Research Article

The Population and its Contributing Capacity for Community Participation: A Thematic Analysis of Catalonian Public Healthcare Professionals Arguments in Health Promotion Designs

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ABSTRACT

The article analyzes the arguments that professionals use to think of themselves and the target population as subjects of participation and its consequences of their inclusion as agents to negotiate health problems and propose their solutions. The study presented has been carried out as part of the development of a *Projecte Demostratiu de l'Agència de Salut Public de Catalunya*: the transversal plan for the education and promotion of health in infants and young in La Garrotxa, which began with the approval of Law 18/2009 on Public Health in Catalonia. For the compilation of the information we conducted 20 interviews with key informants between 2009 and 2012. As an analytical strategy we performed a thematic content analysis. The results show two essential elements from which the arguments about

participation in the design of healthcare policies and actions are articulated: (a) the possession of scientific and expert knowledge as a source of knowledge in unquestionable health and (b) the construction of beneficiaries from their identification to age categories and the attribution of qualities that limit their power to dialogue and negotiate their needs and interventions in health. Finally, we debated about the need to relocate the various actors involved in health processes (professionals, beneficiary population, institutions) in a relational framework that allows for the confrontation of diverse healthcare perspectives to ensure the construction of a politically and socially conscious public health.

Keywords: Community participation; Public health; Community institutional relations; Age groups

What is known about this topic?

- Community participation is a process that implies the capacity of the population to make choices and to work with healthcare institutions to improve the health of the community.

- Community participation has an emancipatory potential because it can promote the problematizing capacity of the population about their experiences and conditions that limit or produce health.

- Social participation leads to strengthening the autonomy of the people and their community interdependence.

- Frequently the name of community participation includes interventions in health that involve the collaboration of the population in activities defined from the outside of the community.

What does this paper adds?

- Healthcare professionals are placed in a role of institutional legitimacy in the definition of health problems and their solutions based on their management of scientific knowledge.

- Healthcare professionals establish attributions to the population according to their categorization by age groups that limit their inclusion in participatory processes.

- It is necessary to promote the inclusion of the young and elderly population in a participatory process to break with the attributions made by healthcare professionals about their population.

- It is relevant to include all the agents involved in the processes of healthcare production (institutions, professionals and the general population) recognizing the capacities and potential of each of them, in order to encourage the construction of a more conscious and active society in the production of their own health.

Introduction

Community participation in health refers to the process by which the population acquires a leading role in the process of identifying needs and proposing solutions for the construction of their own health [1]. Although there is a consensus on the importance of community participation in health promotion since it allows the population to reach their potential in health

[2,3]. There are multiple conceptualizations of it that differ at the origin of the participatory process, as well as in the dynamics of the relationship between agents and its objectives. The polysemy of the concept means that actions of different kinds are inscribed under the term of participation, without referring to the same process [4-6]. Thus, differentiating participatory actions that originate within the community (organic participation) from those induced externally to it by outsider organizations (induced participation) [7].

However, beyond the origin of community participation, it is relevant to highlight the relational dynamics that these produce between the agents involved and the purposes that guide the development of such actions. In this context Briceño-León contrasts the design of participatory programs from healthcare professionals whose objective is to apply them to the population (projects for the population), that usually conceive participation from an instrumental perspective, oriented to the mobilization of resources or internalization of ideas; and practices previously defined by healthcare institutions from those that are oriented to collective dialogue and negotiation between healthcare agents and the population to which interventions are directed (projects with the population), which support participation through their capacity to produce an active and critical community able to mobilize collectively in the pursuit of health goals [8].

In relation to the first one, emphasizing that community participation usually is defined as a collaboration of the community in activities proposed by actors that do not belong to it. That is to say, under the name of "networks of health interventions" many practices of intervention in the community ignore the social actors present in it, being the intervening agents that act from the exteriority of the community defining their problems and possible solutions. They are actions towards the community in a vertical sense (from higher governmental spheres to concrete local space) and external (from outside the community to its interior). These actions have as a consequence the nominal inclusion of the community but the lack of consideration as relevant actors in the process [4].

