together and social cohesion. We think that no method is more effective and efficient to tackle issues and solve problems rooted in multiple causes and in the growing diversity, plurality and complexity of post-industrial societies.

The need to work together to tackle their community issues is usually a fairly widespread concern among professionals, members of social organisations and representatives from the administrations; however, in practice and in day to day work, time, method and the resources required to do this are usually in short supply. The ICI Project has helped to resolve these deficiencies, facilitating the conceptual focus, methodological development of the work and the necessary professional resources.

4. The Intercultural Community Intervention Project overall framework

The ICI Project has boosted collective and shared processes for transforming the social and institutional context to adapt it to diversity challenges and new social needs.

It has a clearly defined method, a flexible and adaptable road map, that has guided the entire process throughout its different phases, accompanied by a series of elements that have been used to promote, highlight and back its progress.

The ICI Process has made progress from day one in establishing collaborative relationships with and between technical-professionals, citizens and representatives from the administrations, to later back them through generating shared knowledge of the local reality and development of joint actions among the three key players.

This has thereby generated relationship spaces that have made it possible to articulate a new type of local community organisation. Participative research was carried out and its results encouraged the emergence of shared knowledge and drawing up community assessments. Action plans have been designed, working from the assessment, that we have called community programming to respond to community issues and the main problems and challenges that local communities are facing, thereby contributing to new approaches and a more appropriate articulation of social policies in the territory.

This whole process has been supported by information and communication actions and by organising community meetings demonstrating contributions made by the different players and shar-
ing the progress. To the same extent, general interest activities have been promoted that have made it possible to build up a culture of collaboration among the three key players, such as organising and carrying out global citizen actions, open summer schools, learning and service activities, health promoting agents, business promotion sessions, holding public dialogue sessions, configuring socially responsible territories, etc.

Due to their crucial importance in the population's welfare, education and health are suitable fields to encourage the confluence of interests and joint initiatives. These specific work fields have made an enormous contribution to the overall community strengthening process.

Through preventive and health promotion actions, such as health promoting agents or service and learning programmes, in the field of education, to name just a couple of examples, not only was it possible to structure collaboration between institutions, professionals and citizens, but it has managed to involve families, young people and children, the three priority collectives for action in the ICI Project.

The overall view of the process and the connection between the different initiatives and actions undertaken within it have been achieved thanks to community teams in each territory that have connected up the three key players and their respective relationship spaces - technical staff relationship spaces, institutional relationship spaces, citizen relationship spaces and participation spaces.

The community teams have acted as a boost, facilitating the whole process, providing consistency to the whole set. Initially, professionals from the community teams were provided by the ICI Project through collaborating social entities, although they were subsequently replaced by professionals from the different public and private resources and services in the territories.

The intercultural community process also has a mediating dimension that has helped to promote living together and social cohesion in the territories. There are several social aspects that this has helped to improve, such as revaluing the different social and cultural collectives or transforming social relations, encouraging dialogue, positive interaction and equal recognition of all parties. However, the greatest mediating achievement being provided by the intercultural community process was promoting a new social context, thanks to mutual adaptation between persons and diverse collectives and adaptation of the institutions to this situation. This achievement can be used as the foundation for a culture of prevention, regulation and peaceful resolution of conflict and for living together and intercultural citizenship.
5. A brief guide to reading or consulting the five volumes of the Joining Forces to Live Together collection

It is advisable not to take each of the volumes in this collection individually, ideally reading them in order, starting with number 1, followed by number 2 and so on and so forth because their contents are laid out to work from an overall view to a more specific focus. If it is not possible to read the five volumes in order and just one volume is going to be read, there is always the chance of consulting the other volumes to go into greater depth on aspects not developed in that particular volume. This is particularly important for numbers 1 and 2.

Within this collection, this volume has focussed on health, provides the intercultural community intervention focus from the health field and the practical elements that have made this possible.

Whilst the remaining volumes, to guide your enquiries, have focussed on:
— Living together and social cohesion: provides the intervention focus and the theoretical elements that help to appropriately interpret the purposes chosen and the expected results and impacts.
— Methodology: provides the methodological, procedure and operational elements that have made it possible to put the intervention focus into practice and give consistency to the resources used.
— Education: provides the intercultural community intervention focus from the educational field and the practical elements that have made this possible.
— Participation: provides the intercultural community intervention focus from the field of positive interactions and citizen participation and its practical application.

However, in the event that it is impossible to consult the rest when reading any of the volumes, this common introduction to the five volumes will give readers a basic, overall understanding of the ICI Project, making it easier to frame that particular volume within the set.

6. Action territories 2010--2013
— **Barcelona (Nou Barris / Torre Baró, Ciutat Meridiana i Vallbona)** · El Torrent Sociocultural Association
— **Barcelona (Ciutat Vella / El Raval)** · Tot Raval Foundation
— **Barcelona (Sant Martí / El Clot)** · Surt, Fundació de Dones
— **Daimiel** · Fundación Cepaim Acción Integral con Migrantes (Migrant Aid Foundation)
— **Elche (Carrús)** · Elche Acoge Foundation
— **El Ejido (Las Norias de Daza)** · Cooperación y Desarrollo en el Norte de África (Aid and Development in North Africa), CODENAF
— **Getafe (Las Margaritas)** · Comisión Española de Ayuda al Refugiado (Spanish Refugee Aid Commission), CEAR
— **Granada (Distrito Norte)** · Asociación Gitana Anaquerando (Gypsy Association)
— **Jerez de la Frontera (Zona Sur)** · Centro de Acogida de Inmigrantes (Immigrant Shelter), CEAIN
— **Leganés (Centro, San Nicasio y Batallas)** · Fundación Universidad Autónoma de Madrid (Autonomous University of Madrid Foundation), FUAM
— **Logroño (San José y Madre de Dios)** · Rioja Acoge Foundation
— **Madrid (Ciudad Lineal / Pueblo Nuevo)** · La Rueca Association
— **Paterna (La Coma)** · Secretariado Gitano Foundation
— **Salt** · Casal dels Infants
— **San Bartolomé (Playa Honda)** · El Patio Canary Foundation and Tiemar Women’s Association
— **Tortosa** · Associació per la Cooperació, la Inserció Social i la Interculturalitat, ACISI (Association for Cooperation, Social Insertion and Interculturality)
— **Zaragoza (Casco Histórico)** · Federico Ozanam Foundation
What is the Intercultural Community health approach?
1.1 How has intercultural community health been defined in the Intercultural Community Intervention Project?

In the Intercultural Community Intervention Project (ICI Project), we understand community health as a social and historical construction that takes on different meanings and senses depending on the period in history, sociocultural contexts that we refer to and agents who talk about it. In this respect, tackling community health required an open mind in terms of the complexity of the issue and considering the different constructions used by individuals, groups, families, institutions and players in each territory for health, illness and care, to be able to understand the relationships and confrontations between the different medical and ethnomedicine systems; in other words, to be able to approach and enrich the different ways of understanding and looking after health and illness from the perspective of different players and different sociocultural contexts.

On the other hand, health and illness are concepts tightly bound to different cultures and particular subcultures (gender, social class, age, etc.) which influence and shape how people experience these stages, forming perceptions, symptoms and social representations where the human body is just one aspect. The incidence of specific illnesses varies among different communities and within these communities, among human groups that interpret and treat ailments in accordance with their sociocultural context and their living conditions. In this respect, their different conceptions of health and illnesses can be seen in how they behave: prevention strategies, self-care, seeking care and following therapy match these conceptions. Standards on healthy and sick bodies are therefore sociocultural constructions that vary over time and space.

Within the ICI Project framework, taking into account the complexity and wide variety of concepts currently used for health and sickness from a social point of view, intercultural commu-
nity health is understood from its integral focus, or in other words as:

A resource for everyday life, not the object of living. A positive concept that emphasises the personal, social and cultural resources in addition to physical skills, where health is not an abstract state but a means to an end that can be expressed functionally, as a resource that allows people to lead an individual, social and economically productive life (WHO, Ottawa Charter, 1986).

Health appears in two intrinsically-linked dimensions:
— The material and social conditions where the life process takes place; this represents considering the influence of so-called social determinants of health (SDH), or in other words, the set of personal, social, economic and environmental factors that condition and determine the individual and collective state of health and wellbeing of a community (objective dimension of the health-illness process).
— The way in which social groups interpret and weigh up these conditions (subjective dimension of the health-illness process) in line with the aforementioned conditions.

To develop what we understand as the full intercultural community health dimension, in line with movements begun halfway through last century in different countries by international organisations, such as the World Health Organisation (WHO), demonstrating the need to move beyond the health-illness binominal, we have to look from the critical-social and ecological perspective that also considers health as a right and public and collective property to be conserved by governments, institutions and citizens.

1.2 What needs does community health claim to meet? What fundaments is it based on?

Community health refers to the ideological movement begun in Europe and the United States in the mid 20th century, developed differently in practice depending on the country. This movement emerges as a response to:
— Recognising that there are collective health problems that cannot be tackled individually, biologically and exclusively therapeutically. For example, child obesity and its relationship with a change in family pace, roles and diet.
— Changes to the epidemiological profile of advanced societies, bringing to the forefront chronic-degenerative diseases, tumours, accidents, violence; multi-causal problem issues linked to “lifestyles”.
— Recognising the importance of social support and community networks for health and tackling illnesses. Social and psychological vulnerability are central elements to understand the cause behind certain illnesses; this is demonstrated by the health situation of the population living in marginal settlements, ghettos or run-down neighbourhoods.
— The economic crisis and the inefficiency of the health care system based on specialized, welfare and curative care and medicalization. For example, undervaluing what the patient has to say in favour of assessment tests, limiting the capability to fully assess health, relating symptoms to the context and living conditions, in order to make sense of the discomfort.

Community health is based on the following fundaments:
— Comprehensive care - holistic concept - personal and continued, with emphasis on promoting health and disease prevention.
— Methods and tools for planning with a starting point in the community health assessment. Participatory, and expressed by the population health needs assessment.
— Multi-disciplinary and inter-sector teamwork. This is a question of coordinating the health centre, the hospital and the nursing home as well as the remaining community institutions, schools, associations, NGOs, whose conceptual models and practices help to enrich the view of health.
— Decentralisation of material and human resources and coordination and functional integration of different health system levels.
— Adapting health needs (felt) and the available resources.
1.3

What does intercultural community health bring to improving how citizens live together?

Social relations and living together, when they achieve balance and harmony, are a source of wellbeing and mutual benefit, helping to improve quality of life.

The health field has enormous interest and potential for implementing the ICI Project. On the one hand, health has always been and continues to be a primordial human concern; good health is the basis for life, and both personal and social growth; it means that you can enjoy your body, environment and relationships. On the other hand, as previously mentioned, social relations, effective support networks, social cohesion, emotional ties between people and groups that live together on a land are key elements for a healthy life.

The intercultural community health approach in the ICI Project has been upheld and documented through studies and research, on the basis that living together and health are intrinsically linked. Different authors have gone into greater depth on this topic, demonstrating that a more cohesive, democratic and equal society is in a better place to tackle the difficulties and adversities affecting collective health, particularly in times of socioeconomic crisis such as now.

It has also considered collective health as social capital that is nurtured and grows as respect is encouraged between the people within a community, with the creation of emotional links and the feeling of belonging, with the existence of emotional support networks and development of skills to prevent and/or tackle conflict situations that are inevitable when humans live together by means of dialogue.

In this respect, constructing community processes based on joint work by different players in a territory to improve how people live together and increase positive ties of recognition, acceptance, respect and support, has led to important progress in improving collective health. In turn, collective health has demonstrated that it is a centre of interest and a common goal for different agents living together in a territory, encouraging joint action, participation and social cohesion.
1.4

What does community action imply for health from the intercultural perspective?

Intercultural community health in the ICI Project assumes that one of the pillars of living together, from the intercultural model, is mutual adaptation among the subjects involved.

So, regarding the incorporation of immigrants in the health system, this means that they have to make an effort to find out about the health system, follow its rules and access it through standard channels. In addition, the actual system should be readapted for this phenomenon, making its services more flexible, training its professionals in cultural skills and making changes to its organisation in order to guarantee and consolidate the universal, fair and effectively equal access to health system services for the entire population. Consequently, it has been considered fundamental in the ICI Project to develop and strengthen spaces for forming stable relationships and encouraging participation between health institutions and the different social agents in the territory, in order to adapt care strategies to health needs.

The health system has had to undergo significant important adaptation processes over the last few years derived from sociodemographic, economic, cultural changes, etc. that have taken place in the country. Maybe the most relevant changes are related to gradual population aging, changes in family structures (dynamics, composition and functions) and particularly, changes due to migratory processes. People coming from different sociocultural contexts with different health structures are particularly affected during their first few years by rules for living together, use and organisation of healthcare services that differ from their own. Re-socialisation regarding these rules and ways of operating takes time as it means changing highly structured pre-learnt patterns.

All these change processes in the health system have required organisational, functional and resource provision changes in certain services (geriatrics, paediatrics, gynaecology, etc.) as well as providing health professionals with skills to improve their understanding of new situations and connections that are made with these new users, improving their skills in diversity management.
From the ICI Project’s perspective, we understand that building a plural and inclusive society should be founded on guaranteeing rights (economic, social, civil and political) for people as well as developing the corresponding social policies alongside.

Immigrant integration has developed from administrations at different levels, either directly through social-health care or education or through subsidies for developing socio-occupational integration programmes. However, the lack of a legal framework to develop national policy beyond strategic plans has occasionally led to a lack of coordination between the different administrations, confusion and even a conflict of competences.

The ICI Project is set out as an opportunity to strengthen, boost and manage to develop principles recognised in the legislative frameworks and in the aforementioned plans and programmes, to the extent that it tends to create bridges, synergies and meeting spaces that permit joint work and better collaboration between managers and players engaged in local action.

During the first stage of the ICI Project, there was a change in the initial context relating to rights to health and care. The economic crisis, the subsequent change in migratory movements, but particularly health reforms introduced by Royal Decree-Law 16/2012 will mean breaking down the universal system that has been a pillar of the welfare state in Spain. This, as we shall see, will cause repercussions in how intervention processes progress in the territories, setting new challenges for living together and social cohesion.

**Community action for health from the intercultural citizen perspective**, in accordance with what has been established, has been understood as:

The contribution and coordinated effort of resources, institutions and social agents, applying methods and strategies to increase the community’s control over their determinants of health, in order to improve opportunities for achieving the best possible level of health, in terms of participation, fairness and taking into account diversity.

As a consequence of these approaches, the ICI Project has advocated implementing the slogan from organisations such as the European Union and the WHO: “health in all policies”, given that the decisions influencing people’s health do not only concern health services, but many other fields of politics.

In line with this principle, it was also considered fundamental to include health promotion as a strategic strand, understanding this to be the set of actions carried out by the administra-
tions, technicians and citizens in a territory to tackle the set of social determinants of health that can potentially be changed; not only factors that might be related to individuals’ actions such as healthy behaviour and life styles, but also determinants such as income and social position, education, work and working conditions, access to appropriate health services and physical environments.

In the ICI Project, health promotion is understood to be a global, political and social process aiming for people to take more control over these determinants of health. It covers actions both aimed at strengthening individual and group skills and capabilities and actions aimed at modifying social, environmental and economic conditions to alleviate their impact on public health. Participation is essential to uphold the action in terms of health promotion.

In this respect, in the different intervention territories, overall healthy processes and strategies have been supported and developed, such as:

— **In the field of education:** including health promotion that moves beyond the different levels of the educational community (school council, school’s educational project, teaching staff, parents’ association, health, social, cultural and sports resources, etc.) such as strategies aimed at conserving the environment, nature and/or cleanliness of the school atmosphere, promotion of healthy habits (food, rest, sport), improving relations in the school atmosphere and education on values (self-esteem, capacity to resolve conflict, solidarity or respecting diversity).

— **In the community field:** including strategies, measures and resources aimed at improving and conserving the environment, attaining more responsible territories in terms of collective health, healthier living habits, removing obstacles that limit relations, living together and access to services.

— **Making the most of policies, standards, plans and strategies to make fairness effective** (Law of Cohesion and Quality of the National Health System, Law of Effective Gender Equality, Catalonia Neighbourhood Law, Strategic Plan for Citizens and Integration, cohabitation and integration plans, WHO Healthy Cities Strategy, etc.).

To do this, intensive intersectoral collaboration has been brought about among the different organisations and sectors involved: town councils, health, planning, education, culture authorities, school institutions (members of staff, parents’ associations), health institutions (health centres, mental health network, hospitals or public health services), social services (day centres), associations and citizen groups (NGOs, mutual support groups, etc.), advocating priority action areas highlighted in the Ottawa Charter for Health Promotion:
— Establishing a healthy public policy by boosting action lines set in the health plans and programmes in each territory.

— Creating environments that support health, boosting experiences based on the Health Promoting Schools (HPS) model, socially responsible cities or territories, development of the health promoter agent figure and experiences based on the learning and service learning model, etc.

— Strengthening community action for health, by setting up or strengthening community support networks to tackle needs or problems, such as community mental health or support for dependent persons, etc.

— Developing personal and collective skills, bringing about empowerment³ and agency experiences at a community level in groups with difficult or isolated situations (old people, young people, women, etc.).

— Redirecting health services, supporting the work of health teams and health professionals, mediating between them and certain community groups certain groups in the community with difficulties, access or communication and understanding barriers due to linguistic and cultural differences.

In the ICI Project, it is assumed that social determinants of health are unequally distributed through the population, as the social divide has increased over the last few years along with social health inequalities. Living in precarious conditions is associated with a worse state of health and low life expectancy. This situation seems easier to understand thinking about people or groups who lack resources; however, social determinants can be associated with health throughout the entire social scale, not only among people with fewer resources.

