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Promotion of healthy and equitable relationships in formal education contexts

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Interpersonal relationships exert a significant influence on health: when they are equitable, they contribute to well-being, but when they are asymmetrical and hierarchical, they negatively affect health. This article proposes a conceptual framework focused on social determinants of health and principles of equity and justice in relation to relational models and education. The text identifies so-called "structural determinants," such as systemic oppression and socio-historical context that tend to normalize expressions of violence. On the other hand, "intermediate determinants" include individual, psychosocial, behavioral, and community aspects that affect health through relational patterns that can lead to issues such as reduced self-esteem, anxiety, stress, depression, and acceptance of violence. The text suggests six areas of educational intervention to promote healthy and equitable relationships that benefit well-being, health status, and protection against violence. These socio-educational interventions can be effective in fostering more positive and equitable relational models.

Introduction

Interpersonal relationships constitute a crucial social determinant for health, fundamental at both the individual and collective levels (Dahlberg & Krug, 2006; Solar & Irwin, 2010). These relationships are considered healthy when the succession of interactions contributes to well-being, enabling development at both individual and collective levels and being associated with positive affectivity and emotionality. Healthy relationships are inherently equitable; to be a source of well-being, they must be voluntary and address issues related to power. Additionally, to facilitate mutual development, they must be based on interdependence, addressing the diverse needs, realities, and aspirations of the individuals involved. Interpersonal relationships established in any community form a network of simultaneous interactions that are widely heterogeneous. Therefore, their study has often been fragmented into typologies (Aron et al., 1996), such as romantic relationships and mother-daughter relationships, or group dichotomies like teacher-student or employer-workers.

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Social determinants of health encompass all conditions of people's lives that influence their health status (Marmot et al., 2013). These conditions explain most social inequalities in health, understood as systematic differences in health status among various groups of people (Whitehead, 1992). Maintaining healthy and equitable relationships positively impacts health, contributing to physical, mental, emotional, and social well-being (WHO, 1946). However, in research on the relationship between interpersonal relationships and health, the focus has been on understanding the negative health effects of certain relational patterns. Therefore, there is little research on the impact of healthy and equitable models on health, but the negative impact of experiences of violence and discrimination on physical, mental, and social health, including racism (Paradies et al., 2015), and experiences of abuse and violence, such as partner violence (Blanco et al., 2004), is repeatedly confirmed. These violences are manifestations of power relations. Power should be conceived not as something possessed or obtained but as a continuously operating web, a field of domination and resistance forces between individuals and groups (Foucault, 1976). The distribution of power in our society is not equitable, giving rise, therefore, to power relations (Diamond, 2022). Violences are manifestations within power relations exercised systematically and structurally, used for the control and subjugation of individuals, violating their rights.

The connection between interpersonal relationships and health is mediated by education, understood as the process of transferring, acquiring, and creating ways of life (Mata, 2010). Through education, each person acquires the social and cultural meanings of the environment in which they operate. Childhood and adolescence are crucial periods in which, through socialization, relational models are observed, learned, and experienced (Elder GH, 1995). Therefore, they are opportune moments to build relationships based on respect and non-violence. In our society, children and young people often experience violence firsthand, whether at home, in educational centers, or in public transportation (Vives-Cases et al., 2021). These relational models based on the use of violence are normalized and legitimized, favoring the reproduction of violence (Ariza et al., 2019).

Educational contexts are crucial for promoting healthy and equitable relational models. Socio-educational actions in formal education contexts have proven effective in modifying behaviors related to interpersonal relationships, with a positive impact on health (Hinkle, 1974). The World Health Organization recommends intervening through sustainable socio-educational interventions over time (WHO, 1997), as they allow learning to identify violence and act against it. Also, acting in the educational context allows addressing both formal and behavioral aspects, as well as the hidden curriculum, that is, all the knowledge, skills, attitudes, and symbolic values acquired implicitly and unintentionally (Pérez-Marco et al., 2020).

Although research on healthy and equitable relationships has increased in recent years, there is still limited published evidence. On the other hand, before implementing socio-educational interventions, it is crucial to theoretically understand the relationship between health, its inequalities and determinants, and relational patterns, especially in an educational context. There is a lack in the theoretical approach to the promotion of healthy and equitable relationships from an equity and justice perspective.