On the contrary, community participation approaches whose goal is the production of democratic societies are aimed at strengthening community networks and empowering people in defining and acting on their own health [8-10]. They thus refer to participation as a process that implies the ability of the population to make healthy choices and to act collectively in order to improve the health of the community, converting community participation in the processes of defining health needs and solutions into symptoms of healthy societies [11].

These last interventions present an emancipatory potential of the community since they are based on the trust towards the community, in the sense that from there the community approach is possible (since the general population acquires an active role in the definition and problematizing of their needs and health problems) and at the same time, community participation leads to the strengthening of ties and trust in the community itself, favoring the autonomy of the people who integrate it and its interdependence [12].

An essential element for understanding community participation from an emancipatory perspective is the capacity of community actions to promote the problematiszation of health needs, understanding problematisation as a practice that seeks social transformation from the same context where that reality is produced, since it involves the identification of community problems through reflection on the experiences in the community and the proposal of actions on them. Likewise, this process strengthens the recognition of people as agents capable of acting and generating transformations of social reality [13,14].

The research from where this article derived was carried out from the development of a *Projecte Demostratiu de l'Agència de Salut Publica de Catalunya*: the transversal plan for the education and promotion of health in infants and young adults in La Garrotxa, executed in 2009-2010. The Projecte Demostratiu de l'Agència de Salut Public de Catalunya emerges from the approval of the Law 18/2009 on Public Health in Catalonia, which contemplates participation as an axis of special relevance in the definition of public healthcare policies: *"especially at the local level, both at the institutional level and the organizational level, intersectoral, professional and communitary"* [Llei 18/2009, of October 22, Public Health, pp. 81072. *Own translation, original version in Catalan]* [15].

Although community and professional participation are key elements for the development of public healthcare policies under the health model promoted by the Law 18/2009 on Public Health in Catalonia, the project Demostratiu analyzed places as agents of participation of entities that act at territorial level on the health and education of the young and infants, but do not open space for those who the project is directed to so they can take part in it. For this reason, the present article analyzes the arguments that healthcare professionals use to conceptualize the target population and its consequences of their inclusion as agents for negotiating health problems and proposing their solutions.

It is important to note that the article considers the statements made by healthcare professionals in Catalonia in the development of the doctoral thesis *"Public health as a problem of government: Analysis of social problems of public health under the model of governance"* which had as an essential purpose to analyze the processes of constitution of public health as technology of government on certain social problems. Specifically, the article reflects on the results obtained that refer to the target population and their participation in the identification of health problems or needs and in the design of healthcare policies [16].

Since the research deals with a number of analytical issues in a complex way, it also derives in two published articles: (a) *"Public health in the health-disease continuum: an analysis from the professional perspective"* and (b) *"Person and the State as agents of responsibility for the production of healthy societies: thematic analysis from the perspective of healthcare professionals in Catalonia (Spain)"* [17,18]. The articles presented deriving from the doctoral thesis share the methodology and informants but differ in the topics addressed, as evidenced in the differentiation of its foundations, the presented analysis and the final considerations.

The article *"public health in the health-disease continuum: an analysis from the professional perspective"* analyzes the arguments that professionals and professionals use to define public health as an area of intervention specifically in health and its consequences. The article (b) *"The person and the State as agents of responsibility for the production of healthy societies: a thematic analysis from the perspective of healthcare professionals in Catalonia (Spain)"* analyzes the arguments used by healthcare professionals in building health responsibilities of individuals and the State in building healthy societies [19,20]. Finally, the present article analyzes the views on the participation of the community of healthcare professionals from the categorization of certain groups and their attribution of knowledge and skills.

Methodology

We have done a qualitative research, as it allows rigorous access to the multiple phenomena and processes of senses' production in health, placing special importance on the people who produce such senses and the environment as a framework of possibility, which allow for the emergency of certain arguments.