It was also considered fundamental from the field of intercultural community health to incorporate the equity approach in practice. This concept features in the principles of the General Health Law 1986, and means that everyone has a fair opportunity to develop their maximum health potential independently of their social position or other circumstances determined by social factors meaning that no one should be at a disadvantage to develop this potential.

In the public policy field, this represents treating people differently so that everyone can enjoy the same rights, also implying that resources are assigned according to people’s needs. Given that many factors affect health (education, work, living conditions, etc.), as we have seen, health equity should be understood in a broad sense, not only as the right to health care for the entire population.

³ In the WHO health promotion glossary of terms, “empowerment for health” is defined as a process by which people gain greater control over the decisions and actions that affect their health. The term is not without its controversy among authors, disciplinary traditions and ideological positioning, both in its theoretical acceptance and in its practical implications. In the ICI Project, when we use the term in the field of health, we are referring to the capability of the subjects, groups and institutions in a community to identify, analyse, question and tackle the social, economic and political structural factors that are the basis of inequalities in the distribution of power in social relations and that have an effect on their collective health.
Translating this equity focus into practice in the ICI Project has strengthened programmes and processes to ensure that the people living in the territory can speak up and help to identify needs and problems on establishing alternatives to the priority aspects that concern them and on distributing resources that influence their quality of life and health, that has come down to improving living together and social cohesion in the territories.

Within the ICI Project framework, intervention from the health field has been approached extensively and across the board, understanding that the different administrations, not only health, and particularly the town councils, have an important influence over social determinants of health, through development of local, intersectoral policies, boosted from their different local authorities (developing town planning to favour more depressed neighbourhoods, improving transport and housing, equipping and locating schools, sports, health and cultural centres giving equal access for everyone in the neighbourhood). To do so, processes have been deployed focusing on intensive intersectoral collaboration between the different organisations and sectors involved: health authorities, planning, education, culture, school institutions (staff meetings, parents’ associations), health institutions (health centres, mental health network, hospitals or public health services), associations and citizen entities (NGOs, mutual help groups, etc.).

1.5 What challenges are set in the field of intercultural community health?

Taking into account the different dimensions of living together and social cohesion identified in the ICI Project, goals in the community health field referring to these dimensions are specified as follows:

— **Integration.** Improve local inhabitants’ knowledge of their rights and responsibilities in terms of healthcare, identifying sectors that find it particularly hard to access the social and healthcare system and use coordinated action to help eliminate barriers making it hard to access resources (adapting rules, opening hours, accessibility).

— **Interculturality.** Adapt universal healthcare structures to social and cultural diversity in the territory and its different needs (operation, organisation, equipping resources, stand-
ards, coordination), specifically for groups with difficult access and/or a vulnerable situation regarding universal healthcare. Improve capabilities/skills and professional resources for managing cultural diversity as far as health is concerned.

— **Living Together.** Increase citizen interest and awareness among different sectors, agents and community groups on collective health issues in the territory, regardless of the group they belong to. Encourage meeting points and positive interactions between different groups and collectives to tackle health problems or issues. Get them engaged and participating (identification, analysis, establishing solutions) by proposing and developing collective actions to improve the territory’s quality of life.

— **Citizenship.** Contribute to the recognition and advocacy of groups, minorities, collectives that are disadvantaged socially or in terms of healthcare due to their physical, social, economic or cultural difference so that they get the chance to receive care in the same conditions. Increase citizens’ joint-responsibility regarding the importance of helping to maintain and improve public services as a guarantee that everyone can enjoy the right to health and education.

— **Community strengthening.** Reinforce the association framework (starting new groups or associations focussing on improving collective health from the intercultural community perspective). Strengthen the function and task of existing groups and associations aimed at improving quality of life and enriching their potential by incorporating the intercultural community perspective. Increase citizen participation in meeting spaces intended to tackle matters related to community health.

Community strengthening occurs when the entire community is included. This sees the territory as an intervention unit where the administrations, professionals and population play a primordial role. In this way, the community health intervention strengthens the community in so far as it strengthens relations between the population and professionals, making it easier to understand the state of health and strengthening health promotion actions.
1.6
What does working from a community perspective imply in the Intercultural Community Intervention Project?

In the health field, health and illness phenomena are considered to be collective phenomena, emerging from the dynamic created in a community by interrelating its economic, educational, healthcare subsystems, etc.

These emerging phenomena are going to crop up in a variety of guises in the different fields⁴: individual, group, institutional, community. Therefore it is important to know about the theoretical contributions corresponding to each of these fields and consider their specific nature in actions that are programmed, in order to work across the board and be able to read problems from the focus of the specific nature of this community’s dynamic at a given moment and with its own history.

Following Bleger’s approach, the listed fields are as follows:

a. Psycho-social field (individuals): refers to individual expression of health-illness processes although considering all their links or interpersonal relations.

b. Sociodynamic field (groups): takes the group as the analysis unit; the family as a primary group, the group of equals, formal and informal groups, as well as the different meanings given to health-illness within it.

c. Institutional field (institutions): tackles positive interactions within the groups and with the institutions governing them; schools, hospitals and health centres, work, etc. and the different ways in which these institutions are represented and tackle the health, illness and care processes.

d. Community field (community): includes the social collective. This field, with the most to tackle, includes all the above, so from the ICI Project we understand that to deal with health from a community direction, we have to work from these different perspectives: with the subjects, their families and relationship networks, with formal and informal groups and associations, with the institutions and the technicians that work in the field.

⁴ Bleger’s field theory, from social psychology, considers the human being as a whole in specific situations and in its interpersonal links (present and past) and it understands the field as the extension of events or human links (BLEGER, J. (1976). Psicología de la conducta. Buenos Aires: Paidós, p. 60)
The persons, groups and families live in local contexts where social determinants of health influence and determine their living conditions. The understanding of collective health, bound to a collective, historiographic gaze and located in these local contexts helps to identify the challenges and potential aspects of the territories and reassess the role of the different players, resources and assets in health that each possesses.

1.7 How was the community health intervention designed?

Health, as has been made clear, constitutes a field of enormous interest for implementing the ICI Project that is being presented, given that it is one of the basic reference points for persons, families and institutions due to its implications in developing a community’s living, educational, productive, cultural and social potential. It therefore has a strong impact on the whole social aspect and cohabitation relationships, so it should be a major concern and priority for governments and citizens.

The ICI Project works from the basis that from the field of intercultural community health, in accordance with the aforementioned principles, preventive and promotional intervention can be encouraged that favours integration of people, contributes to social cohesion and, in short, provides society with skills to face up to its problem issues and challenges relating to health, living together and intercultural citizenship through progressive participation in developing local shared space.

The intervention’s approach works from considering the importance of working with all the players in the field and the existence of equal possibilities and responsibilities in exercising the rights of all the inhabitants regarding improving collective health.

In the ICI Project, the Specific Intercultural Community Health Line of Action has been developed in parallel to the Global Line of Action and the other two specific action lines (Socio-educational and Citizen Relations), meeting a community intervention schedule that has been methodologically articulated over three years of running the ICI Project, as we will see over the fol-
lowing sections. These three fields of action have centred the emphasis of their actions on the work to be done with children, young people and families, for a variety of reasons:

**Children, youth and family** represent key groups in terms of promoting and improving collective health; it has been shown that putting effort into improving the health of these three collectives is an effective way of looking to the future.

*Family* is the primary socialising nucleus where we start to acquire the basis of behaviour and related to health: hygiene, diet, forms of communication and relations, etc.

*Childhood* is recognised as a key stage to learn responsibly about healthcare. Parents’ education and lifestyle will be essential in this learning. An educational and communicative relationship that involves dialogue and putting across values such as health from early childhood can be effective when dealing with changes or crises in each subsequent stage.

The ICI Project’s community health field goal has been to encourage processes for meeting, dialogue and collaboration between the different players in the field (administrations, technicians and citizens), attempting to improve existing relations, capabilities to identify and analyse needs together, health problems and assets in the territory and to propose and develop inter-sector and integral strategies aimed at improving collective health.
What is an Intercultural Community health intervention?
Having developed the conceptual bases and the fundamentals on which to base the intercultural community health field, this chapter presents the practical application of these bases by means of different proposals and experiences from the intervention territories.

2.1 What were the starting premises in the intercultural community health field?

1. Health in its holistic and complete sense, understanding that it is influenced by a wide variety of determinants (individual, environmental, educational, economic, etc.), is conceived as social capital and a universal right to be preserved and implemented by the government and different administrations, both healthcare and non-healthcare. Including the equity focus, social determinants of health framework and fighting social inequalities are a priority for Europe and the WHO, so it is essential to include them in the project given its character and aims.

2. The health level for a community does not depend exclusively on how healthcare institutions act. Policies implemented from the government and different administrations have an impact on community health so it is fundamental to assess this impact and work across the board with different sectors to improve health: “health in all policies.”

3. Improved health is tightly bound to improved living conditions, working conditions and the environment rather than interventionalist care. This shows the Project’s relevance to health promotion, understood as the capability of subjects and communities to recognise their own health needs, their capabilities and resources to administer joint solutions to the problems.

4. The idea of “agency” in any human collective, meaning the recognition of potential within a territory, of the persons that live in it and the institutions shaping it, to be healthy in their organisation, interactions, living together and solidarity relationships, cultural wealth and traditions and to jointly and democratically recognise, tackle and manage their problems and conflicts.

5. Improving how we live together and positive management of diversity and conflicts helps to improve quality of life for people and groups and therefore improve collective health. Healthcare and educational institutions, families and the community are relevant actors in health
promotion, due to their educating and socialising function.

6. Intercultural community health implies healthcare agents and citizens joining forces to mutually adapt, emphasising alignment between people who share significant aspects related to local development, rights and quality of life.

7. Healthcare institutions are meeting points for a wide range of professionals and citizens working from different conceptions of health and illness; these professionals have great potential to promote living together and social cohesion from the health field.

8. Backing an inclusive institutional model to manage diversity that considers:
   — Healthcare institutions (hospitals, health centres and care devices) as potential intercultural spaces where professionals and users have a common aim to improve collective health, under the principles of equity and fairness.
   — Healthcare interaction programmes as a representative reflection of existing diversity.
   — Healthcare as a right that considers diversity, the right to individual and collective identity, the feeling of reciprocity and solidarity.

9. Emphasis on promoting personal, social and community skills and resources and responsible and healthy social environments to:
   — Break down existing physical and symbolic barriers and configure a new interaction arrangement.
   — Meeting health needs expressed by the community.
   — Inter-generational learning, active participation from families, young people, children, etc.
   — Producing documents for health promotion processes, tackling collective health improvement and putting across “best practices”.
   — Future co-management and self-management in practice.

In this respect, the social intervention approached to develop the community health field in the ICI Project presents an initial hypothesis directed at encouraging actions based on health promotion, in other words, activating the capability of the institutions, entities and citizens to create a healthy community, focussing community action on the determinants of health and seeing proper management of existing cultural diversity as an opportunity and need, as well as appropriate use of healthcare resources.
2.2
How is the Intercultural Community Intervention Project structured in the intercultural community health field?

An intervention team was responsible for implementing the ICI Project in each of the 17 territories. By working with the rest of the benchmark social entities in the action zones, they generated alliances with local administrations, professionals from different fields (health, education, social services, etc.) and citizens, in order to encourage community development processes and make it easier to find and establish synergies between the different players in the territory, working from existing plans, programmes or action strategies, to improve mutual knowledge of community resources, recognition of the technicians’ work and the important role played by social entities and citizens in community development.

This intervention team, made up of four professionals with social development and mediation experience, identified a manager/guide for the community health field to implement actions corresponding to this field. In addition, the team in charge of the Scientific Division (DECAF) also had a professional as a reference point from the health field, with the complementary role of monitoring, support and technical guidance for certain teams and territories.

Finally, developing the field called for a consultant with experience in community health, public health, intercultural issues and mediation whose role was to propose appropriate strands for the field and theoretically and methodologically guide the different ICI Project stages, assess its progress in the different territories and support training for intercultural community intervention teams (ICI teams) throughout the process. The following team provided the ICI Project outline, monitoring and supervision:
Graph no. 1. Engaged players

Endorsed by
General Secretary of Immigration and Emigration (Ministry of Employment and Social Security)
Spanish Federation of Municipalities and Provinces (FEMP)

Management and Coordination
"la Caixa" Foundation
Scientific Management
Carlos Giménez (UAM)

Advisory Committee
Marco Marchioni (IMM)
Milagros Ramasco (UAM)
Miquel A. Essomba (UAB)

Intercultural Community Intervention Team

Neighbourhood or intervention zone

Town councils and other administrations

Education
Community health
Citizen relations

Children/Youth/Families

Citizens and association movement

Technical-professional resources
2.3

What was the initial context for the Intercultural Community Intervention Project?

2.3.1 A shared action model, applied to different territories

From the outset, the ICI Project has worked from a shared action framework and model although applied to territories not only with high social-cultural diversity but also territories belonging to regions and Autonomous Communities with very different policies. This aspect was fundamental when adapting the ICI Project to the peculiarities and idiosyncrasies of each territory and when identifying and making the most of the development opportunities that appeared in each case.

We know that the framework in which the social integration policy has unfolded in Spain, specifically in the health field, is wide ranging, and it is not possible to identify a clear dominating model or an explicit official discourse, directed towards multiculturalism, assimilationism or interculturalism. On the contrary, a fragmented set of immigration policies have been developed in a complex skills framework. So, its centralising character imposes constrictions on the Autonomous Communities’ power but, at the same time, these regions have the most authority affecting social integration (social services, health, education, employment and housing). These responsibilities are occasionally shared with local organisations, within the framework set by the State’s migratory policy, mainly focussed on flow control.

These regional and territorial differences are demonstrated in the different ways of applying social integration polices. In the same way, differences can be seen in immigrants’ situations and their integration process in each community and, within them, for example, whether or not there are limitations for joining the census and/or access to certain services or educational, healthcare or social resources. Behind this, we can see the difference in economic and social structures that clearly has an effect on unequal installation of immigrants and the actual migratory process (Laparra & Martínez, 2008, p. 23-28).
The processes to transfer health competences to Autonomous Communities took place at different times. In addition, the models in which the institutional relationships are structured among the administrations with both health and immigration competences (town councils, municipal services, social services, regional health services, healthcare services, etc.) have been resolved differently.

In some cases, flows and formulas have been established for coordination between municipal and regional resources and even with other administrations related to health (planning, environment, traffic, education, etc.), establishing common plans, programmes and health protocols and coordination devices. In other cases, work has been done independently demonstrating a lack of coordination and intersectoral work, both between healthcare and social resources and with the rest of the resources related to health, where the different administrations developed actions in parallel.

In turn, starting up an intercultural community process requires keeping in mind sociohistorical and territorial characteristics, density, concentration or spatial dispersion, diversity and processes for settling groups in the territory, historical and prior experience baggage among the inhabitants (citizens) relating to creating and maintaining neighbourhood, association networks, community participation dynamics, types of relations between administrations, technicians and citizens. It is essential to have detailed knowledge and analysis of these elements.

Implementing the ICI Project in the different territories therefore began marked by diversity. This diversity was not only territorial (small, medium sized or large cities, rural areas) but also institutional (type of institutional and political structures developed in each town and existence of health plans or programmes, social services, immigration, inclusion, etc. prior to the Project affecting the field of community health that might work for or against its development process) as well as the relationship and participation dynamics between institutions, technicians and citizens.

Some examples of this territorial and institutional diversity are shown below.

— In Catalonia, there is the Ley de Barrios (Neighbourhood Law) (Law 2/2004), a project led by the Department of Territorial Policy and Public Works that comprised deployment from different areas (infrastructures, health, education, etc.) of a series of actions aimed at reducing the risk of social exclusion for inhabitants of marginal neighbourhoods or that are particularly vulnerable. The Department of Health, through the Neighbourhood Health Plan, has been supporting community health programmes tackling each neighbourhood’s specif-
ic needs. This basis was fundamental to include actions from the field of the five territories located in this Autonomous Community.

— In Andalusia, the Local Government Health Board worked from the Andalusian Health Plan, considering a decentralisation strategy so that public health promotion and prevention programmes can work as closely as possible with citizens. In other words, they were running the local Project to Develop the Local Health Network (RELAS), a cooperation project with local entities to draw up local health plans by means of intersectoral and participated actions, working in a network, under local government leadership. In the case of Jerez, this project favoured a series of synergies and opportunities that were consolidated over the three years.

— In the Madrid region, relations between City Hall, the Madrid Health Service and Health Promotion and Prevention Services varied between the city of Madrid and other towns. In some cases, they could be described as deficient or even nonexistent, leading to parallel development of plans and programmes or the existence of duplications and/or gaps due to lack of coordination between these administrations.

Another interesting aspect to highlight was the diversity regarding the composition and training of the actual ICI teams, in charge of implementing the ICI Project, and their prior knowledge and experience in the community health field. The field was new to the majority of the ICI teams, except in some cases where they had prior experience. To compensate, the team members worked from wide-ranging experience in the field of socio-cultural entertainment, social intervention and mediation which, in the long-term, enriched the development of the field with interesting proposals as we shall see later on.

2.3.2 Town council centrality in the field of intercultural community health

Local Administration’s proximity to citizens and their organisations makes it easier to get more immediate and real knowledge on their problem issues and help them to make decisions faster and apply measures to any problem. This requires a new type of democratic leadership from Local Administration and a change in how services are provided from the inter-sector aspect, involving greater participation from social agents.

The "la Caixa" Foundation signed agreements with the fifteen local corporations where the ICI Projects are located (one for each intervention territory, with the exception of the town of Barcelona, working in three territories) in order to guarantee full participation from Local Administration and appropriate coordination with public administrations.

Town councils have long-standing tradition and experience in the public health field given the influence of its policies in aspects that determine quality of life and health for the population living in the territory.