1. The Use of Conceptual Frameworks to Explain Health Inequalities

Social inequities in health and social determinants of health have been extensively described in scientific literature (Dahlgren and Whitehead, 1991; Solar and Irwin, 2010). Given the complexity of identifying the elements and mechanisms through which social health inequities occur and reproduce, theoretical explanations are often accompanied by graphical representations that synthesize information and facilitate understanding. Conceptual frameworks have proven useful in explaining health inequities at various territorial levels, such as in the case of the Spanish State (Commission to reduce health inequalities in Spain, 2012), as well as in cities or urban areas with specific characteristics that distinguish them from other areas of action, such as the country or autonomous community (Borrell et al., 2013).

Conceptual frameworks have been previously used to illustrate the links established between health and specific types of power relationships. Examples include the conceptual framework describing different processes and contexts influencing health inequities in women and mothers (Trujillo-Alemán et al., 2019) or explaining gender-based violence in the partner environment (Artazcoz et al., 2019), which have advanced understanding of the relationship between social structures, such as patriarchy, and health. They are also used to understand the relationship between capitalism and health, as introduced in the conceptual framework to comprehend the complex relationship between climate change and health in the context of Mediterranean climate cities from a social and climate justice perspective (Marí-Dell'Olmo et al., 2022), or more recently, to describe the social mechanisms explaining the inequitable distribution of the incidence and mortality of COVID-19 (Vásquez-Vera et al., 2022).

Many of these conceptual frameworks include interpersonal relationships as "social and community networks" (Dahlgren and Whitehead, 1991), emphasizing their importance in addressing the adverse effects of social inequalities on health. Some conceptual frameworks also incorporate 'social cohesion and social capital' (Solar and Irwin, 2010). However, these conceptual frameworks do not explicitly include interpersonal relationships as a social determinant of health. This is a limitation in addressing health processes, such as the impact of violence, where interpersonal relationships are a key determinant, but also in understanding the well-being provided by some relational models.

The objective of this article is to propose a conceptual framework of interpersonal relationships as social determinants of health and health inequities in children and young people. A proposal for the applicability of this conceptual framework will also be presented, aimed at promoting healthy and equitable relationships through socio-educational interventions in formal education contexts, including the second cycle of early childhood education, primary, and secondary education.

2. Conceptual Framework for Healthy and Equitable Interpersonal Relationships

The conceptual framework of social determinants for healthy and equitable interpersonal relationships, as presented in Figure 1, is based on recent work (Forcadell-Díez, Juárez Martínez, et al., 2023). This conceptual framework builds upon previous frameworks describing structural determinants and includes mechanisms that generate and sustain social hierarchies (Solar and Irwin, 2010). It explains that these determinants result from the unequal distribution of power (Whitehead, 1992) and also influence interpersonal relationships (Foucault, 2018).