We highlight the potential of reflexive, complex and detailed analysis that the qualitative methodology presents by admitting an open and flexible research design, making possible the integration of new and emerging senses in the process of access and analysis of information [21,22].

In the development of research, language acquires special relevance both for the access of arguments and for their analysis. From our perspective, language not only allows us to describe the lived reality but also to create its senses from the set of existing meanings and social practices situated socially and historically that put them in use [23-25].

The importance of language in the development of research leads to the choice of individual interviews as the technique of information collection. The technique produces a structured conversation framework that allows access to arguments that describe ground and ponder on various events, situations and experiences [26,27].Thus, the interview establishes a guided dialogue that allows the reconstruction of meanings about the counted reality.

We have conducted 20 interviews with key informants in the framework of the deployment of one of the *Projectes Demostratius de l'Agència de Salut Publica de Catalunya: the Transversal Plan of education and promotion of health in infants and young people in La Garrotxa*. As mentioned in the introduction, these projects were initiated during the elaboration and approval period of the Public Health 18/2009 in Catalonia, which contemplates participation as one of the essential axes for the construction of the public health model in Catalonia [15].

For the deployment of the Demonstration Project, an organizational structure composed of different hierarchical levels was established. The top level (Management Team) established the strategic lines of the Project, while the lower levels (Working Groups) worked on specific themes and activities.

The selection of informants was based on the identification of the "Operating Team", which acts at an intermediate level, coordinating practices and speeches of the Management Team and Working Groups in two ways: on the one hand, it translates the general guidelines of the Management Team into concrete proposals in the territory. And, on the other hand, it takes and guides the proposals of the Working Groups to give them a global meaning in the specific Project and following the lines of the Public Health model of the Autonomous Community.

It should be noted that the composition of the Operational Team is not arbitrary. Those responsible for the Project's deployment assume that the Operational Team has a strategic function that transcends the Project, since it puts to work together different public health agents of regional and territorial levels that could be part of a future Territorial commission of Public Health.

Given its relevance in the articulation of local senses (territorial level) and with general meanings (autonomic level) and its strategic potential, we have interviewed the members of the operational team as key informants. All members of the operational team were interviewed. In the course of the project, we also identified other key informants who, although were not part of the Operational Team, were directly linked to the Project. These were referents of the Operational Team (drivers or limiters of activities) that were invisible in the explicit scheme of the organization but played an essential role in giving meaning to the Project and, in particular, to deepen the objectives of the research. A total of 12 interviews were made with members of the operational team and 8 interviews with referents of the operational team. The 20 interviews allowed saturation of the information necessary for the research.

Interviews were carried out during the project execution period (2009-2010) and after the end of the project (2011-2012) in order to reflect and to deepen the information found in the first period. The interviews were recorded in audio and transcribed in their entirety. We corroborate the reliability of the transcriptions from the verification of their correspondence with the recording of the original audio. The language of the interviews was Catalan or Spanish, according to the informants' preference. The excerpts from interviews were translated from the original language into English for the presentation of the results in the article. The average duration of the interviews was one hour (with durations ranging from 45 minutes to an hour and a half).

A monitoring committee composed of professionals of the Department of Health and investigators of the Department of Social Psychology of the Autonomous University of Barcelona was constituted to guarantee compliance with ethical principles and scientific quality of data collection and analysis.

The script of the interviews approached the foundations of Health, the conceptualization of Public Health, its areas and problems; the identification of key agents for the design of public healthcare policies; health responsibilities; the reasons for promoting health; the main intervention elements in health promotion, the identification of intervention subjects; the role of

intervention subjects in the intervention process and conflicts of interest; the importance of the Public Health Law of Catalonia as a framework for thinking about public health and perceptions and conflicts present the development of the demonstration project.

Interview classification codes were constructed taking into account:

- The professional area of the person interviewed: general public health (SP), health promotion (Pm), health protection (Pt), epidemiological surveillance (V), catSalut (public health insurer of Catalonia) , Education (e).