Local corporations have planning and urban development competences or, in other words, they can define the city or neighbourhood model, the distribution of public space, squares and parks, the mobility and the transport, the type of quality for homes or the distribution of the neighbourhood’s resources (schools, infant schools, cultural centres, health centres, sports centres, commercial areas) and their accessibility, that can make it easier to eliminate barriers, improve environmental health (air quality, water quality and waste treatment), provide green areas, recreational zones, etc.

However, they also have the capacity to influence other sectors that determine health such as education (with programmes supporting schools, families and teaching staff, coordination between education levels, encouraging healthy eating, literacy programmes, adult education and cultural activities), in the field of work and employment (developing training programmes and encouraging employment, establishing dialogue and agreements with companies and industries), and in the restaurant sector (healthy affordable menus, workshop schools), with heritage and culture, strengthening historical town centres (transformation and use of heritage buildings) and in sport, with a network of key resources to encourage healthy leisure and living together, etc.

As a consequence, linking the ICI Project and the ICI team to the Town Council was key and strategic to carry out development and intercultural community intervention processes in the field of health, understood in its full sense, considering that one of the field’s initial strands is tied to the “health in all policies” slogan and that the town council has a wide-ranging capacity, as we have seen, to deploy healthy policies from different boards.
2.3.3 Healthcare fragmentation and sectorisation

The new primary care model has excessively reproduced the traditional medical-handout model, causing involution over the last few years. Actually, despite the progress made in Spain in the health sector, from the implementation of the healthcare reform (early 80s), directed towards the community and considering the importance of health promotion and preventing disease (progress and developments making our healthcare system and its professionals one of the best in Europe), the handout system has prevailed.

Currently, the healthcare system and health professionals are trapped with the obsession of the assistance praxis that prevents development of the principles of community action, collective view of health problems, interdisciplinary team work and community participation in plans and programmes\(^6\)\(^7\).

On the other hand, cultural diversity in our society and in the healthcare system required organisational and functional adaptations and changes in how resources are distributed locally, as well as skills training for healthcare professionals to better understand new situations. Adaptations and changes related not only to increasing immigrant population that required more care in specific areas such as gynaecology and paediatrics, but to needs derived from an aging native population. These adaptations and changes have not been made to the extent and at the rate that they were required.

Community health action is favourable ground to overcome healthcare’s characteristic tendency towards segmentation, partition and specialization, a tendency that has been growing over the last few decades, establishing airtight knowledge areas with a lack of dialogue and, therefore, finding it hard to tackle current health problems and work in a comprehensive and integrated way, specifically on improving quality of life for societies.

In the community health field, the healthcare system, particularly health centres and teams that provide care, constitutes a fundamental substrate to implement actions aimed at health pro-

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7 Report by the Association to Defend Public Health, March 2011. Fundamentos de la atención primaria y evaluación de las medidas de mejora adoptadas por las Comunidades Autónomas (Fundaments of primary care and assessment of improvement measures adopted by Autonomous Communities) http://www.observatoriosanitariomadrid.org/informes/1973-fundamentos-de-la-atencion-primaria-y-evaluacion-de-las-medidas-de-mejora-adoptadas-por-las-comunidades-autonomas
motion and improving how we live together so it became essential to find out about progress, set-backs and the situation of these resources to implement the ICI Project.

There can be no doubt that one of the most exciting and beneficial challenges of the ICI Project was to help overcome an antiquated sector-based approximation of social action to delve into the difficulties of an integral approach that can tackle complex health phenomena. Let’s look at the ICI Project’s way of thinking and what it brings to the community health field.

2.4 What does the Intercultural Community Intervention Project bring to the health field?

The ICI project is not just another project competing against other projects, but it has its unique features that are a key element. Let’s look at what it has specifically provided for the three players (administration, technicians and citizens) was identified in the intercultural community health field.

For the different administrations in the universal healthcare (including its social aspect), education, planning, environmental, sports, culture sector, etc.:

— Emphasis on living together and intercultural citizenship, understanding that it is essential for improving collective health.
— The commitment to achieving greater citizen involvement in the territory’s health problems, through participative processes in the intercultural community intervention. Both these matters, although they appear to be central in documents framing healthcare policy, are not really integrated in practice in the plans, programmes, action strategies and in the services portfolio in primary care, their development having been left to different organisations outside the healthcare system, associations, NGOs, mutual help groups (GAM), foundations, etc.
— The ICI team is conceived as a mediating resource par excellence, among the different administration sectors engaged in health, essential for improving quality of life. There are difficulties around meeting and dialogue, administrative-bureaucratic obstacles concerning working together, lack of coordination and interaction among these sectors.
— Dynamic and living knowledge of the territory’s characteristics. Due to their location in the
territory and the contacts that can be deployed with different stakeholders and entities, the ICI teams have a strategic position from which to develop the ICI Project, derived from knowledge of the different groups, the problems and needs that the citizens express and perceive, resources related to health and the real situation of the plans and projects being developed.

**To the technicians** who are working in the different administrations and organisations within the community’s institutional framework:

— Pooling information, sharing a wide range of information. The ICI project brings about, encourages and strengthens meeting spaces for these professionals to debate health problems facing the community and the chance to tackle them from different and complementary perspectives.

— Establishing theoretical and methodological work bases with cultural diversity, intercultural perspective and knowledge of mediation as a tool for living together.

— Facilitating alliances, making the work they deploy visible from each of the sectors: education, health, environment, etc. In short, “keep on adding”.

**To citizens in general:**

— Empowerment of certain groups or collectives to the extent that they have information, guidance or spaces where they are heard and they can participate.

— Visibilisation of the existence of needs and problems in certain groups, demonstrating situations of inequality in relation to access to universal healthcare resources.

— Strengthening meetings between population, technicians and administration and create spaces for participation and channels and strategies to encourage it.

— A place for mediation between the socio-healthcare resources and the rest of the community resources who are engaged in some way in health issues in the territory in question.

Therefore, they have relevant potential to boost and reinforce intersectoral action from the framework of community health, understanding that this is achieved by incorporating an integral view of health and assuming that the actions with the greatest impact include health in all policies, keeping in mind the framework of the social determinants of health in order to move forward towards equity.

**The ICI teams, in turn, can be considered as technical resources to boost and strengthen strategies and initiatives in the territory tending to promote the population’s health,** particularly for vulnerable or excluded groups or any experiencing difficulties to enjoy vital opportunities in equal conditions. Its fundamental task has been:
— Develop strategies, actions and interventions aimed at increasing awareness, control and the management capacity of the three agents (administrations, technicians and citizens) on the social determinants of health (environment, living together, working and living conditions, diet, transport, culture, gender, etc.).

— Encourage and strengthen intersectoral work, implying knowledge of action plans and proposals to reinforce areas where ICI projects are supported (citizenship, interculturalism, community relations, education, health) by means of inclusion in meeting and participation spaces (health boards, school health councils, participation forums, health commissions, parents’ associations, etc.).

— Encourage inclusion of the intercultural community health perspective in spaces and actions where they participate, thereby also becoming a pedagogic resource to the extent that, with its praxis, they demonstrate the possibility of developing this focus on community health actions.

### 2.5 How was the intercultural community health action developed in operation?

Operative development of the action in the field of health involved different phases:

— Establishing the operative conceptual framework for the specific field of health, support and monitoring in the process of forming and training the ICI teams, alongside developing actions in the territory.

— Implementation of the ICI Project and deployment of community team action through the initial approach to the real situation in the territory, identification and establishing relations with its different players engaged in health and presenting the ICI Project to society.

— Identification of existing public and private health resources in the territories, stating their participation in community life and inviting encouragement for positive interaction.

— Establishment and consolidation of stable connection spaces and the necessary information and communication instruments.

— Implementation of actions promoting health, action lines in community health framed within reference models (healthy territories, health promoting schools, community-based health agents, actions promoting health in different collectives).

— Development of community monograph, assessment and programming. Deployment of par-
ticipative research with the territory’s key agents.
— Development of coordinated and cooperative actions between different technical resources related to the field of health, and citizens as active agents in health promotion, bringing about participation from the diversity within the community.
— Consolidation of complete, new and significant experiences in the field of health, in compliance with the identified needs. Assessment and dissemination of experience results.

Table no. 1. Development phases for the intercultural community health line in the ICI Project

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2.5.1 Phase one

— Shaping the ICI teams
— Approach to the actual situation in the territory
— Positive interactions with players in the territories

In accordance with the initial context, the work programme developed during the first phase of the ICI Project included two levels of action:
   a. Shaping the ICI teams
   b. ICI team actions on the territory
a. Shaping the ICI teams

Establishing the operative conceptual framework for the specific field of health, support and monitoring in the process of forming and training the ICI teams, alongside developing its actions in the territory.

In terms of operative group psychology (Bleger, Pichón-Rivièra, Lapassade), for a group to operate as a work team organising its action around common aims, a process is required to pool and face up to different initial reference outlines (different interests, knowledge, experience and mechanisms to tackle the new task, ways of understanding the suggested conceptual framework and putting it into practice) in order to be able to shape a common ECRO, meaning a conceptual reference outline that is operative and allows team members to do their jobs coherently.

The field of intercultural community health within the Project was initially presented as a “new” and, to a certain extent, unknown field. Although health in principle is a question about which any group can talk and be aware of, we know that it has different senses, meanings and representations for different social and cultural groups.

So, as previously mentioned, technicians from the ICI teams in general worked from limited knowledge of the conceptual and methodological bases of community health, in its integral focus, of how this field of knowledge was built, how the healthcare system works and is structured, the different roles and functions taken on by healthcare professionals. In addition, this required developing skills to connect and work on this field, in so much as it was not a field of intervention that they had already handled.

It also worked from different conceptualisations and directions related to what it might mean to include intercultural community health in this type of project: from more free care-based positions, based on a biological and individualistic conception of health/illness processes to more holistic and integral positions that consider health in its bio-psychosocial dimensions, understanding the contribution and inter-relation of these factors in collective health.

In accordance with what was suggested, part of the phase one plan consisted of incorporating a favourable reference framework in line with the ICI Project, so that teams might operate in this field from their non specific place of mediation, with the idea of generating relations among the three main players (administration, technicians and citizens) and in different fields and engaged in health (schools, pharmacy, patients’ association, civic centre, health centre or town planning area).
This conceptual framework for community health is summed up in the following table:

| — | Integral conception of health; holistic meaning (bio-psychosocial). In its public and collective aspect, as a crossroads between different sectors, engaged in a territory’s health situation, not only its healthcare, but also the economic, social, educational, occupational, association and sports aspects. |
| — | Emphasis on health promotion, as this is the most relevant field of action for this type of project, aiming to improve living together and manage diversity in a territory. Taking into account the starting point and initial experience among the teams, the field’s very breadth and ambiguity allows wide-ranging and diverse deployment of proposals and community actions connected to the different sectors mentioned above. |
| — | Emphasis on the idea of ‘agency’, in that the citizens living in a territory have the capacity to recognise and take on the problems that concern them and that they consider affect their state of health and manage any possible solutions jointly, implying the need to have community participation from the outset, in analysing and setting out the intervention strategies. |
| — | The positive aspect of health, not only a field focussed on studying and detecting problems linked to health but also considering the potential of a territory and its inhabitants to be healthy in its organisation, interactions, living together and mutual support, cohesion, cultural wealth and traditions, capacity to tackle problems together, etc. |

Spaces were set up during phase one for meeting and training, in order to make it easier to talk about and include theoretical and methodological fundaments supporting the specific line of action in intercultural community health in the teams’ praxis. The ICI information and training process was developed through different channels and formats:

| — | Drawing up and delivering the basic ICI Project document: Intervention guide on the Intercultural Community Intervention Project. |
| — | Structuring work spaces and training with the teams and/or coordinators, plenary sessions, meetings for coordinators and topic-based seminars, used to transmit and discuss the fundamental principles, conceptual, legislative and methodological frameworks on which this specific line of action is based within the ICI Project, providing reference bibliography, guidelines for the action according to the base of experiences and support documents in line with the ICI Project phase. |

The topic-based areas covered in the meeting and training spaces, and in the base documents during phase one, were as follows:

| — | Integral focus on health and legislative frameworks including the right to health. |
| — | Social determinants of health; conceptual models. Social inequalities for health and the equity focus. International and national health strategies to reduce inequalities. |
| — | Community health movement; conceptual and methodological bases. Health promotion and illness prevention. |
| — | The health system and primary health care. Organization and operation. |
| — | Approach to the community health situation: methods and indicators. Planning and programming in community health. |
| — | Participation structures in the field of community health. |

It was only as the theoretical and methodological bases of the intercultural community health field were laid out and developed and the ICI teams were designing the work schedules and the
successive programming, with varying assessment, that they became aware of the potential of developing this field.

Therefore, the ICI teams’ work during the first phase required laying out and systematically reinforcing basic concepts and notions on the fundamentals of intercultural community health to help conceptions more tightly bound to the dominant biomedical and free care-based model make progress, both from the general outlook and in the healthcare field, towards more holistic and integral conceptions, along the ICI Project lines.

It took time in this process for these models and conceptualisations to be reviewed, incorporated and gradually assimilated into the corpus of the teams, requiring specific training programmes.

The hypothesis that has been confirmed in developing the work for this type of project is that, particularly during phase one, it will be necessary to consider the time and the conceptual and methodological training work that the ICI teams need to incorporate and get the intercultural community health bases up and running as part of the programming.

**b. ICI team actions on the territory**

Implementation of the ICI Project in this phase also represented deployment of the community team action through the initial approach to the real situation in the territory, identification and establishing relations with its different players engaged in health and presenting the ICI Project to society.

The aim of this first approach and analysis work was to establish a general overview of the situation in the territory and the trends in the different sectors that have an impact on health in order to get a first look at the areas that require greater attention due to experiencing significant deficiencies, needs or problem issues or, on the contrary, others that presented greater strength and potential.

In parallel, an attempt was made to make the most of the occasion to initiate contacts, be introduced, present the ICI Project to the territory resources and set up strategic alliances in order to favour processing adapting to existing cultural diversity. In this respect, the ICI teams per-

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8 To approach health needs, Bradshaw's needs diagram can be used as a model to assess health topics and priorities according to where they come from (BRADSHAW, J. “A taxonomy of social need”. New Society. Harvard, March 1972), in which he differentiates between:
- Normative need: An expert defines the need by means of defining standard rules or criteria they wish to be attained.
- Perceived need: People are questioned to find out about their needs, translated into problems or expectations by this group or community.
- Expressed need: Based on the information for use of preventive, curative or promotional services. This means that it is the equivalent of the health service demand, how the people use the services or they transform the need into action.
- Comparative need: This consists of defining the needs according to comparing results between different territories or services, considering the need to be the element that gets the worse results.
formed significant work; in some cases more extensive, in others more intensive and in some, working in both directions, in order to find a position, get to know the different players (institutional representatives, technicians and social entities) that were key or relevant in terms of the specific line of action in health.

In addition, an approximation was made regarding knowledge of the plans and programmes, strategies and actions related to care and improving the territory’s health, laid out and approved by the different administrations and social players, exploring the real development of their lines. It is well known that there is actually a shortfall between the targets and the budgets stated in these plans and health programme and the real specification. Even in these cases, there can be no doubt that they have the symbolic power of having been published and endorsed by the corresponding powers and, therefore, they are an unavoidable reference framework.

This approximation was occasionally made from a view that was more limited to the biomedical or free healthcare-related perspective, in other cases from a broader and more integral view of the territory’s health, involving differences within the spectrum of players and institutions encountered during their work (environment, planning, education, etc.).

From the outset, the ICI teams demonstrated their great capacity to penetrate the community fabric and skills to work in community relations, surely due to the profile and experience of its members, a relevant aspect for the ICI Project given the diversity of fields and players that it had to work with. This therefore gave great complexity of levels and contexts in which to act, bringing up the matter of criteria and boundaries for the ICI teams when establishing links between players with different interests so that the teams’ capability for action was not exceeded.

The starting point was different depending on the teams, as some had valuable prior knowledge of the territory, its social, neighbourhood, association, institutional resources, etc. from prior intervention there from different organisations or institutions. Other teams, on the contrary, had to start this process and establish an initial framework of relations. Both situations can have their strengths and weaknesses.

The schedule set by the ICI teams for the year, with both aims and action lines that were global or specific to the three fields (social-educational, community health and citizen relationships), are characterised by the diversity and wealth of the proposals, in line with the territory’s characteristics, universal healthcare resources and experience from prior work, actions underway and the diversity of the social fabric.
The community health line initially required more time to specify action proposals because, as mentioned previously, the ICI teams (due to their composition, training and prior experience) perceived the healthcare question as far-off and distant. It was necessary to be immersed in the health system to find out about and approach the healthcare world and the cultural aspects governing it. However, its practical baggage and its training in the field of the social, educational and intercultural mediation represented a strength to the extent that they have been able to apply their tools and skills, working as a mediating bridge between these worlds and subcultures - educational, healthcare, social - and favouring knowledge and recognition of the other.

In this respect, the following was suggested as relevant:

— The need to reinforce the idea of intersectoriality, approximation, dialogue and agreement between the different sectors tied in with improving health. In so much as health is a cross-discipline subject, a collective value to which different players in the territory contribute (politicians, professionals and the population), it can be used as a common cause that congregates, encourages alliances and shared work.

— The importance of ICI team organisation. There should be a manager for each field, but with dynamics that favour establishing synergies between them. This is not a matter of being specialists in education, health or citizen relations.

— The need was established to set up synergies between the different fields of action in the ICI Project, in so far as they can make the most of the results in a field (education) by searching for synergy with the other fields. What actually happens is that the education system and the healthcare system have carried out parallel development and traditionally, schools have been one of the fields with the greatest interest for promoting health.