- Level of decentralization of their work: autonomic level (NA), regional level (Nr) and territorial level (Nt).

- Professional training: biology (B), teacher (D), medicine (M), pharmacy (F), veterinary (V) and environment (MA)

- Two working meetings of the operational team were also recorded. One at the beginning and another in the middle of the project. These are identified as: R1/EO and R2/EO.

Analysis

Once all the interviews were transcribed, we performed a thematic content analysis [28]. For this purpose, we performed a first stage of identification of sense segments - topics and subtopics - of potential relevance for the analysis [29]. Once we had identified the themes and sub-themes, we started the first categorization of the information, based on the articulation of the set of interviews (which maintained the production context of each identified theme) and the set of statements that referred to the same theme (which allowed a more specific analysis of it). From these two materials, we had elaborated 3 products: a) conceptual maps of each theme and sub-theme, with particular reference to their internal relations and links with other themes; B) description of each topic as a possible category from the compilation of all the statements made by the interviewees - limiting their interpretation in the form of notes and comments; C) verification of links between emerging categories and research objectives. In this last point, it is important to emphasize that given the importance of increasing receptivity to unforeseen senses, we had identified the topics and subtopics in an inductive way, and after their identification we established links between them and the research objectives.

After obtaining these 3 products of analysis and in articulation with the interviews transcribed in full, we began a second phase with the objective of understanding how the statements that healthcare professionals develop in the exercise explain, argue and understand the Phenomena. Here we began the analytical stage: (a) we identified the positions of each person interviewed in the framework of institutional relations and the common and opposing arguments they handle; (b) we searched for connotations that appear in a repetitive way in their statements and analyzed the meanings they acquired in the construction of

certain realities, and their effects; (c) we identified the objects (health, illness, knowledge, materialities, etc.) and subjects of which they speak (professionals, institutions, risk population, beneficiaries, etc.); (d) we analyzed the effects of the senses identified and the construction of certain objects and subjects in the dynamics of relationships between people and institutions.

The analysis process allowed us to configure the categories and subcategories and establish relations between them, starting from the themes and sub-themes initially identified, obtaining a complex image on Public Health and allowed us to configure a complex and detailed image on the views on community participation by healthcare professionals.

Results

The article presents two essential elements that derive in arguments about community participation in the design of health policies and actions. First, they refer to the possession of unquestionable knowledge in health and the strategies to intervene on it and, secondly, to the identification of certain groups as lacking criteria or autonomy enough to actively engage and collectively define their needs in health. Thus, the arguments presented are structured around two segments of meaning:

Professional positioning as agents of knowledge and decision in health

Public healthcare professionals identify scientific knowledge as a space for the production of knowledge deprived of political interests and social conditions, based on the objective detection of reality. In this sense, they affirm that those who possess knowledge based on science are located in a space of undisputed legitimacy in the definition of needs of population health and in the deployment of activities to respond. Thus, based on the scientific method, the production of knowledge is dissociated from those who produce it in order to emphasize the legitimacy of the same from their objectivity.

"What we have analyzed is a health problem (...) Of course we cannot tell the young people (...) we would have to move on the grounds of evidence (...) This is evidence and that's it." (F1/EO/R1 Page 3)

Therefore, health problems and actions based on the scientific method enter into the field of the unquestionable and non-negotiable of any participatory process with the community.

"And this in principle is not debatable, well <it is not debatable>, it is debatable, but it is based on the SCIENTIFIC analysis of reality" [emphasizing the scientific word] (F1/EO/R1 Page 2)

Healthcare professionals oppose scientific knowledge to that produced in the context of everyday life. In this sense, the community does not have access to the definition of its own needs since health needs are identified in a space of scientific rigor. On the contrary, they express that the space open to the community debate obeys to strategies to make more efficient the action in health on certain health problems previously identified under the legitimacy of scientific evidence.

Under this view, community participation would make it possible to qualify the actions in health, adding the accessory components to it, making more or less effective the proposed activity from those who are in positions of knowledge, for managing or supporting scientific knowledge.