Among the actions carried out in this first phase in the field of community health, the following should be highlighted:

— Promoting joint meeting and work spaces among healthcare technicians, local technicians (town councils) and public health and between them and the other sectors.

— Participation in commissions, forums and health boards in the territory.

— Support for carrying out sessions, meetings, celebrations and get-togethers on health promotion and prevention of disease.

— Development of observation, research and analysis on the actions carried out in the community health field in the territory.

— Shaping groups among professionals and citizens to promote healthy life styles and prevent health problems in the territory.

— Carrying out awareness raising actions to promote community health from an intercultural perspective.

— Carrying out other actions: Advice to teams and professionals, support to draw up healthcare communication tools, resources, guides, etc.
2.5.2 Phase two

During the second phase of the ICI Project, community health works towards consolidating spaces for connecting, work and continuous cooperation with the different resources and agents in the territory engaged in the health field, in order to make progress with the shared knowledge process for the health situation in the territory and identify needs, health problems, assets and resources to fully tackle them from participative action in a network, leading to improving health in the territory.

These objectives revolve around three axes:

— Intersectoriality
— Empowerment
— Health promotion

— **Intersectoriality**: supporting intersectoral, cooperative work between administrations, technical resources and citizens who work to promote health, in order to encourage processes adapting to existing cultural diversity.

In this respect, during the second phase, technical staff relationship spaces were consolidated, by progressively implicating healthcare sector professionals. In addition, in some territories, technical programmes were set up specifically related to the health field that went by different names (health boards, health programmes, community health group, etc.), bringing together professionals from health centres, social services, municipal health centres, mental health, drug addiction centres, patient associations, social entities, etc. This fact represented fundamental progress to the extent that in some cases these resources were not aware of each other or were not connected despite working in a field with common and complementary interests and aims.

ICI team actions and work ran on different levels (administrations, technicians and citizens, both organised and non-organised) implying different dynamics depending on the type of audience in these relationship spaces. This requires an organised social response given that health is a social product in that its players and the actions go significantly beyond the boundaries of the so-called “health sector”.
In the plenary sessions and meetings held at the start of phase two, a need was detected to reinforce the conceptual and methodological framework of intersectorality in the field of community health within the context of the ICI Project, given that thought should go into the approach for actions run by the ICI teams in this respect, to identify the model from which the inter-sector aspect is being tackled and, tied to this, matters relating to representation, power relations and participation from the different players.

In addition, it was necessary to go into greater depth on institutional theory in so much as it offers a basis for thinking about and guiding the work done with the different players. It should be taken into account that a substantial part of the intersectoral work implies different and ideally progressive gradients (depending on the outline) of connections, cooperation, coordination and integrated work among players belonging to different institutions and community devices that, in turn, have different cultures (ideology and values, organisation, operation, rules and dynamics for relationships, etc.). It is not the same to work in/with the school field at its different levels as in/with the healthcare field, in/with the association field and within each of these sectors, differences must be considered according to whether it is public, private, concerning patients or neighbours, etc.

**Graph no. 2. Inter-sectorial and inter-institutional work**

One support tool that was extremely useful throughout the ICI Project was mapping and spatial representation, geo-referencing and mapping of the different resources contacted according to the areas of work and belonging, exploring the actions that they deploy, the type of relations between them and with other resources and their contribution to improving the territory’s
health according to the corresponding fields of action (healthcare, social, educational, etc.). All this involved studying the ICI team situation and alliances in this mapping to weigh up opportunities and threats to meet objectives.

— **Empowerment**: Encouraging actions aiming for people and groups to increase their control and capacity for management over determining factors for health, associated both with shared knowledge of health needs and problems perceived by the political leaders, technical resources, association framework, groups and citizens, and with setting priorities and proposals for intervention among the players, administrations, technical resources and citizens.

Connected to the previous strand, phase two structured the methodology and subsequent phases to collect information on health problems and needs and on existing health resources and assets in the territory, in so much as they are perceived by the different agents in the community through a research and active participation process. To do this, corresponding data and indicators are requested on the state of health and the quality of life among the population from the managers in the administrations involved and a broad and representative sample was selected of social agents that live and/or work in the territory who might provide both objective and subjective information on the aforementioned topics.

The methods used for this information compilation were interviews, hearings, talks, nominal groups or discussion groups, etc., by organising programmes to listen and talk to key informants (people living in the neighbourhood, managers and professionals from the different universal healthcare, association, educational resources, etc.). The aim was to provide contrast and discussion on localised or existing information, in order to prioritise needs and problems by sharing them as they might connect up with the community programming for the third year of the Project intervention.

Participative action firstly implied giving a voice to different stakeholders to later share and transmit the information obtained to the rest of the community or other organisations by means of meetings, spatial representations, dramatisation or other techniques and, also, frequently carrying out actions to transform the real situation. This was a matter of bringing about, strengthening or boosting spaces to disseminate and discuss existing information (proven and based on systematic work) so that administration, technicians and citizens could find out about, have an opinion and decide on current or necessary strategies to tackle some of the problems or aspects identified in the shared knowledge process.
During phase two, significant progress was made on systematising the communication plan, information and communication systems that allow information to be shared among the different players engaged in the ICI Project. Among the tools and instruments designed, there are the meeting minutes, blogs, informative notes for the local media, quarterly reports, audiovisual materials, etc.

The reports, under the “Sharing” slogan, are used to highlight fundamental aspects of the activity being developed during this phase and are essential as an information, coordination and dissemination tool for the ICI Project’s work and progress in the territory. The ICI Project in Carrús (Elche, Alicante) can be used as an example. The first issues of the report were used to present the ICI Project, provide information on its open summer school, programming, development and assessment and account for the start of drawing up the community monograph.

Universal healthcare resources guide. Another collaborative and intersectoral tool was drawing up guides with information that provides a better understanding of the different resources, programmes and actions available for the population’s health needs. The process of drawing up
these guides was, in itself, a medium that facilitates and improves knowledge of the territory’s assets for professionals in the different sectors.

The following picture shows the Health Guide for Las Margaritas neighbourhood in Getafe (Madrid), drawn up by the community health group, with participation from Las Margaritas Health Centre Primary Care Doctor and Nursing Care Division, the Territorial Public Health Service, the Getafe Municipal Health Centre, the Drug-addiction Integral Care Centre, different Getafe health associations that act in Las Margaritas and the Las Margaritas neighbourhood association.

**Drawing up educational and audiovisual material in the health field**: the ICI teams working with the social and cultural, healthcare and educational resources, social entities and organised citizens in the territory, worked hard on drawing up and adapting information, education and communication resources in the health promotion field (recipes, leaflets, posters, stickers, flyers, info-capsules, audiovisual materials, etc.).
CHARLA SOBRE
HÁBITOS SALUDABLES
PREVENIR EL RAQUITISMO

 صحّة كي معیار
(رکش) بثیونکی کمزوری کي روکتیهام
کی باری مین بات

Doctora: Mª José López Mendía
Fecha y lugar:
Miércoles, 23 noviembre, 17:00 h.
Centro Deportivo La Ribera
(Paseo del Prior, 16)

con Servicio de LUDOTECRA

Proyecto de Intervención Comunitaria Inter-cultural
INTERCULTURALIDAD Y COHESIÓN SOCIAL
One matter that was clear in the ICI team interventions is the importance that the needs and problems detected are expressed and presented in formats adapted to the different subcultures of the population and professional sectors at which they are aimed.

Specifically, in the healthcare (health) field, given that the prevailing model is biomedical and the predominant gaze is the individual clinical focus, healthcare professionals (socialised in this model) tend to talk about health problems as rates, risks and trends, finding it hard to visualise them as social facts as opposed to biological individuals. Presenting the community needs and problems detected in a compatible format with this model occasionally implies some translation and semantic reduction, initially involving quantifying and medicalising it, to demonstrate its relevance and get it on the health agenda.

However, the way in which citizens perceive and express health needs and problems differs from professionals, referring to a set of interlinked meanings that people and groups establish between the health-illness processes and their historiography, ties and relationships in their life (family, school, work, friends). For this reason, mediation and approximation work on these issues is highly relevant as it reflects this polysemy, different nuances and complementary gazes, without aiming to reduce or simplify it.
— **Health promotion**: bring about initiatives and strengthen existing initiatives focussed on promoting health as an essential element to improve quality of life.

ICI Project development insisted on the importance of tying in and aligning priorities and actions developed in health with any featuring in administration plans and programmes (healthcare, education, social services, etc.) in order to reinforce feasibility and get the necessary backing. As mentioned above, the ICI Project is not just another project as it aims to connect up existing strategies.

In addition, the need was recognised for the teams to handle the terminology corresponding to each administration, the specific codes and the language explaining needs, action strategies or priority criteria, in order to be able to set up dialogue with the technicians and make certain agreements and collaborations without implying becoming slaves to them.

In territories where there are integral projects or Strategic Plans in the field of administration (citizens, living together, integration, etc.) and any in which the educational, social and health fields are fundamental, ICI teams can develop, as demonstrated in practice, a decisive influence to incorporate the ICI Project’s priority strands, the intercultural perspective, integral health, health promotion and equity in the different policies, strategic lines and actions that are brought up.

Despite the difficulties outlined in the health sector to develop the intercultural community perspective, within the healthcare system there are sectors working to recover and develop health promotion actions, convinced that this model makes a longer-lasting impact on public health. This was a question of strengthening alliances with these committed professionals working at the different levels of the healthcare institutions so that the ICI teams might become a resource that strengthens the efficacy of their work, to the extent that they help to put different resources in contact and review their work.

Over this time, complex health problems and situations were detected in the territories such as domestic abuse, defencelessness of some groups, vulnerability of others, public health risks, etc. This required thinking about the role that ICI teams should occupy, taking into account that, as they are not health professionals, they can identify and transmit information on these situations to whoever has competences in these fields.
2.5.3 Phase three

- Developing shared knowledge: community monograph, assessment and community programming, plus holding a variety of community meetings.
- Significant experiences in community health.

During phase three, the community health objectives continued to converge towards consolidating work spaces and continued cooperation with the different resources and territory agents engaged in the field of health, in order to complete the shared knowledge process, with the finalisation of the community monograph, drawing up the assessment (identification of health needs and problems and setting priorities) and community programming (setting and meeting common intervention objectives) in order to improve the territory’s health.

The global line became more intense, focussing the ICI teams’ work during the first period of this phase on drawing up the community monograph work and holding the 1st Community Meeting. During the second period, the focus was on validating the assessment and establishing community programming with the three main players, preparing and holding community meetings in parallel.

The work process followed by drawing up, agreeing on and spreading the word concerning the community monograph, assessment and programming, as well as preparing the corresponding community meetings, brought about a latent opportunity for joining forces in a network of healthcare professionals with other players in the territory engaged in health promotion. This represented a fundamental boost to making progress and strengthening the intersectoral and cooperative work among administrations, technical resources and particularly concerning citizen participation.

These processes brought about workspace programming and specific methodology that made it possible to compare and contrast views and organised participation from the different agents. In these spaces, it is possible to contribute, analyse and reflect on the territory’s health needs with actual healthcare professionals, other technicians from other sectors and with citizens, providing a joint and more contextualised view when deciding on priorities. In all cases, pooling, provision and contribution from the different players and sectors highlighted a strong symbolic character.

The three main players supported and participated in drawing up the focus and the processes developed to validate the assessment and prepare community programming. Continuity was
maintained for actions envisaged during the year in the health field, running the intervention lines programmed with barely any deviations. This made it possible to tick off the different milestones and products within the overall line.

The territory’s health gradually became a growing point of interest as this work progressed, to the extent that the intercultural community health focus and health promotion represented proposals open to participation that brought about convergence, managing to incorporate and implicate healthcare resources, their managers and actual citizens in the discussion-action processes.

At the end of this phase, the existing technical staff relationship spaces were expanded and consolidated with the three main players, so that practically all the territories had a technical staff relationship space in which professionals from the universal healthcare sector participated, either in the overall programme and/or in the driving nucleus. In some territories, this structure turned out to be extensive and solid in the community health field, such as the case of Raval (Barcelona), where community assessment revolves around the health axis, setting up different work commissions in line with the most relevant identified and prioritised needs in the programming.

However, difficulties emerged in other territories to find health technicians in the technical staff relationship spaces so alternative channels were chosen to ensure they were connected to the programme, such as keeping them informed and in contact with ICI Project progress, encouraging them to take part in talks, hearings and community meetings, involving them in specific actions, etc.

In addition, by the end of this phase, practically all territories had one or more specific participative structure in community health that was being consolidated and strengthened over time. Technicians from the (municipal and regional) universal healthcare field, representatives from (local or district) administration participated in these structures to a greater or lesser extent plus, on many occasions, citizens (organised or individually), associations, volunteers, etc.

These structures have contributed to progress in establishing synergies and collaborative work between the different specific lines and between the different sectors engaged in tackling health needs and problems detected in previous phases. In addition, they have been fundamental in terms of setting up consensual community health programming.

Therefore ICI teams made progress in strengthening, expanding and consolidating relations and alliances with the three main players in order to ensure sustainability for actions in pro-
gress and feasibility for community programming, despite the fact that continuous cuts in social
and healthcare services represented a threat and, occasionally, limited any chance of involving
healthcare professionals in intersectoral and community work programmes. Despite this, the
third phase saw that programmed objectives had been broadly met; the ICI teams knew how
to combine times, intensity and organisational capacity to meet the different challenges, situ-
atations and requirements set up in the territories.

2.6
Priority action lines in intercultural
community health

During the second phase, significant progress was made in the different territories in terms of
running different experiences and making new proposals in the health field that were shared,
analysed and discussed in the plenary sessions, meetings and health focus sessions organised
from the advisory team with the ICI teams from the 17 territories.

In accordance with these processes and experiences, priority action lines were identified in inter-
cultural community health, establishing the following reference models as inspiration plus cri-
teria for implementation:

— Healthy territory
— Health promoting schools
— Community based health agents
— Actions promoting health

Let’s look in more detail at these suggested reference models and some examples that illustrate
how their relevant proposals, experiences and new practices were deployed.

Healthy territory

From this model, the city, territory and district are conceived as complex and dynamic. This is
where people live together, developing life, daily activities and political decisions that govern
them (economic, social, cultural, educational, leisure-related, etc.) so, as we have seen, they play
a determining role in health. The physical environment, or habitat, also determines how people
relate to each other, how they live their lives and their lifestyles, so it is the ideal place to articulate measures that redirect public policies in favour of health.

The World Health Organisation (WHO) Healthy Cities Strategy is one of the most visible and important demonstrations of applying the health promotion focus principles and methodology in the real practice of local public health. The concept of “healthy city” should be understood in terms of processes, not just results. Any city can be healthy if it commits to health, if it has a structure to work on health and if it starts a process to achieve it, promoting healthy lifestyles and creating environments to encourage them.

This strategy aims to improve the environments that affect health positively or negatively according to external factors (environment, employment, education, housing and poverty) that, among others, are the main determinants of health, beyond the field of healthcare. The methodology consists of creating and implementing municipal health plans based on intersectoral cooperation and citizen participation.

**Health promoting schools (HPS)**

This model aims to make it easy for any educational community to adopt healthy lifestyles in an atmosphere encouraging good health. It outlines the possibilities for schools, if they commit to it, to instil a healthy and secure physical and psycho-social environment. The work bases promoted by HPS are:

- Integrating health promotion into school programming; implying an innovative didactic methodology, open to daily situations and student experiences related to health.
- Looking in further depth at health contents; not just conceptual but particularly concerning life attitudes and skills that improve students’ abilities to lead a healthy life.
- Consolidating the teaching staff’s teamwork as the main health promotion agent in school, with management team support to integrate education for health within the school’s educational project.
- Promotion of a healthy environment and a positive school climate that supports health and

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9 The European project emerges from the joint initiative from the WHO Health promotion and Environmental Health sections (1987). It began with 11 cities although this later grew to 31 (including Seville and Barcelona); in 1998, San Fernando de Henares was added in phase three of the project and as the project expanded in Spain from 2003, five more cities were added in phase four (2003-2008): Barcelona, Gijón, Vitoria-Gasteiz, San Andreu de la Barca and Leganés. Now in phase five (2009-2013), a further five cities have joined: Orense, Salamanca, Villanueva de la Cañada, San Sebastián de los Reyes and L’Hospitalet de Llobregat. The project created such expectation that national and regional networks were quickly developed. There are currently national networks in 29 European countries and around a thousand cities participate in this movement.

10 The European Network of Health Promoting Schools project (EnHPS) aims to establish a group of model schools in the WHO European region that can demonstrate the impact of the policy and practice of the health promoting schools in the broadest of the educational and healthcare sectors, both nationally and internationally. More than forty countries from the WHO European region are currently part of this network. The main aim is to attain a healthy school that makes it easy for the whole educational community to adopt healthy lifestyles in an atmosphere that favours health.
student wellbeing and the rest of the educational community. Search for collaboration relations and implication of families in the educational project.

— Collaboration with territory’s universal healthcare services to improve interaction and synergy with the surrounding resources, promoting a school that is open to the community.

Health promotion at school is a priority area in which practically all ICI teams, without exception, have worked, increasing considerably as the ICI Project moved from one year to the next.

The convergence of interests and guidance between the specific socioeducational and community health line can be found in this field that has been sown for success. The open summer school, back in its first year, represented a starting point and was used as a probe to check the effectiveness of joining forces. Later, opportunities and potential were identified in the educational programme to incorporate actions throughout the whole school year.

In the territories within the Healthy Cities Network and/or the Health Promoting Schools Network, this was a unique opportunity to recall the principles on which these models are based, the commitments implied by belonging to these networks and, from there, bring about their development. When the case did not arise, this model was used as a reference and guide to promote and uphold its gradual implementation.

**Community-based health agents**

The ICI Project understands a community health agent to be a person who has received special training on aspects of health promotion and education and who wishes to offer support on health aspects to persons, groups or collectives in the community field where he/she does his/her job.

This community agent is usually proposed and/or picked by pre-defined criteria, agreed among health professionals and the field (family, educational, association, community, etc.) in which he/she works to promote healthy practices in these contexts and in their community, in coordination with health staff. This usually refers to people with broad knowledge who are well-integrated in the target group or collective where he/she is planning to work, and where he/she also enjoys recognition and credibility.

Boosting the health agent figure becomes increasingly more interesting for the ICI teams, projected on to different figures that had to be defined and differentiated appropriately so as not
to get confused and be able to move forward in specifying them according to contexts, functions and field of action.

**Actions promoting health in collectives**

As mentioned above, according to the Ottawa Charter, WHO (Geneva, 1986), health promotion constitutes an overall political and social process for persons to gain control of determinants of health by taking part in analysing and proposing solutions to health problems that affect them. It not only covers actions directly intended to strengthen individual skills but also targeting modifications to social, environmental and economic conditions, in order to lessen their impact on public and individual health.

Health promoting experiences were developed in the 17 territories for different collectives relating to different topics of interest in the territory, including encouraging healthy habits among different ages and collectives (diet, leisure, sport, illness prevention, etc.), parenting skills, mental and emotional health, enabling mutual support and mediation groups, holding themed meetings on health or developing health contents in the local media, among others.

The ICI teams in the different territories, working from these aforementioned models and depending on certain conditioning factors such as shaping the actual team, the characteristics and history of the territory and the resources engaged, the opportunities, sustainability over time, etc., developed different experiences inspired by these models, although taking on their own identity and definition as they were specified and shaped, in accordance with the aforementioned factors.

## 2.7

**Significant experiences in intercultural community health. Five illustrative examples**

The diversity of interventions deployed in each intervention territory in the health field follows a common development outline with the following stages:
1. Initial identification of the situation in the territory, challenges and how health contributes to living together.

2. Identifying opportunities to work with resources and devices that develop health plans and programmes in the territory. Connecting the initiatives to reference models and action models in community health.

3. Contact and relationship with local agents, establishing synergies through support for existing initiatives and/or proposing new initiatives.

4. Helping citizens to take part through collectives, associations and diversity support.

5. Connecting up current initiatives, relations and programmes generated from community health work with the shared knowledge process, the action priorities identified for health and the community agenda.

Five of the experiences carried out in the intervention territories are mentioned below that, without claiming to represent the full range of experiences developed, might be used as examples:

— Carrús neighbourhood (Elche). Promoting health in the educational and community environment.
— Raval neighbourhood (Barcelona). Shared knowledge and identification of priority health lines.
— Zaragoza Historical Centre. Working towards a Healthy Territory.
— Logroño. Health promotion and improving positive interactions among professionals and locals in the neighbourhood.
— The Salt neighbourhood (Gerona). Young health agents, educational intervention and youth participation.

**Experience in the Carrús neighbourhood (Elche). Promoting health in the educational and community environment.**

Carrús is a neighbourhood of Elche (Alicante) with 66,618 inhabitants, of which 21.7% are of foreign origin. It has a high number of older people, along with children and adults resulting from migration over the last few decades.

This is a territory with little cohesion, where how the groups live together can only really be classed as coexistence, leading to spatial and social segregation. As the ICI Project went on, setting up different places to meet and connect, plus boosting community actions, living together improved in terms of equality and the population learnt to value and respect differences.

Experiences in the field of health have been encouraged and carried out from the ICI team with territory agents, working with the socioeducational and citizen relations field.

The aim of the action was to develop different interlinked educational activities contributing to health promotion and encourage healthy habits within the framework of community action and interculturality, making the most of the different neighbourhood programmes, beyond health centres, and implicating all community resources, in an attempt to encourage teamwork, coordination and collaboration among them.
Graph no. 3. Players and synergies from the Healthy Schools (Carrús, Elche)

The action was aimed directly at the whole school community (teachers and other professionals in the centres, families, students, etc.) but also indirectly at community resources, other locals from the neighbourhood, etc.

The **coordination structure** is the health commission for the neighbourhood technicians featuring representatives from the ICI Project, from different Town Council departments, Vinalopó Salud (health centres, hospital and support units), Valencia Health Agency, schools, M. Hernández University and other technical resources such as Caritas, Proyecto Hombre, chemists, local police, Teacher and Community Worker Training Service, neighbour associations, immigrant associations, student associations, parent associations, etc.
Actions performed

— **Carrús Jove radio programme**

With support from the Youth Ministry, Ràdio Jove Elx, J. Martorell high school, healthcare, community and local resources from the neighbourhood, the programme was led by young people tackling topics of social and healthcare interest for the neighbourhood.

— **Health Promoting School**

The Health Promoting School model was developed at J. Martorell high school with a structured and systematic plan in an attempt to get the education community (teaching staff, students and families), health resources and other community-based resources and persons to work together and run actions benefitting health and wellbeing for students and teaching and non-teaching staff in the neighbourhood.

— **Open summer school**

Health promotion is incorporated across the board through sport (urban orienteering race, visit to nature spots, sports days, ping-pong and basketball tournament) and specifically through giving workshops on emotions, dancing, women and science, sexuality, sexually transmitted diseases, diet and healthy cooking, heat waves, drug prevention, etc.

— **Healthy walks**

The Carrús community health programme “Carrús Actúa con Cuidados” to include priority lines of work on the neighbourhood citizens’ habits and lifestyles. Over a hundred people walked three different routes, adapted to their physical condition.

— **Health promoting chemists**

The neighbourhood chemists can also promote health and prevent illness, tackling issues such as stopping smoking, healthy eating, osteoporosis, etc. Health and social resources participated in the project.

— **Project among Women**

Weekly programme to meet up and talk where women, accompanied by different professionals, tackle health promotion topics (healthy diet, self-care, social relations, first aid, handling stress and anxiety) working from the participants’ own interests and knowledge. This is promoted by Elche Town Council, Carrús Health Centre, Cáritas Elche and Fundación Elche Acoge working with Fundación Secretariado Gitano, Schools Psychopedagogic Service and other social organisations.
These projects provide a significant boost to the neighbourhood’s collective health due to joint implication and action from both technical and community resources pursuing a common aim: health promotion.

After the work, the team discussed how it important it was that all activities promoted by the territory’s resources should provide meaning to neighbourhood diversity, carrying out continuous actions, inter-linked and integrated in the programming for the territory’s different resources, promoting critical discussion on health topics that interest everyone and reinforcing healthy attitudes and habits among locals in the neighbourhood.

**Experience in the Raval neighbourhood (Barcelona)**

The Raval neighbourhood (Barcelona) is characterised by an intense mixture of collectives from different origins, cultures and religions. It is inhabited by people born in Barcelona or Catalonia (33.3%), people from the rest of Spain (14.4%) and people born abroad (52.3% of which 5% have Spanish nationality) with a small representation from the gypsy community in the district.

The community health line in the neighbourhood began by implementing the ICI Project from a neighbourhood organisation platform, the Fundació Tot Raval, in order to promote a com-
munity with greater control over factors that affect their health. In concordance with the ICI Project methodology and the community health bases, the following process was followed that allowed a community health action plan to be defined together:

— Identifying the administration linked to Raval’s health and the neighbourhood’s resources, presenting the ICI Project and inviting them to participate.

— Shaping an institutional group formed by seven public institutions and the inter-sector Community Health Commission, formed by over fifty resources from different fields in the neighbourhood and from which three working subcommissions are formed: mental health, affective-sexual and reproductive health and old people.

— Drawing up a participative study focussed on neighbourhood health, as a result of the knowledge and experience exchange among the different players in Raval.

— Discussion and analysis of the most important problems identified, after which three strategic action lines were defined to tackle an intercultural, gender and life cycle perspective, following an inter-sector concept: mental health understood broadly and throughout the population, affective-sexual and reproductive health and healthy aging.
The actions proposed for each of the lines aimed to strengthen:
— Encouraging healthy lifestyles, emotional education, psychosocial skills and parenting skills.
— Strengthening networks and family, neighbour, social and community ties and promoting participation programmes.
— Knowledge of others (fighting rumours and stigmatisation), of neighbourhood resources and what they do plus knowledge of rights and responsibilities.
— Articulation between resources and professionals from different fields (educational and socio-educational, healthcare, sports, social, cultural, etc.).
— Overall concept in actions. Mentoring

Some of the actions that emerged from the community process are:
— The guide to resources and actions in Raval, compiling over 700 actions from 145 resources and services that work in education, health, social and cultural fields, among others, making an overall analysis.
— Health backpacks, educational and recreational tool, designed from and for promoting health among children between 4 and 7 years old. This refers to three backpacks with different themes: healthy habits, emotions and gender. They are accompanied by specific training for educators and include books selected together, a guide with objectives, methodology, assess-
ment proposal and recommended bibliography, a didactic game to work on the topic plus a reading list and additional materials. This was an initiative from the Reading Network, formed by 19 centres and entities, taken up by six neighbourhood socioeducational entities and two libraries, also implicating social, educational, community health and parents association agents.

— *Health promotion in the Carnival festival (Ravalsotada)*, community activity involving over 35 neighbourhood, social and cultural organisations from Raval. In 2012, under the “Salut-Accions” slogan, the entities worked on promoting healthy habits, choosing this as their theme and basing their costumes on it. This was a great success. Working from an activity in the territory, it was possible to project community health as a significant element for managing diversity and joining forces for a common objective, capturing it in a practical, symbolic and transcendent activity for Raval collectives, managing to implicate organisers, neighbours, families, schools, etc.

To date, the ICI Project in Raval has been very highly valued: new relationships and meeting spaces have emerged and the sum of synergies for a common aim, considering neighbourhood diversity from the best recognition for everyone within it.

**Experience in the Zaragoza historical centre**

The historical centre of Zaragoza is a privileged area located in the city centre, well communicated and boasting many services, with enormous heritage tourism, shopping areas, etc., although the adjacent neighbourhoods are very downtrodden areas of the city.  

*The Carrera del Gancho* is an event around which different festival commissions work throughout the year and involving practically all the social, cultural and other types of organisations and entities. The different groups are organised around a selected theme to build and draw up different actions, connected to the target project, where artistic creativity is key in this multiple and diverse montage.

The ICI project worked on the healthy neighbourhood model, deployed in many different directions: raising awareness on the influence that the physical, ecological and sociocultural environment has on collective life, developing proposals to improve quality of life, territory cleanliness, ecosystem sustainability, encouraging healthy habits among all ages and groups through collective sport and cooperation, etc. For this purpose, different technical spaces were built for

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11 Information taken from the executive summary from the prior study carried out by the ICI Ozanam team in 2010.
relations or commissions to deploy a coordinated and integral action:

— Community Health and Environment Commission for the Carrera del Gancho, including participation from the City Council and Aragón Government Environment department, the Ozanam Foundation, the health centre, other services and related centres and community agents, associations and different collectives. Drawing up Healthy do’s and don’ts along with the Aragón Government Public Health department involved more resources and environmental collectives.

— Cleaning, Community Health and Environment Commission for the Historical Centre, from which the different collectives proposed and developed actions to improve community health.

**Actions run** by these commissions include:

— *Drawing up Ten Commandments for Children’s Health* implicating intersectoral work between education and health so that children can express themselves and creating a healthier neighbourhood in schools, working in the classroom from the pedagogy of shared participation with the teachers to include the process in their programming. Coinciding with the Saludabilis Tree exhibition route, the project is linked to the Carrera del Gancho, displaying all the material created by the children and teenagers in the process, involving over 350 children and young people from 8 to 16 years old.

— *Cardio-walks* are preventive activities promoting community health that improve state of mind, physical wellbeing and strength, bringing about positive relationships and experiences. An open group of adults meet up every week, starting out from the health centre to walk different routes; sometimes they are enhanced by trips to museums, social resources, treasure hunts or healthy lunches, combining exercise, friendships and culture. Organised by the health centre, the walks received a special mention at the EBRÓPOLIS Award for Citizen Best Practices in 2011, for their application “Gastando suela por el Gancho. Engánchate a los grupos de paseo” (Wear down the streets for the Gancho, get hooked on our walking groups), as an example of implicating public services and medical professionals by applying community development methods.

— *The Urban Community Garden and a leisure place for children*, boosted by the Carrera del Gancho social-educational commission, a school, a group for seniors and a group of neighbours supported by the ICI team. The private site, divided into plots, is looked after and worked among everyone involved. A leisure space for environmental sustainability, bringing nature into the historical centre, embellishing it and creating spaces for meeting up, participation and intercultural and intergenerational friendships, also contributing to environmental education.
Environment Week Organisation, with the aim of raising awareness among neighbours on the importance of cleanliness and care for the streets and possible repercussions on community health. It also helped to overcome obstacles making it hard to live in a healthy environment.
Experience in Logroño. Promoting health and improving relations among professionals and locals in the neighbourhood

The intervention took place in the Madre de Dios and San José neighbourhoods, traditional working class neighbourhoods that are now on the periphery of the expanding city. Coexistence is widespread although there are also cohabitation spaces, fundamentally through associations. There is also tension or hostility regarding the use of public parks in the summer.¹²

In its approach to the territory’s health situation, the ICI team detected a series of circumstances in the field of intercultural community health, the existence of inequalities in accessing healthcare services for certain groups, the difficulty to access the health centre for external agents (including the actual ICI team) and the health centre’s needs and interests to resolve this situation and improve its care quality.

The aims set in the community health field in accordance with this initial context were:
— Improving knowledge of the sociocultural conditioning factors that limit equal access to healthcare resources for certain groups.

¹² Information taken from the executive summary from the prior study carried out by the ICI Rioja Acoge team in 2010.
— Promoting health and preventing disease among the most vulnerable groups.
— Improving knowledge among the most vulnerable population groups in the territory on how health resources work.

It aimed to promote the healthcare professionals’ interest in factors that condition the population’s health, setting up a two-way relationship between health centre professionals and citizens, building trust between the two sides and getting professionals involved. In addition, it also promoted developing health guidelines that respect cultures and adapt to social and cultural diversity.

In this respect, actions encompassed the territory’s entire population, considering the existing diversity although paying particular attention to vulnerable collectives that find it hard to access health services.

The strategy was sector-based, setting up joint work spaces between health professionals and women’s groups from different origins, working from the needs these groups expressed. Special care was taken with communication, symbols, language, spaces and image and support was sought to reinforce and extend the actions: citizen and religious leaders, associations, babysitting for the children.
This represented implication from different players: Citizens (formal, informal, community leaders), Administration and technicians (health centre managers and professionals, babysitters) and the media, plus joint running of the following actions:

— *Open training sessions* (200 participants) on healthy habits to prevent rickets, health advice for travellers, family planning and monitoring pregnancies.

— *Drawing up didactic material* adapted to cultural diversity: nutrition pyramid and health advice for travellers.
The experience contributed to the community process:

— Trust in a community development methodology based on teamwork. It should be symmetrical among the different players (administration, technicians and different groups of citizens) engaged in the health/care processes, highlighting and reinforcing the need for mutual cooperation to make the experience work.

— Improved accessibility for the most vulnerable collectives or those with difficulties or obstacles to access equal healthcare, creating new intercultural professional-citizen relationship spaces and improving how people live together by setting up plural programmes around collective health.

— Improve and expand health professionals’ cultural skills.

**Experience in the Salt neighbourhood (Gerona). Casals dels infants. Young health agents. Educational intervention and youth participation**

In Salt, the main problems among the immigrant population are long-term unemployment and poor quality jobs; the fact that some of them are illegal immigrants makes the situation even more complicated. There is a noticeable process of ghettoization in the city centre neighbour-
hood, in some schools and in certain neighbour communities, where overcrowding situations are detected. In general there is a climate of coexistence, depending on the time (dividing up parks and squares, use of shops, health centres...)\textsuperscript{13}.

There is a high school drop-out rate among children of foreign families, leading to processes that point to segregation, such as the native population abandoning state schools.

Health professionals asked for more elements in care praxis to look after citizens from prevention and health promotion. The Pla de Salut Jove has existed since 2007, framed within the Pla Educatiu d’Entorn and the Pla Local de Joventut de Salt, run by a health agent who spent ten hours a week on it until 2011.

From the ICI Project, in accordance with detecting this need felt by the citizens, it proposed networking by linking in administrations and professionals in order to optimise their intervention. In addition, it was suggested to connect youth groups positively to the community and the territory. The proposal is based on reciprocal behaviour: implementing experiences in which citizens share spaces and knowledge. The action aims to strengthen autonomy and reinforce a free socioeducational programme for young people.

**The ICI Project aims** were therefore:

— Find new answers to health needs and problem issues, working from the existing situation.
— Design consensual and coordinated actions among health professionals, using and strengthening community participation.
— Implicating and providing skills to citizens in terms of achieving healthier lifestyles and surroundings.
— Listening to requests from health professionals and citizens’ needs.
— Optimising/reinforcing an existing health promotion resource.

This aims to construct critical citizenship on the environment’s real needs, implying upholding dual intentions: pedagogic (improving learning quality) and supportive (offering a participative answer to a social need).

This process is based on a training model of learning and service intervention, not only as an educational proposal but also as community development, understanding that the action has

\textsuperscript{13} Information taken from the executive summary from the prior study carried out by the ICI Casals dels Infants team in 2010.
repercussions on the very people carrying it out and on whom the services are focussed, making an impact on children, families and old people. This experience therefore refers to training young health agents, making the most of Pla de Salut Jove.

In accordance with these approaches, a service-learning project is defined in three phases:
— Social need and service that the young people can perform.
— Working from the environment in an attempt to improve it.
— Learning what this service will bring to young people. Commitment, reflexive practice. Transformation perspective.