The community from its ascription to age groups: permeability of health discourses and intervention capacities

The second element corresponds to the construction of the "other" from an evolutionary perspective that has implications in the attributions of agent power in the very definition of its health. In this sense, healthcare professionals establish distinctions about subjects objects of health intervention based on their identification with age groups. That is, the age grouping of people derives from being constituted as more or less profitable subjects and more or less susceptible to community participation in their own health process.

Therefore, healthcare professionals establish a distinction between groups of early age (childhood and youth), adult and late (old age) attributing to each of these groups certain qualities of permeability to public health actions and certain Participatory (in)capabilities to define their own health needs. Thus, this second category is composed of 3 subcategories:

Permeability of age groups on health actions: Firstly, interviewees characterize the early age groups as subjects under construction, open to the internalization of new knowledge as the basis of their daily practices. Therefore, they assume that health action in this group is indispensable for the construction of healthy adults.

From the assumption that the population of early ages are highly influential, healthcare professionals highlight a positive view of such influence as an element that makes the group of young people more permeable to the discourses promoted by public health institutions and a negative view, which refers to the finding that there are other sources of influence on the health practices of people who can contradict institutional discourses and register with equal force in the habits of the population.

"For example 10% of the girls between 14 and 18 years old had a belief that in the first sexual intercourse they did not get pregnant...sometimes they have beliefs because they have not been educated or it hasn't been explained to them" (F1/O/Pt/NR/F Page 2).

Secondly, adulthood becomes a group with a difficult impact on the change in its practices since it is conceptualized as a period in life where people already have internalized certain health habits, being less impressionable to the actions of intervention in public health. In this sense, they assume that as the population grows older, practices become less modifiable. In addition, stability in health practices of the adult population is linked to its vital trajectory, social context and values and beliefs, factors that, in its view, make it difficult to introduce changes in health habits.

Finally, under the same logic that gives plasticity to the young population in the assumption of new habits, the passage of time derives to identify the older population strata, such as health intervention groups with less capacity for adaptation and behavior change.

"They learn, we don't learn when we are older, when we are older we are the way we are and that is it (...) Young people, of course, learn and learn" (F1/EO/Pt/NT/MA Page 23).

Participatory (in) capabilities of age groups to define their own health needs: As we have shown in the previous lines, healthcare professionals attribute to the young population the greatest plasticity to adapt and learn from the environment and social discourses, internalizing them in daily practice as health habits. This element serves to constitute the young population as a basic collective, the object of intervention of public healthcare policies. However, within the "young population" category, there are two major age groups: children (between the ages of 12 and under) and youth (between 12 and 25 years old).

They characterize the infant population as an innocent collective, without knowledge of health criteria and without temptations towards risky behaviors; as a blank paper on which one can proactively begin to delineate the construction of a potentially healthy subject from the incorporation of health criteria by those who are accredited. In the game of establishing health criteria and not calling for temptations of unhealthy behaviors, healthcare professionals propose to act on the population under 12 years of age from the promotion of general life skills, aimed at enhancing relational and personal decisions that allow for health practice decisions.

"If you, from zero to ten which is more or less what was said but since we have the line up to twelve we draw from zero to twelve, you have to do is work positioning with respect to dependencies not drugs but dependencies, in what sense?, in the sense that you have freedom, you have to be able to choose, you have to be autonomous" (F3/EO/Pt/NT/MA Page 6)

On the other hand, they assume that the population of the second age group, youth, presents an absence of risk awareness of their practices related to health since, according to healthcare professionals, the adolescent and young population see life as an unquestionable and undisturbed fact. That is, they consider that the young population is self-constructed as immortal and therefore devoid of concerns of the effects that may have the development of carefree practices for health.

"Health is not a concern for young people (...) young people has an ideal perception of health. They are invincible; they do not die" (F1/EO/Pt/NT/V Page 15)

"When you are young, you always think that it will not happen to you because (...) young people are immortal...of course they have this perception" (F2/EO/Pt/NR/B Page 16)

The arguments about the older age group change completely, since they focus on the construction of old age from the loss of physical and mental capacities, as well as the loss of social networks of support and care. In this sense, health actions are aimed at compensating for the shortcomings associated with this stage.