What does it bring to the community process?
— Generating an active group of young people committed to the environment.
— Enriching ties.
— Strengthening educational investment in health.
— Working directly with non associated citizens.
— Obtaining greater knowledge of the real situation.
— Providing answers -health professionals interacting with the community.

The health promotion actions developed by community health agents were aimed at the territory’s inhabitants as a whole, considering all existing diversity, but paying particular attention to priority collectives and the gypsy population, that is in the majority.
What were the main achievements in Intercultural Community Health?
Firstly, it should be highlighted as a relevant success that the territory’s health has become one of the priority centres of interest in the intervention territories, incorporating the intercultural community health focus and health promotion into the strategic action framework alongside the other lines. All this followed the ICI Project’s principles directed towards an integral view of health, integrated in the different public health policies or, in other words, aimed at the group and understood as the community’s organised effort to reach the best possible level of health involving different sectors (social, educational, work-related, healthcare, etc.).

Really, during the first stage of the ICI Project, as we saw, a set of actions was deployed framed in this specific line of action as a new, relevant and strategic contribution to the extent that it worked from an integral conception of health. Just like the other action lines, it was not developed as separate, isolated sector-based work but tied to the central strand of the project with a clear feeling of process.

Secondly, consolidation and maintenance of relationship spaces between sectors and professionals with the community represent a great achievement for the ICI Project, taking into account the current context. Indeed, restructuring of the healthcare and educational system linked to the crisis, serving as a backdrop (particularly during the second and third year of the ICI Project), and continuous cuts in social and healthcare services with the subsequent increase in workload for professionals, represented a clear set-back threat for implicating technicians in the intersectoral and community work spaces. However, not without some difficulty, it was possible to maintain the achievements made over previous years in the field of community health, moving forward significantly in consolidating the strategic action lines identified during the second phase.

Thanks to all this work, significant progress has been made in terms of knowledge and identifying health needs and problems, as well as in setting priorities and common aims for interventions in the health field. The ICI teams therefore managed to strengthen, expand and consolidate relations and alliances with the three main players in order to ensure sustaining actions in progress and consensual community programming feasibility.

On the other hand, consolidation of the community process after three years of intense work, along with the fruits it is bearing and the dissemination of results, seems to assume a guarantee which encourages administrations and health care professionals to maintain their participation and involvement in the process.

To summarise, the following can be highlighted as achievements in this process:
3.1 Consolidation of community health bases and fundaments

During the first stage of the ICI Project, it was possible to incorporate the conceptual and methodological bases of community health into the ICI teams’ praxis to the extent that, along with the territory agents, shed light on the potential of the proposal based on the holistic model, health in all policies and the influence of social determinants of health.

The Community Health Line was converted across the board in many cases, incorporating integrated and integral actions both in the Global Action Line and in the other Specific Action Lines, inspired in this model, as well as from a specific perspective, through the particular work developed with health field resources (supervisors from administrations, technicians) and citizens.

The territory’s health took centre stage for all this work to the extent that, as the ICI Project went on, it was including the community health focus and health promotion, managing to incorporate and implicate healthcare resources, their managers and the actual citizens, in the reflection-action and, therefore, in praxis.

3.2 Progressive implication of territory agents in intercultural community health

As the different ICI Project phases unfolded, there was a noticeable increase in the number of participants in the activities for these three collectives: family, children and youth.

In the relationship spaces for the different sectors and when designing and programming activities both in the field of community health and in other action lines (education and citizen relationships), the teams met the challenge of boosting the role of the three main players (representatives from
the administration, technicians and citizens) to become more active and committed, letting the ICI teams step back, in terms of maintenance and sustainability of the processes that were developed.

The following graph shows the exponential increase in the number of participants in the activities developed in the territories over the three years and their sociocultural diversity.

**Graph no. 4. Activities and participants in health activities between 2010 and 2013**

3.3

Clear increase in activity in the intercultural community health field

Assessment of the activity and interventions carried out by the territory ICI teams has been really positive, not only due to the number of initiatives generated and maintained during the first stage, but also due to having listened to and combined the demands and intense, diverse pace of the different lines of intervention and due to the nature of these interventions, allowing progress to be made and the principle action strands to be looked at in greater depth: intersectoral, empowerment and health promotion.

The data register shows the clear increase of activities that took place from the second year onwards in the field of health, maintaining them in the third year, except for the drop in activity during Christmas and summer holidays and in the summer period, where the volume of activity falls for all ICI Project lines.
Graph no. 5. Report on community health actions. Month-on-month evolution per year

Year 1 (Sept 2010 - Aug 2011)

Year 2 (Sept 2011 - Aug 2012)

Year 3 (Sept 2012 - Aug 2013)

3.4

Strengthening intersectoral and cooperative work

The health resources for the different territories were connected and gradually engaged in the intercultural community intervention process brought about by the ICI teams, through different channels that in many cases have become complementary, by means of their collaboration and/or implication in the technical staff relationship spaces and also through their participation and implication in existing or newly created specific health programmes.

At the end of the third year, the existing technical staff relationship spaces were expanded and consolidated with the three main players, so that practically all the territories had a technical staff relationship space in which professionals from the social-healthcare sector participated, either in the overall programme and/or in the driving nucleus.

Also in practically all the territories there is one or more specific participative structure in community health. These structures are run, with greater or lesser implication, by technicians from the (municipal and regional) socio-healthcare field, representatives from (local or district) administration and, on many occasions, citizens (organised or individually), associations, volunteers, etc.

The situation of these structures at the end of the third year, in summary, is as follows in the intervention territories in the different autonomous communities:

— **Catalonia - Clot:** Intercultural Healthy Meals Programme (technical and voluntary resource) and Mental Health Group (involving the three main players)

— **Catalonia - Nou Barris:** Health Group and Work Group for the Family Support School.

— **Catalonia - Raval:** Community Health Monitoring Group and mental health, sexual and reproductive health and old people sub-commissions (technical resources and social entities).

— **Catalonia - Salt:** Work group for Community Health Action, proposed to incorporate technicians from the Gerona Regional Service, work to consolidate it as a significant body for the Local Administration.

— **Catalonia - Tortosa:** implication from technicians and professionals from the community
health field in the city technical staff relationship space and in the 6-16 programme, attempting to implicate young people and their families so that specific lines flow together overall.

— Valencia - Elche: Health Commission (technicians and citizens), organising health sessions, implementing health promotion actions, connecting up the Administration.

— Valencia - Paterna: community work boards on health and technical work board on health, dedicated above all to assessment (Paterna). It decided, by consensus, to focus on health, specifically prevention and promotion of health and on leisure and sports.

— La Rioja - Logroño: Meeting Space for Community Health and Citizen Health Group (technicians and citizens), very active, diversity brought to the meetings and actions.


— Canary Islands - San Bartolomé: commissions to draw up the assessment for the basic zone.

— Andalusia - Granada: community health drive (technicians and citizens), consolidation of cooperative learning boards.


— Andalusia - Jerez: Technical Health Commission: This technical staff relationship space was dismantled as it was considered that the Local Administration Social Welfare, Equality and Health area duplicated its functions after being incorporated into RELAX (Red de Espacios Locales de Acciones en Salud/Network of Local Health Action Spaces).

— Madrid - Getafe: Community Health Group, Community Team and Community Health Group (universal healthcare resources, representatives from the Administration, technicians, members of associations and individuals)

— Madrid - Pueblo Nuevo: Health Board (technicians from the Madrid Health Service, Municipal Heath Centre and Territorial Public Health Service) and Socioeducational Board (representatives from schools, the Madrid Health Service, the Municipal Health Centre and the Territorial Public Health Service).

— Madrid - Leganés: Service-Learning (ApS), Health and Solidarity, setting up a technical space involving technicians from the different administrations, participation in the school health board.

The following graphs show variations in the number of informed, collaborating and engaged technical resources identified in the health field, from the first to third year, showing a successive increase in the latter, despite the fact that the aforementioned current cuts and adjustments in the health sector do not provide or in any way facilitate professionals’ dedication to the community field.
Graph no. 6. Evolution of technical health resources

3.5 The community monograph, assessment and programming and consolidation of alliances between the three main players

Continuous shaping and consolidating work and cooperation programmes among the territory’s different resources and agents engaged in the health field have led to progress in terms of knowledge, identifying health needs and problems, establishing common priorities and objectives for the intervention and tackling them fully, in order to improve the territory’s health.

The work process followed by drawing up, agreeing on and spreading the word regarding firstly the community monograph and subsequently the assessment and programming, plus preparing the corresponding community meetings, provides latent opportunity, reinforcement and continuity for the collective work and work in a network of healthcare professionals with the remaining players in the territory engaged in health promotion. This represented a fundamental boost to make progress and strengthen intersectoral and cooperative work among administrations, technical resources, and particularly for citizen participation.
These technical programmes have made it possible for the actual healthcare professionals to contribute to, analyse and discuss the territory’s health needs with other technicians from other sectors and with citizens, providing a joint and more contextualised view when picking priorities. Pooling, provision and contribution from the different players and sectors highlighted a strong symbolic character in all cases.

The second and third year of the ICI Project were overshadowed by restructuring in the healthcare and educational system due to the crisis plus continuous cuts in social and healthcare services with the subsequent increase in workload for professionals. As previously mentioned, this represented a clear set-back threat in terms of implicating technicians in the intersectoral and community work programmes. However, not without some difficulty, achievements made during the previous years in the community health field have been maintained, and significant progress has been made in the identified strategic lines.

### 3.6 Progress in priority action lines in intercultural community health

The diversity of experiences and initiatives developed from the ICI Project in community health in the different intervention territories was enormously varied and new. As mentioned, during the second phase, this required identifying the strategic action lines in this field and the reference models in which this variety of proposals can be framed in order to handle common terminology for their definition, systemise their content and define the precise requirements to implement them, in line with the ICI Project’s fundaments. These lines will be specified as: healthy territory, health promoting schools, community-based health agents and actions promoting health in collectives. The analysis of the progress and achievements made along these lines during the first ICI Project stage, working from the comments made by the actual professional teams, makes their worth and progression clear:

#### Healthy territory

Different territories (Raval, Jerez, Zaragoza, Leganés, Madrid, Paterna) developed actions inspired by the model known as “healthy and responsible territory”, attempting to improve
the environment and quality of life for citizens through joint work and implication of the people forming part of it. This model’s goals include actions for environmental sustainability, participation from community agents and maintenance of healthy environments, commitment and intersectoral work among administrations to improve living and working conditions in the neighbourhood, managing common leisure spaces for living together. Some examples are as follows:

— Barcelona (Raval): awarded first prize in business excellence and socially responsible territory in Raval, organised by Xarxa Laboral, whose aim is to raise awareness among agents in the territory to help improve the environment and quality of life for citizens and individual or collective commitment to the neighbourhood’s wellbeing. In its third edition, it was awarded to actions promoted from the ICI Project run by chemists to help old people: www.youtube.com/watch?v=xbr-r0niDc.

— Zaragoza: work developed by the ICI team so that community health is considered as a work strand in the Integral Historical Centre Plan and the consolidation of the Community Health Commission for the Carrera del Gancho as a place for coordination and stable participation to boost health promotion projects with growing implication of resources.

— Madrid (Leganés): the boost has been seen from the Social Affairs Board and through its Health Promotion Area, for actions promoting healthy leisure for families with messages focussing on improving habits, as reflected in the “Separate well, recycle better” Family Recycling Day.

**Health promoting schools**

Practically all teams have run health promotion actions in schools; increasing significantly during the first stage alongside synergies between both fields.
It is necessary to highlight the participation of health technicians in coordination structures (socioeducational boards), educational field technicians in health activities (as can be appreciated in the graph) and implementation of intersectoral actions (healthcare, educational, municipal, minor and family sector, social entities, etc.). Although it is not possible to talk about complete development of the health promoting schools model, just in some cases, important progress has been made along this model’s line. A few examples of this:

— Madrid (Pueblo Nuevo): fundamental milestones have included integration of Primary Care Centres for the community of Madrid (Madrid Health Service) in the technical staff relationship spaces: socioeducational board and its participation in health promotion and preventive activities in primary and secondary schools coordinating with the Municipal Health Centre in the Salud a Punto municipal project. In addition, the education for health project was set up in a primary school in the territory, inspired by the health promoting schools model that has been used as an action model and benchmark for best practices for technical resources on the social-educational board.

— Elche (Carrús): technical health resources are interlinked in the open summer school, running first aid workshops for instructors by the Carrús health centre, on sexual and emo-
tional education by the Sexual and Reproductive Health Unit, on sun care in the summer by the Vinalopó Hospital, on preventing addictions by Proyecto Hombre, on health and diet by the Public Health Centre, and on healthy cooking by the Associació per al Desenvolupament Rural del Camp d’Elx, la Associació de Restaurants del Camp d’Elx and Vinalopó Salud.

— Madrid (Getafe): by means of joint work between the Municipal Health Centre and Las Margaritas Health Centre, they designed and jointly gave sex education workshops in the neighbourhood schools.

— Lanzarote (San Bartolomé): the link between schools and healthcare resources has been strengthened as a consequence of the shared knowledge process linked to community programming – boosting educational and healthy alternative from leisure, sport and free time, generating meeting points in the community field.

Community-based health agents

The figure of the health agents has clearly developed in the different territories, being projected towards different figures that have been consolidated over the second and third phase. During the second year, work was done to define and properly differentiate these different figures according to certain characteristics – contexts, functions, fields of action, etc. in order to be able to establish their specific nature clearly. Some examples to illustrate achievements are:

Valencia (Paterna): continuous implementation of the figure to match the proposed model of the community-based health agent (ASBC) by incorporating new agents trained as ASBCs who run healthy actions on information, mentoring and promotion of health in the neighbourhood.

In other territories, other figures have been developed and consolidated, such as the Vip’s Gold community health agents network, supported by the Salt team or community agents in Tortosa: *The young Vip Premium health agents, beyond the ages, origins and/or specific health problems, have thought about complementary educational needs to the children's school in their neighbourhood and town, and their contribution and ties within it. This has then created a common project to improve conditions in which they use public space. In addition, from and in equal conditions, they have been able to successfully promote new behaviour guidelines for people, thereby facilitating intercultural relations between young people, children and families that encourage living together.* (Gerona, Salt)

*Work continues with young people, participating in their informal spaces: we continue to pay close attention to relations with the first crop of young university graduates with Berber origins in the city of Tortosa in order to improve young people’s behaviour and attitudes by taking on board mediating skills and cooperative dialogue, attempting to get these young people to be lead-


ers in the community, capable of generating intercultural transformation within their native community and as a positive example for future generations, in addition to being facilitating agents and educational agents within the community and outside it. Some of these young people have been involved as volunteers in the global citizen action (ArtXiBarri) and also in the open summer school. (Tarragona, Tortosa)

**Actions promoting health in collectives**

All the territories have developed health promoting experiences aimed at different collectives and in relation to different topics of interest in the territory.

The following graph shows how the number of participants clearly rose for activities aimed at these collectives: family, children and youth. During the third year, the increase was particularly significant in activities aimed at children, where the number of participants was multiplied by five.

**Graph no. 8. Participants in community health activities**

```
Participants in community health activities

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>552</td>
<td>809</td>
<td>1,265</td>
</tr>
<tr>
<td>Children</td>
<td>136</td>
<td>419</td>
<td>527</td>
</tr>
<tr>
<td>Young people</td>
<td>419</td>
<td>527</td>
<td>1,691</td>
</tr>
</tbody>
</table>
```


**3.6.1 Other significant achievements in health promotion**

In addition to the progress mentioned in the priority lines for health action, we should mention progress in the territories, in relation to initiatives where there is greater implication from the
health centres and inclusion of health promotion in different identified areas of interest. Let’s look at a few examples where the actual teams discuss them:

**Health centres open to the community**

Despite the difficulties that health centres and primary care teams are experiencing linked to cuts, the implications for RDL in 2012 and the care overload, practically all territories maintained implication from health centres and care professionals in community health promotion actions, tending towards the model of centres open to the community.

The significant increase of activities carried out by the neighbourhood health centre (where before nothing was done) or participation and initiatives in the technician and citizen meetings in carrying out the community assessment gives us indicators of the community process in health. Little by little, resources start taking on the different actions leading to health promotion and they are capable of linking them together to turn them into a common strategy that will be the community programming. (Alicante, Elche)

**Including health promotion in different experiences**

As has been shown, health promotion has become relevant in the framework of actions implemented and maintained during the first stage, as can be appreciated through the following examples.

— **Promoting intergenerational relationships**

The Intercultural Meals Programme generated by Clot to work on healthy eating habits, in collaboration with CAP Clot, also promotes intergenerational and intercultural relations in the same sessions, working with younger people and people of different origins. (Barcelona, Clot)

— **Promoting emotional health among young people**

Tortosa continues its specific work with young people and the activity linked to the mountains as a pilot experience. Climbing and mountains are used as the instruments to work on social-emotional health with these young people bringing about situations that, far from their daily existence, puts them in a position where important elements come into play such as managing emotions (controlling fear, self-esteem, trust in others, etc.) It was interesting to work on social determinants of community health through mountains and climbing and everything this implies in the emotional and affective sense. (Tarragona, Tortosa)

— **Intercultural cohabitation and health promotion**

The most important and symbolic activity carried out in this line this quarter was the day to pro-
mote living together for Ramadan, a meeting space to bring together technicians and citizens in the territory, working on awareness raising, promotion and information on health in Ramadan and also the chance to try different meals that are typical at this time and talk about their health benefits. This session also included talks on Ramadan, its meaning and its health benefits and advice to follow (particularly because it falls in the hottest summer months this year), also highlighting different religions living together in las Norias de Daza. (Almeria, Ejido)

— **Integrated health promotion action**

*For the second year in a row, we have finished the "Por un millón de pasos" initiative experience with collectives from the South zone and this year’s new initiative aimed at primary schools. This action is framed within the Integral Child Obesity Plan and has promoted active health promotion dynamics involving different educational and citizens agents such as teaching staff, management, parent representatives, parents association, student’s family members on their own behalf and a total of more than 400 students from the different schools. (Jerez)*

*The 4th Cooperative Learning Board has consolidated the health milestones process even further with the added bonus that, this time, as it was in the format of a community talk, it encouraged greater implication from citizens in the community process. (Granada)*

**Drawing up materials for information, communication and health education**

During the third year, more progress was made on the joint design and drawing up of relevant materials for information, communication and health education: resource guides, deviation protocols, educational leaflets, information sheets, magazines, healthy backpacks, intercultural recipe books, audiovisuals, short documentaries, capsules and health content for the radio.