Specifically, the people interviewed conceptualize the elderly as a group that gradually loses social relations, since they assume that many people live alone, that there is a gap of links with younger generations, and loss of family members by separations and / or death of relatives. They also link loneliness with physical and cognitive deterioration coupled with the loss of material resources to confront daily life with certain independence.

In terms of the configuration of the elderly population in the emphasis on negative aspects associated with aging, it is configured as a vulnerable group that, without public health action, is highly susceptible to loss of quality of life and health. In this perspective, public healthcare professionals propose to act to minimize the effects of decay associated with old age (mainly cognitive deterioration, loneliness, nutritional deficiencies and lack of physical exercise).

[About elderly people] "I have a theory that, that...people who are left alone, are the main candidates to have Alzheimer's after a short time (...) you see they hang themselves, you know?" (F2/EO/Pt/NR/B Páge 17)

Implications of the relationship between expert subjects and subjects lacking criteria for community participation

The ignorance of health criteria, added to the belief of immortality of the young population, is elements that detract from the capacity of the young population to act in the negotiation of their own health needs and actions. In parallel, under the legitimacy of professional knowledge, based on practice and scientific knowledge, the ability to define intervention strategies and areas of action on the health of the population is attributed.

"This I do not know. Asking for the kids' opinion, okay, but... asking for their opinion as to whether they want to be trained with...with...with health topics, like other things eh? (...) you say you want to learn, to learn healthy habits? I do not even know if they know what healthy habits ar, or if they really want to participate" (F2/CD/CS/NR/M (a) Page 10)

In this sense, participation of the young population in the definition of their own health needs is relegated to second place. Thus, health action far from being considered under a participative view becomes unidirectional. Those who handle the knowledge in health (professionals) identify problems and needs of health and exclude the people subject to intervention from the debate on what their problems are and how to intervene them. They are, as some interviewees have explained, passive sectors of action in health.

[About young people: they are] passive sectors (...) we never proposed that there was an active participation, but that they were the recipients of...the work that was done (...) ...we never suggested their participation" (F3/EO/E/NT/D Page 4)

Finally, since they constitute the elderly as a group marked by physical, mental and relational deterioration based on the dependence that they associate with this group, public healthcare professionals interviewed take on a paternalistic role, whose consequences derive in the construction of old age as a collective with limited capacity to act. That is, they propose interventions aimed at compensating for the deterioration through care

and material resources, attributing, as a counterpart, a scarce capacity for self-management.

"Promoting health in older people I think is basic, because if not we'll reach a point that...a lot of dependence, you know? Many people with problems" (F2/EO/Pt/NR/B Páge 17)

Discussion

The presented work focuses on arguments by healthcare professionals about community participation, but requires dialogue with the young and elderly population in order to open said dialogue and promote the meeting spaces between the various actors involved in the construction of empowered and healthy communities.

Community participation is understood as an essential dialogue process for building a human rights-based health approach. To be transformative, it requires placing all actors involved in the participation process (users of health care systems and professionals) in positions that allow sharing power relations. Sharing power relations would open a process of negotiation, conflict and encounter of different health perspectives, resulting in the emergence of new problematisations on health and in the implementation of innovative intervention actions on them [6].

On the contrary, the results presented evidence the limited recognition of the population to which the interventions are directed as active and reflexive subjects in the processes of health production. As a consequence, the identification of health problems and the development of interventions is performed from the outside of the beneficiary population [4]. In this sense, community participation in health is limited by the power relations established between health institutions and the community, since healthcare professionals are positioned in a space of unequal power in the establishment of relation rules of the dynamics of participation [30].

The results show that the low recognition of young and elderly population as active subjects in the identification of problems and the proposal of health interventions is linked to two essential aspects:

- The recognition of a legitimate and indisputable professional knowledge endorsed by scientific knowledge.

- The attribution of limited knowledge, interests and valid capacities to act in the health of the population to which they direct the intervention.

In relation to the first, and in coherence with the results obtained in the research, that the expert and scientific figure gives institutional legitimacy to interventions on the population, since they are attributed the authority and ability to establish criteria for defining social problems and actions to act on them [31]. However, "*not to build as positivist hyperempirism does, without question, accepting whatever concepts are proposed to it...Is still a way of constructing because it implies recording and ratifying something that is already constructed*" (p. 178) [32]. In this sense, opening up to a debate that unquestionable [33,34] could destabilize the established relationship of institutions to

their population, since it would allow to rethink existing health discourses and their consequent interventions.

In relation to the second, the limited attribution to act that healthcare professionals give to the young and the elderly population serves to justify their lack of inclusion in processes of community participation, but they give a feedback to the construction of passive subjects, limiting the possibilities of the production of reflexive and empowered subjects about their health processes. The need to strengthen the role of community agency through the construction of a politically and ethically involved citizenship becomes imperative [35]. A process in which health institutions and professionals work together with citizens in the context of complexity that involves health problems. That allows for the identification of problems and the development of collective and politically involved solutions that link heterogeneous knowledge with community mobilization and change [13].

Thus, in line with the reflections of the development of participatory processes *with* and *in* the community requires breaking the conformity of healthcare professionals with the logic of vertical linkage between institutions and the community [35]. This rupture would allow the recognition of the population as an agent that needs to be heard and that can propose efficient actions in health. Such an action would allow to overcome the barrier that limits community participation to an area of action secondary to the institutional definition and oriented to the modulation of previously stipulated interventions.

The inclusion of the young and elderly people in participatory processes could allow to generate discussing spaces where they could problematise every day issues and contexts, developing critical consciousness of their lives and enhance their capacities to change what they think is wrong [36,37]. In this sense, to include young and elderly people in participatory processes is an essential element for Health Promotion policies, that allows people to develop their health potential because it elevates their capacities to think and act over multiples factors that determine their health [38]. In this line, empowering the agent power of the population recognizing their relevance as actors in defining their reality in health and its transformative potential would strengthen community bonds and personal reflexivity and autonomy, a primary goal for building a healthy community [12].

Conclusion

In this article we intend to know and reflect on what are and how articulate are the arguments about community participation in the design of healthcare policies and actions in Catalonia within the framework of the development of a public health project conceived as participatory in integrating agents and institutions of different levels (autonomous, regional and local) and transcending health to the incorporation of entities operating in the territory in multiple areas (education, youth, security, etc.), but that obviate the incorporation of the population to those who direct their interventions.

The results show that the absence of community participation is due to the recognition of institutional professionals as holders of irrefutable knowledge that enables them to determine the health problems and establishes proposals for action towards the community from the outside. Likewise, the lack of inclusion of the population in the identification of problems and design of solutions on their own health obeys the attributions of the population according to their categorization to age groups, lack of knowledge, interests and capacities of health agency. In this sense, in the article we have identified that extreme age groups (older population and young population) are constructed from their comparison with adulthood, the first being thought as the loss of abilities and autonomy reached in adulthood and the second as the stage of formation (and therefore a stage of incompleteness) of criteria and autonomy over health practices.

The exclusion of the young and elderly population in the processes of health production closes the dialogue of these groups and limits the possibility of rebuilding the population based on their potentialities. This results in the verification, by healthcare professionals, of the previously existing attributions and the design of paternalistic interventions.

It becomes imperative to break this attributional loop to reposition all agents (professionals, beneficiaries, and community tissue) in a space of knowledge and potentialities confrontation and encounter. This would allow, on the one hand, for the configuration of politically and socially aware institutions open to the novelty and questioning of their actions in health; and on the other, for the construction of a reflexive, demanding and socially committed population in the production of its own health processes.

Ethical Approval

Acknowledgement

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