**In summary, the achievements have allowed:**

— Health to be identified as a collective value of the community to which both political and professionals players contribute as well as the population.
— Implication of local authorities and healthcare and educational administrations, fundamentally, in work initiatives.
— Promoting the feeling of local belonging by implicating the community in actions to improve health.
— Articulation of the population’s participation with professionals in developing public health policies.
— The implication of associations and citizens in developing health promotion actions in the community.
— Developing interdisciplinary work through meeting spaces and developing coordinated initiatives among public and private resources.

The following table shows a panel compiling some of the initiatives developed in the field of intercultural community health and health promotion by each of the territories that, without claiming to boast the aforementioned wealth of experiences, can offer an overview of the processes and topics covered.

### Table no. 2. Panel of community health initiatives by territory

<table>
<thead>
<tr>
<th>Territory</th>
<th>Initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barcelona - Clot</td>
<td>Healthy eating. Intercultural healthy meals programmes, recipe books.</td>
</tr>
<tr>
<td>Barcelona - Raval</td>
<td>Socially responsible territory community monograph and health priorities.</td>
</tr>
<tr>
<td>Barcelona - Nou Barris</td>
<td>Salut als Barris. Parenting skills and healthy lifestyles for young people.</td>
</tr>
<tr>
<td>Tarragona - Tortosa</td>
<td>Social-affective health in young people. Mediation and health agency through sport and mountains.</td>
</tr>
<tr>
<td>Gerona - Salt</td>
<td>Young health agents and service-learning (Youth Health Plan) for living together.</td>
</tr>
<tr>
<td>Almeria - Ejido</td>
<td>“A tu salud” (To your good health) space. Health promotion and joint action between citizens and professionals.</td>
</tr>
<tr>
<td>Cadiz - Jerez</td>
<td>“Por un millón de pasos”. The three agents engaged in actions promoting health in the area.</td>
</tr>
<tr>
<td>Madrid - Pueblo Nuevo</td>
<td>Health and education boards. Salud a Punto in schools and health promoting schools.</td>
</tr>
<tr>
<td>Alicante - Elche</td>
<td>Service-learning. Literacy and communication for health over the radio. Radio programmes and young people.</td>
</tr>
<tr>
<td>Valencia - Paterna</td>
<td>Community-based health agents. Training agents, carrying out actions promoting health.</td>
</tr>
<tr>
<td>Logroño</td>
<td>Citizen health group. Coordination of culturally adapted actions on healthy eating in the neighbourhood.</td>
</tr>
<tr>
<td>Lanzarote - San Bartolomé</td>
<td>Health Promotion. Medicinal vegetable garden. Actions to look after the environment from schools, families and community.</td>
</tr>
<tr>
<td>Ciudad Real - Daimiel</td>
<td>Intergenerational project and service-learning.</td>
</tr>
</tbody>
</table>
What have we learnt? A few recommendations to improve Intercultural Community Health Interventions
The health field is favourable for community development processes

Running the ICI project in different territories has demonstrated that the field of health, understood in its holistic and full sense, is a favourable field for community processes. As we have been mentioning, health, wellbeing, improved quality of life for a collective community make up a sensitive field to generate dialogue, meeting, consensus and local scale collaborative action processes.

Indeed, as the ICI Project has demonstrated, health is a subject crossing all fields constituting a concern for administrations, technicians and citizens, so it is used as a cause for argument, topic of common interest that brings together, encourages agreement and joint work for the different players in the field.

In addition, it has clearly shown the relationship between living together and collective health, understood as social capital that is fed by and increases with the existence and strengthening of support, friendship and recognition networks.

Incorporating the equity perspective and the right to health

Three priority areas were identified in the field of public health at the start of the century, with a view to analysing the sociodemographic, epidemiological and social trends: aging (care for chronicity and dependency), migrations and diversity management (from a social point of view and specifically in the healthcare field) and inequalities in health. One decade later, bearing in mind the effects of the crisis and the cuts made in key fields, some of the fundamental questions continue to include:

— The clear increase in social inequalities in health and new social groups that have become poorer, lost rights and relationship networks.
— Situations linked to aging (chronicity, dependency, care and carers).
— The situation of child and youth vulnerability. Mental health problems (daily discomforts, medicalisation, suicide attempts, social support networks).
— Situations linked to migration issues (immigration and emigration) that need to be updated again due to constant change.

Many of the priorities identified in the community monograph points, assessments and programming run from the ICI Project in the territories pointed to tackling these aspects, needing to keep this background in mind and continue working and moving forwards to make the equity focus effective in order to generate community empowerment processes, alleviate unfair situations and drive interventions among collectives that most need them.
Health professionals’ implication in community action

To the extent that the ICI Project includes health promotion as an action strand, it has made it possible to connect with healthcare resources in an area that, although barely given any room in the services portfolio in primary care, constitutes an essential aspect of community health providing content and opportunities to develop actions in which healthcare professionals can make a great contribution from their promotional and educational function.

We showed how restructuring the healthcare and educational system linked to the crisis, serving as a backdrop for the ICI Project and the continuous cuts in the social and healthcare services with the subsequent increase in work load for the professionals represented, as we have mentioned, a clear threat of a set-back in implicating technicians in the intersectoral and community work spaces.

However, not without difficulty, we have seen how the achievements made over previous years have been maintained in the community health field and significant progress has been made in terms of consolidating action lines throughout the ICI Project. In this respect, it is essential to work to overcome threats linked to the healthcare professionals’ situation. There is the need for the Administration to back and support community work, not fall into volunteering, maintain the continuity of the processes, gain ground on the obsession with handouts, reinforce its function, etc.

On the other hand, as the community process took root and became consolidated in the territories, thanks to the intense unspecific work implemented and maintained over three years by the ICI teams, working with key agents in the territory (Administration, technicians and citizens), the actual administrations and health professionals, with a view to progress and results, took on this process that strengthened and added values to their function, representing an endorsement that encourages each side to maintain participation and implication.

The training process is key for shaping teams and their actions.

It was fundamental for implementation and development of the ICI Project to have the necessary time and space to deploy the conceptual and methodological work and training that the teams required to incorporate and make operative the intercultural community health bases, as part of the programming and intervention in the territory. Parallel development of this training process is essential as support for how ICI team actions develop in the field, adapting contents and didactic methodologies to the requirements and demands from the different ICI Project phases. These training spaces were being transformed over time, and the teams asked about sharing
and discussing the different experiences in progress and bringing in specific content that would shed light on the territories’ own challenges.

With a view to the second stage, it is necessary to consider the training/shaping needs for the new structures and teams in charge of development and sustainability of the community processes in the different territories, specifically concerning community programming, taking into account its level and field of responsibility – local district structures, community teams. Experience tells us that it is necessary to have training spaces for these teams to build their reference and operative conceptual outline. Although it works from all the experience in the first stage, we should not forget that the new organisations and tasks require these spaces.

How can we manage the complexity of community intervention?
Community intervention implied a great complexity of levels and contexts in which to act, and clear aims had to be set for the different process phases, criteria and limits in the deployment of ties and relations, in establishing commitments and expectations with and between the players in the territory with different interests, so that they did not exceed the teams’ capacity for action.

The fact of combining the different times, dynamics and interests of the institutions, entities and technicians with those set from the actual ICI Project has challenged the teams’ capacity to look after and manage this complexity. Some of the key aspects that have contributed to this work are:
— The community team members’ prior training and experience baggage in the community social psychology field, mediation, interculturality, pedagogy or education, community development, etc. has all been fundamental. In the case of the health field, despite lacking experience in the healthcare field, the teams generally demonstrated their great capacity to penetrate the community fabric and skills to work in community relations from the start, surely due to the profile and experience of its members, a relevant aspect for the ICI Project given the diversity of fields and players that it had to work with.
— Along the same line, the importance of thinking about the structure and internal organisation of the community teams has been demonstrated, plus how effective this is for deploying its action in the territory. In this respect, it was good for operations that there was one person in charge of each field. It was also fundamental to set up dynamics that encouraged synergies to be formed between them. Within the ICI Project’s philosophy, this was not so much a matter of specialising the references for each field but integrating and adding up their contributions.
— In ICI Project development, the relevance of incorporating and running the institutional theory has been remarked on and made clear. The community health line model recognised that
for an action to have community focus, it has to consider different fields: individual, psychosocial, group, institutional and community as such. It is essential to recognise the different institutional dynamics in the territory, organisations and operations, ideology and values experienced by the technicians in their work.

— In the ecological health model, although a broader, more complex and comprehensive view of the community context has been incorporated, the institutional aspect is often forgotten. In the community development processes, both in the field of health and in the other fields (educational, social, participative, etc.), it is necessary to go into greater depth into the institutional theory in so much as it offers a basis for thinking about and guiding the work that is being done with the different players, given that a substantial part of the intersectoral work implies different and ideally progressive gradients (according to the outline) of relationships, cooperation, coordination and integrated work among players relevant to different institutions and community devices that, in turn, have different cultures, ideology and values, organisation, operation, rules and dynamics for relationships, etc. It is not the same to work in/with the school field at the different levels as in/with the healthcare field or in/with the association field. Within each of these sectors, it is compulsory to also take into account the differences depending on whether it is public, private, for patients or neighbours, etc.

— The mapping, socio-grams and cartographic representation of the data, players and the different resources contacted according to the work areas/belonging in the territory was a very useful support tool throughout the ICI Project. These tools make it easier to understand the territory as an intervention unit and relations between professionals and population in looking after health challenges and opportunities, allowing the actions that unfold to be explored, the type of relationships they maintain between them and with other resources and their contribution to improving health in the territory according to the corresponding fields of action (healthcare, social, educational, etc.) studying the situation and alliances for the ICI team in this mapping and in accordance with it, anticipating the opportunities and threats to meet objectives. Another fundamental tool has been the use of dramatisation techniques in developing the intercultural community intervention teams’ skills.

**Foundations and strengthening collaborative work between community fields**

The intervention developed has shown the potential for establishing synergies between the different fields of action. This is an essential aspect because, as we have seen, results can be made profitable in a field (education, health) if we look for synergies with other fields. What actually happens is that the education system and the healthcare system have worked in parallel and traditionally, schools have been one of the fields with the greatest interest for health promotion.
One of the most exciting and useful challenges in the ICI Project is helping to overcome the sector-based approach to problems and needs felt and expressed by the community that lives in a territory, to go into greater depth into the vicissitudes of a holistic and integral approach from which to tackle the phenomena in a complex way. In the case of the ICI Project, a holistic and integral approach means, on the one hand, capacity to articulate the global line and the sector-based line, while on the other hand, the capacity to articulate the different sector-based lines.

An emerging trend over the last three years of the ICI Project has consisted of weaving greater complicity between the sector-based lines corresponding to the socioeducational aspect and community health from which considerable actions have been derived in practically all the territories.

Health education in schools is a priority field for health professionals. Education and health are intrinsically linked in so much as health is a resource for daily life that highlights social and personal resources, as well as physical aptitudes. In addition, it is known that educational level is one of the main determining factors for health and good health is essential for getting good educational results (Suhrcke & de Paz Nieves) Within the ICI Project, the field of community health understands that health promotion aims to improve control over determinants of health. Therefore, health and wellbeing of the educational community is related to feeling good about yourself, with others and with your surroundings.

Looking forward to the second stage of the ICI Project, the need arose for the two fields to work together. In the ICI Project preview, intercultural community health has been incorporated into the framework of the strategic action and community programming, integrating with the other lines. With a view to the second stage, an extra step will have to be taken, thinking about what is represented by working for joint health-education or joint education-health actions by planning experiences that flow together towards actions that are integrated between the two fields.

We are talking about integral intercultural community health and integrated educational action and conditions that should arise for them to be classified as such. The proposal is that it moves forward in this synergy by creating integral and integrated actions that consider collaboration and alliances between both sectors to reinforce results and multiply effects in new experiences.

On the other hand, there can be no doubt that it is crucial for citizen relationships to work with the field of health. There is a lack of visibility for the different project content and a need for current and future potential to be carefully analysed. It is necessary to stop at this aspect and analyse it in depth, as it is key for strengthening and developing community programming in the second stage.
The territory as a living entity

The ICI Project has demonstrated that to develop community work in general and specifically in the field of health, it is fundamental to consider the territory as a living thing, alluding to the health of its population.

A territory can be considered as the components that make it up in a static and flat way, like a desert, or shedding light on its dynamic perspective, like a living thing that has a biography and has the capability to generate processes for meeting, agreement, confrontation and dialogue under its skin.

Developing the community monograph has shown the importance of overcoming the static and unequivocal health assessments from which participative community action can be generated.

The work processes followed by drawing up, consensus and socialisation both of the community monograph at first and the assessment and the programming secondly, as well as preparation of the corresponding community meetings, facilitated a substrate of opportunity, reinforcement and continuity for the collective work and work in a network of healthcare professionals with the remaining players in the territory engaged in health promotion, representing a fundamental boost to make progress and strengthen the intersectoral and cooperative work among administrations, technical resources and particularly for citizen participation.

Questions that have been strategic for developing the Intercultural Community Intervention Project. Boost from "la Caixa" Foundation and scientific-technical support

Availability and backing from "la Caixa" Foundation to promote and finance a project aimed at improving living together and social cohesion has been essential and strategic in current times, to build bases and anticipate cooperation structures between the players in a territory in order to be able to give more effective answers to the territories’ social demands. The idea of including the field of community health was also correct due to reasons mentioned initially.

In addition, the possibility of having management, consultancy and scientific-technical monitoring along the way has meant that essential continual supervision and support were available to uphold and contrast the fundament of the ICI Project in practice and carry out detailed monitoring of the progress and deviations of the different territories. It is necessary to highlight the work carried out by the scientific management, particularly by the territorial reference points, fundamentally intensive over the three years, offering close, continuous and personalised support to the teams in the actual territories. Without the structure of coordination, con-
sultancy, training, monitoring and assessment, it would have been difficult to achieve and demonstrate the aforementioned results, so it is essential to dedicate time and resources to these fundamental aspects of the ICI Project.

Community health in times of crisis

Since the ICI Project began, the economic crisis has made a significant impact on the most vulnerable collectives, drastically increasing social inequalities in Spain. “Growing inequality is a problem for democracy”\textsuperscript{14}, stated Michael J. Sandel, professor of Politics and Justice at Harvard. We have gone from a market economy to a market society. The fact that market values are imposed on areas such as health or education brings enormous risks for a democratic and fair society, as we are seeing from day to day. Democracy is tied in with sharing spaces, valuing common good and working on reinforcing public, service, common goods spheres.

The WHO (2009)\textsuperscript{15}, in its declaration on “Health in times of a global economic crisis: Implications for the WHO European region”, reminded us that it is necessary to make sure that health systems continue protecting the most vulnerable collectives to behave as competent economic agents, preventing an increase in social inequalities in health and the consequent worsening of the outcomes in the population’s health.

The toughness of the cuts in social policies, arguing that a welfare state built over the last few decades cannot be sustained, the ineffectiveness of adjustments to the occupational field and the incessant increase in unemployment are taking extensive sections of the population to the limit, both immigrants and natives although according to the studies, the effects are more acute for immigrants), with important repercussions on exhaustion or disappearance of integration plans and strategies developed until now and favouring competition, due to scarce resources, between social groups in precarious situations.

Faced with the situation that puts social cohesion at risk and progress made in the different fronts of social life, it is essential to generate and expand community development processes and management of diversity on a local scale as described, demonstrating the capability to develop community strengthening strategies in the field of health and provide instruments to manage conflict constructively through listening, dialogue and coordinated action.


Bibliography
Bibliographic references


Complementary bibliography


Support bibliography and interesting links for reference models


Healthy Cities and Ineq-Cities project


**Health promoting schools**

LIBRARY OF HEALTH PROMOTING SCHOOLS:


Network of healthy schools in Europe:

Aragonese Health Promoting Schools Network:

Health promoting School in Asturias:
http://recepscantabria.blogspot.com.es/2013/04/escuela-promotora-de-salud-de-asturias.html.


**Health promoting agents**


**Health assets**


**Interesting links**


*ePPI-Centre*. Centre that offers systematic reviews and development of review methods in social sciences and public policies. http://eppi.ioe.ac.uk/cms/Default.aspx?tabid=3236

*Health Development Advice HDA*. Practical guide and assessment to improve public health and correct organisation of professionals and services in the United Kingdom.

*World Health Organization*. Regional European Office for the WHO providing access to independent and reliable information on the health situation and evidence for it. http://www.euro.who.int/en/home
The Campbell Collaboration. International research network that runs systematic reviews on the effects of social interventions.

They seek out the best research in health, they ask health system users about their experiences and periodically update their information.

Eurosaludred. European Network of Health Promoting Agencies (since 1996). The members are the national health promotion agencies or Healthcare Ministries and it includes all 15 member states as well as Norway, Iceland and future members of the European Union (Slovenia, Hungary, Romania, Czech Republic and Estonia).

International Health Promotion Union. UIPES is an association of persons and organizations working on health promotion and education. It was founded in 1951 and has members in over 80 countries.
http://www.iuhpe.org/index.php/

Information System on Health Promotion and Education (SIPES). Promoted by the General Sub-management for Health Epidemiology Promotion from the Ministry of Health and Consumption and the Health Promotion Units for the Health Boards in the Autonomous Regions and Cities; its main purpose is to exchange information and best practices on health promotion.
http://sipes.msc.es/sipes2/indexAction.do

SOPHIE is a research project funded by the 7th European Community Framework Programme. Its aim is to generate new evidence on the impact of structural policies on health inequalities and develop innovative methodologies to assess these policies in Europe.
http://www.sophie-project.eu/index.htm
http://www.sophie-project.eu/publications_other.htm

Programme of Primary Care Community Activities (PACAP). The Community Activities Network (RAC) is conceived as a network of groups in action, belonging to or with some kind of connection with a health centre, carrying out some kind of participation activity or community intervention.
http://www.pacap.net/pacap/Saludcomunitaria
https://saludcomunitaria.wordpress.com/
Work Group on Community Oriented Primary Care (APOC).
http://www.apoc-copc.org/home.htm

Basque Society Community Care Group on Family and Community Medicine.
http://www.osatzen.com

Extremadura Society of Family and Community Medicine.
http://www.sexfyc.es/index.html
Glossary
This glossary compiles the main terms used within the framework of the Intercultural Community Intervention Project according to the meaning this project has given each one. This is not a scientific-technical catalogue claiming to exhaustively compile the entire range of interpretations for the same concept, although it does intend to often a simple explanation for the specific and operative meaning given to each term from the ICI Project focus and methodology.

A

Assimilationism
This is a sociopolitical model or proposal, contrary to the ICI Project philosophy, to manage diversity in multicultural contexts based on cultural uniformity, understanding this to be a process where the minority acquires the values, language, culture and identity of the majority.

B

Belonging
Belonging is usually considered to be a person’s self-assignation and identification with a collective. The ICI Project perspective has promoted the feeling of belonging for persons and collectives with their local community as a necessary step to encourage cohesion and living together.

C

Citizenship
Beyond the concept of citizenship bound to belonging to a political community, normally a Nation-State, and the rights and responsibilities derived from this, exclusive to the nationals of this State, the ICI Project considers citizenship from its social and living together dimension above all, with the defining traits of community participation, working together to achieve general interest and implication in building an intercultural and inclusive local community, independently of national origins or cultural belonging.
Coexistence

Coexistence is a type of social situation where, as opposed to cohabitation, there is barely any relationship between the people belonging to different social and cultural collectives living in the same space and time. They coexist but they do not cohabit. This is the predominant social situation in most local contexts, characterised by passive respect between persons and collectives, with no positive interaction between them and failing to tackle any latent conflict that might exist.

Cohabitation/Living together

Cohabitation/living together is a type of social situation where people, independently of their social or cultural belonging, communicate and relate to each other, respect each other mutually, share values and common interests, work together and interact positively and prevent and resolve conflict creatively. Living together requires continuous learning and it is a dynamic process that we can always build on.

Collaborators

Participation from persons, players and protagonists in the ICI Project framework revolves around three circles that define the degree or level of participation in it: informed, collaborating and engaged. Collaborating persons or players participate from time to time in ICI Project actions or activities. Depending on their availability over time, they could become engaged or simply informed. The actual flexibility of the intercultural community methodology makes it possible to change how much they participate.

Collaborative relations

These are the essence of the intercultural community process; without collaborative relations between the three key players in the community, we cannot talk about emergence, existence and consolidation of the process. The ICI Project methodology is channelled towards bringing about this type of relationship, deemed “improbable” due to being practically exceptional in the local socio-political context.
Community
Although there are different definitions of community that cover spatial frameworks (local community, regional community, national, European, international community, etc.), or look at traits shared by human groups or collectives (values, interests, customs, language, culture, etc.), for the ICI Project, the community will always be local (a neighbourhood, a zone, a village or a city) and it will be made up of four structural elements: territory, population, resources and demands from the population.

Community-based
This is the type of social intervention promoted by the ICI Project where the community not only receives the actions but it is also the key player in its own social and cohabitation development process.

Community information
This is a fundamental element of the intercultural community methodology: it is used to inform the local community as a whole about progress within the process and the existing initiatives and participation programmes. This consequently helps to make the process public and motivate people and players to take part or get involved in it. Community information can be put across in the following ways: information sheets, posters, leaflets, websites, social networks, blogs, etc.

Community meeting
A community meeting constitutes a symbolic meeting place between the three key players in the local community, sharing and pooling the work done by each one within the framework of the intercultural community process.

Community methodology
This is a set of methods that guaranteeing cohesion between the focus inspiring the ICI Project and the specific practice of working in local communities. It is made up of a series of methods, instruments, techniques and actions to promote the local communities’ starring role in their own social development process and when constructing living together and intercultural citizenship.
Community monograph
This is an indispensable community methodology instrument that has the fundamental purpose of allowing analysis and overall understanding of the intervention community plus shared knowledge, making it possible to establish an assessment and planning aimed at improving the existing situation and connecting the different initiatives with the overall community and intercultural process.

Community organisation
Community organisation is the process by which the three key players in the local community come up with participation programmes, the relationship spaces, and the community adapts them to develop community programming as effectively as possible.

Community programming
This is a key methodology element to make progress in the intercultural community process. It marks a qualitative leap in collaborative relations between key players by jointly programming a series of actions to meet the priorities set in the community assessment.

Community team
This is a fundamental element in the intercultural community methodology, acting as a resource for the actual process, enabling collective relations between the three key players and making it easier to move forwards in the different Project phases (shared knowledge, assessment, programming, etc.). Initially, the community team was essentially made up of the ICI Project intervention teams but, as the intercultural community process went on, it incorporated professionals from other public and private resources in the territory.

Conflict
Conflict is not conceived as negative in the ICI Project but as an opportunity to improve situations involving inequality or exclusion that might occur in a local community. From this perspective, conflicts, even latent conflicts, are tackled creatively and resolved positively.

Culturalism
Excessive or one-sided emphasis on the cultural factors that have a negative effect on appropriate management of diversity. The ICI Project philosophy rejects this type of differentiating emphasis, preferring to work on common values and shared interests.
Culture
We understand culture to be the set of guidelines for behaviour and meanings for reality (rules, values, beliefs, customs, etc.) expressed symbolically and forming a relatively structured whole shared by a population (differing according to gender, age or social class) that is transmitted from generation to generation, as a device for adapting to the natural and human environment and therefore a changing reality.

Demands
This constitutes one of the community’s structural elements comprising explicit or implicit requests among the population to solve problem issues or satisfy their needs and interests. It comes down to the intercultural community intervention process to identify them, make them visible, prioritise them and respond to them.

Difference
The ICI Project has applied the principle of the right to difference that implies respecting identity and rights for each differentiated person, group and social and cultural collective.

Discrimination
Discrimination consists of treating persons or collectives unfairly, compared to other persons or collectives in similar situations, due to their national origin, gender, age, social collective or belonging to ethnic or religious groups. There are two types of discrimination: direct and indirect. The first essentially matches the previous description. The second occurs when an apparently neutral rule, criterion or practice puts some people or collectives at a specific disadvantage compared to others.
Engaged
Participation from persons, players and key players in the ICI Project framework revolves around three circles that define the degree or level of participation in it: informed, collaborating and engaged. Engaged people or players include anyone continuously participating in actions, activities or relationship spaces for the ICI Project. Depending on their availability over time, they could change to collaborate or simply be informed. The actual flexibility of the intercultural community methodology makes it possible to change how much they participate.

Equality
Democratic principle that recognises equal rights and responsibilities for all citizens and proposes equal treatment in the eyes of the law. Enforcing this basic principle occasionally requires policies that promote equal opportunities, overcoming social, economic and cultural obstacles that affect more disadvantaged persons and collectives. This principle guides the intercultural community intervention’s own actions.

Ethnic group
The ethnic group is characterised by having cultural, physical, linguistic or religious traits assumed by its members or attributed by others that form part of wider societies where they relate with other majority or minority ethnic groups within it.

Ethnic minority
Any ethnic minority is an ethnic group but not all ethnic groups are an ethnic minority. This is usually characterised by a situation of subordination, marginalisation or lower status compared to the majority groups in society.
Ethnicity
Ethnicity refers to social identification of a human group working from the cultural, physical, linguistic characteristics that they supposedly share. Ethnic group is often confused with race, meaning sociocultural attributes with genetic attributes. While the ethnic group has scientific and sociopolitical recognition, race lacks scientific validity as, on the one hand, the boundary of the racial group depends on as many and whichever classification criteria are taken into account (cranium shape, eyes, hair, etc.) and, on the other, genetically inherited traits neither determine nor explain sociocultural traits. Beyond “physical race”, “sociopolitical race” is relevant meaning representations and discourse on the racial aspect.

Ethnocentrism
Attitude that judges or values other cultures from our own perspective, considering the customs, values, belief, etc. of our own group as the best, normal, correct and even superior.

Foreigner
Citizens who do not hold the nationality of the State where they are living, subject to the specific laws that regulate their stay in the country and that establish the civil, political or social rights of anyone with access to them.

Ghetto
This refers to a concentration of population belonging to a social or ethnic group or groups in determined urban areas that are usually segregated off from the rest of the city, normally perceived negatively by the rest of the population. The term ghetto is associated with negative connotations - poverty, poor housing, lack of security, etc. and this is usually due to combinations of discrimination, social exclusion and spatial segregation.
Global action line
This is the backbone of the intercultural community processes, as the action line that has defined the focus and methodology of the whole ICI Project, establishing the guidelines and the process, organisational and technical elements required for development.

Global citizen action
Global citizen actions are strategic due to their potential to involve the three key players and present the intercultural community process to the majority of the population in the territory and make an impact on the collective imagination, either by raising awareness on a specific topic or by helping to promote the feeling of belonging to a territory.

Hostility
As opposed to cohabitation and coexistence, hostility is a social situation where relationships between people belonging to differentiated social and cultural groups are charged with lack of trust, suspicion, avoidance and rejection, including non regulated conflict and clear demonstrations of verbal aggression and even physical and symbolic violence.

Identity
This refers to how persons and human groups are perceived and define themselves. Identity has a self-conception component as well as attribution and even recognition by other groups or society.
Impacts

Impacts refer to the effects and changes that intercultural community intervention has caused on the social context. Impacts should be measured in the medium and long term in relation to the ICI Project’s goals: social cohesion and living together and intercultural citizenship.

Inclusion

This is the process that, by identifying the sociocultural differences between people and collectives and their specific needs, promotes the policies and social changes required for their equal presence and incorporation in society. From this perspective, in intercultural community processes we would be talking about inclusive local communities: a) when there is an increase in positive interactions between collectives and a re-assessment within the community of the most disadvantaged; b) when there are mutual adaptation processes between collectives and standard and institutional changes that acknowledge this situation, and c) when the shared image of the community is improving.

Indicators

The ICI Project indicators make it possible to permanently monitor and assess the progress of the intercultural community processes in each territory and from the overall perspective. This includes qualitative indicators that can identify the different situations the territories are going through and quantitative indicators that make it possible to measure how far goals have been met through results and impacts. Depending on what we are trying to identify or measure, both types will be classified according to: 1) initial indicators, 2) process indicators, 3) results indicators and 4) impact indicators.

Informed

Participation from persons, players and key players in the ICI Project framework revolves around three circles that define the degree or level of participation in it: informed, collaborating and engaged. Informed persons or players are any that do not participate in actions, activities or relationship spaces in the ICI Project either because they cannot or do not want to, but they are always informed about how the process is progressing. Depending on their availability over time, they could go on to collaborate or become engaged.
Integration
There are many conceptions of integration but from the perspective of intercultural community intervention this is the process of mutual adaptation between differentiated sociocultural groups where minorities are incorporated into society by means of equal conditions, rights, responsibilities and opportunities without this representing the loss of their identity or cultural traits whilst the majority accept and incorporate the standard-based, institutional and ideological changes required to make the above possible.

Intercultural community assessment
This is a crucial element in the intercultural community methodology as it makes it easier to pass on shared knowledge of what is really happening in community programming. Assessment can prioritise the local community’s demands, obtained from the participative research process and express them as specific actions that will be reflected in community programming.

Intercultural education
Approach to education that takes into account cultural diversity, strengthens exchange between different cultural subjects and that, in turn, guarantees own cultural knowledge and facts, strengthening common elements and not differences. It is developed from a global perspective that involves all parties: school, students, families and environment.

Intercultural mediation
Intercultural mediation emerged as a mediation method in contexts with a significant multicultural aspect that has been applied to different fields: education, healthcare, legal, social, etc. Its more community-based dimension has been applied to the ICI Project, providing the focus to bring together the entire intervention in terms of purposes to achieve and the specific intercultural methods that have inspired the community methodology and made it possible to resolve conflict creatively.

Interculturality
Compared to the multicultural approach that recognises sociocultural diversity through the right to difference but without creating real interrelation situations between the different collectives, interculturality is a sociopolitical approach that aims to overcome this situation, promoting a new social context, emphasising points in common rather than differences and where positive interaction and collaboration between sociocultural collectives is the norm.
Key players
Community processes are framed within the social, political and institutional context of local communities, where their key players are representatives from the democratically elected administrations, professionals belonging to the public and private technical resources working in the territory and citizens who live in this territory.

Learning and service
Learning by carrying out community service. This is an educational proposal where learning takes place by means of people providing services to their own community, thereby helping to improve the society around them.

Living together and intercultural citizenship
The ICI project’s intervention focus is living together and intercultural citizenship, understood to be a framework to build positive relations and interactions between citizens from the same local community, independently of their administrative situation or social or cultural belonging, where they share rules, values and common interests.

Milestones
These are actions or specific achievements that take on strategic and symbolic transcendence to demonstrate qualitative leaps in the intercultural community process. Some examples of this type of actions would be: holding the first community meeting, the first technical staff relationship space meeting or presenting the community monograph, among others.
Objectives
These are the goals or achievements to be attained in the ICI Project or in any of its action lines, making them both general and specific. The ICI Project has two general aims that can be summarised as generating local processes to promote social cohesion and living together and intercultural citizenship and validating and transferring an innovative and sustainable social intervention practice.

Open summer school
This is an element that accelerates the community process thanks to its potential to connect collaborative relations between key players and due to the visibility of the community process in the territory because it satisfies an important citizen need, covering part of children and teenagers’ leisure time during their summer holidays (although not only then) by means of recreational-training actions.

Participation
Participation constitutes an essential, cross-discipline element running through any intercultural community intervention, as a means as well as an end. Without participation from the three key players and citizens, there is no intercultural community process. It has been tackled from its different dimensions: as an exercise in citizenship and participative democracy and as an element of social cohesion and living together, among others.

Positive discrimination
Treating people differently in a way that aims to correct negative social conditions originating from discrimination towards a group or person. This is the only type of discrimination that has a place in the ICI Project and only when it is considered relevant.
Prejudice
This is a prior presumption about a person or group based on partial, biased, indirect or incomplete knowledge.

Products
Products are the results that appear in any type of material required to make the process visible and make progress within it. Examples include the monograph, community programming, publishing a guide or editing a video, among others.

Public
The adjective *public* has two fundamental meanings in intercultural community processes: on the one hand, it means that the community process is public, open to everyone who wishes to participate whilst on the other hand, it means that it should inform the community about any progress and allow access to the documentation and knowledge that the process is generating.

Racism
Active discrimination of persons or groups for reasons related to their origin or ethnic or cultural features. ICI Project approaches fight racism, along with other types of discrimination.

Relationship spaces
These are programmes bringing together participation from key players in the local community and the organisational structure being given to the intercultural community process. Due to the different roles played by the key players within the process, there are three different types of programmes: technical staff relationship spaces, institutional relationship spaces and citizen relationship spaces.

Resources
Resources are one of the community’s structural elements where public and private technical-professional resources are essential both in terms of attention to persons and collectives’ specific needs and when resolving local demands from a complete and community perspective.
Results
ICI project results are the specific effects or consequences of the set of activities developed within the strategic action lines. They can range from the number of participants in certain activities to carrying out the community assessment as a result in itself.

Segregation
Institutional or social practice consisting of separation and isolation of persons or differentiated sociocultural collectives, either physically or spatially, or in certain fields of public life.

Social cohesion
There are different conceptions of social cohesion, the majority of which emphasise common wellbeing, equality vs inequality, resolving conflicts through democratic frameworks, citizen participation or respecting sociocultural diversity in their approaches. The ICI Project, from the local community perspective, promotes cohesion through social ties, participation from the different key players in the community, resolving any possible conflicts positively and legitimising institutions.

Social exclusion
Process by which a person or social group cannot be fully developed as an integral member of society in full right, supposing a loss of rights and responsibilities, characterised by lack of access to resources that this subject or group require to feel part of society.
Specific action lines

Intercultural community processes have developed three specific action lines (health, education and citizen relationships) that, revolving around the global action line, have inspired and strengthened the whole process. The fields of health and education, due to their focus on common social rights for the whole community and implication among different administrations, resources and players, are strategic programmes to establish collaborative relationships between key players and to bring together collectives and players’ common interests. In exchange, citizen relationships have been decisive in terms of involving citizens in the process and encouraging positive interactions between people belonging to different sociocultural collectives.

 Territory

This is one of the community’s structural elements. It refers to the intercultural community intervention’s geographic and spatial field, marked out by its political-administrative dimension: municipality or part of a municipality (zone, neighbourhood, district, etc.).

 Unit

Principle of unit in diversity: implies full recognition and constant search for real and effective equal rights, responsibilities and opportunities as values and purposes shared by distinct sociocultural collectives.