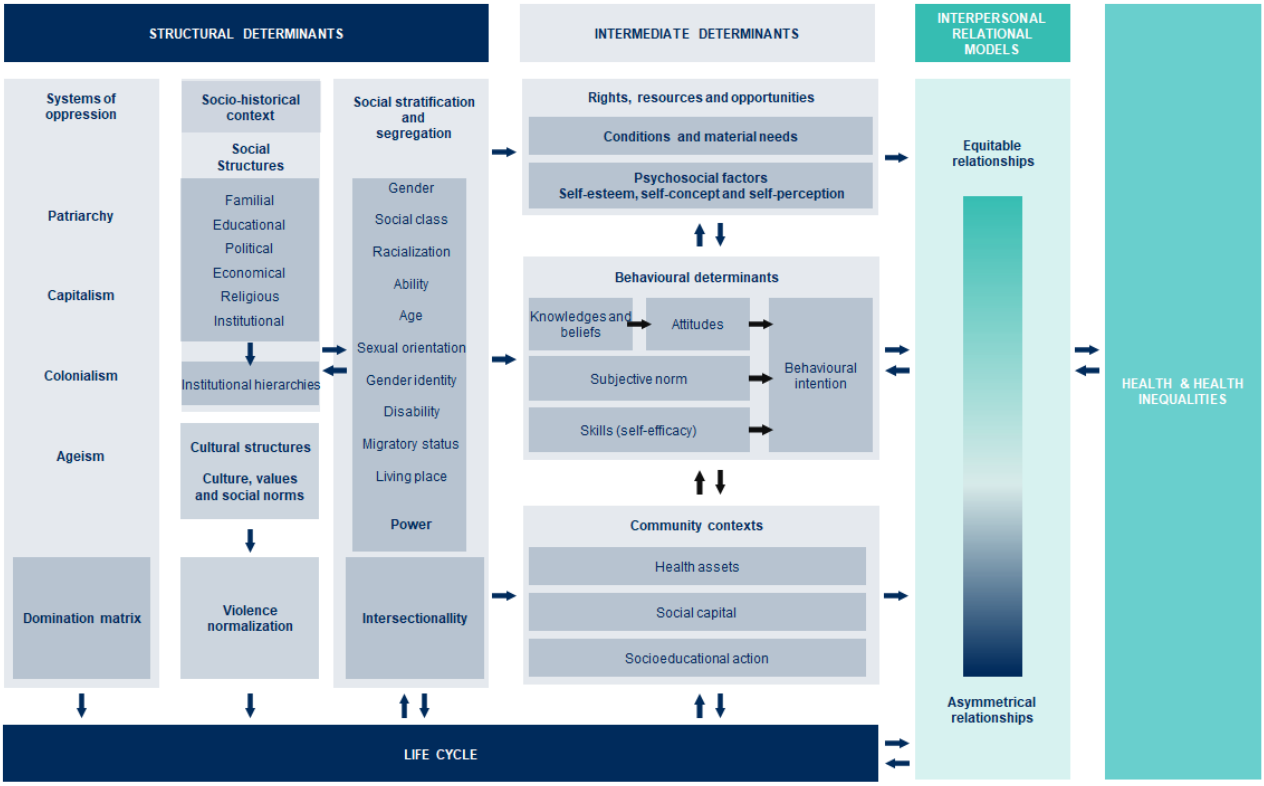
2.1. Structural Determinants

The structural determinants of social organization include systems of oppression, social and historical context, and social stratification and segregation. Firstly, systems of oppression are shaped by patriarchy, capitalism, and colonialism. Their effects are not independent but act collectively, distributing power and resources inequitably among social groups.

Patriarchy is a binary, sexist, cis-heteronormative, and monogamous model of social organization based on exclusive dichotomies such as feminine-masculine. It stereotypes the masculine as superior, undervalues the feminine, and reduces sexuality and affectivity to the complementarity of the woman-man binomial (Anne Fausto-Sterling, 2000). The implications of this system include social norms, institutional systems, nuclear monogamous family, division between the public and private spheres, separation between productive and reproductive work, and beauty standards.

Capitalism is a model of social and economic organization based on the privatization and unequal distribution of the means of production within power relations, leading to the progressive accumulation of capital and power in a minority of the global population—the dominant social classes (Krieger et al., 1997). The capitalist system generates social norms, taking the owning class as a moral and behavioral reference, and stereotypes of social class are generated from childhood that perpetuate inequities (Pearce et al., 2019).

Diagram 1. Factors determining healthy and equitable interpersonal relationships in the adolescent and youth population.



Source: Own elaboration based on the conceptual framework by Forcadell-Díez, Juárez Martínez, et al. (2023).

Colonialism is a form of global social organization where a hierarchy of human groups is created through physical attributes and stigmas that socially identify and disqualify their bearers through processes of social comparison, based on stereotypes and prejudices, shaping the racist imaginaries of colonizing states. Racism impacts health and its inequalities from childhood and throughout life through social, psychological, and economic mechanisms such as acculturation, segregation, discrimination, and deprivation (Cheng et al., 2015).

The last system of oppression presented in this conceptual framework is ageism, an organizational condition of society that allows adults to maintain a position of superiority over children, adolescents, young people, and the elderly. An adult-centric dichotomy between youth and old age emerges, socially obliging individuals to place adults. This dichotomy denies childhood, adolescence, and the elderly as political subjects and negatively influences self-perception during these stages, such as the idealization of youth associated with beauty, energy, and potentiality, perceived as a set of standards to aspire to and maintain (Duarte Quapper, 2012).

Secondly, the structural determinant we call socio-historical context refers to the social, political, and cultural mechanisms that shape and maintain social hierarchies at a given historical moment (Solar and Irwin, 2010). This socio-historical context is the product of the correlation of forces that occurs in the field of power relations at a specific moment and context.

Social structures include the different systems that exist in a society and consist of hierarchical relational patterns between social groups. An example is the education system. The hierarchies of political institutions choosing a type of educational curriculum, educators executing it in the classroom, economic institutions and their ability to determine what should be learned from a utilitarian perspective, and religious institutions, whose morality permeates educational relationships. Power relationships produced within the nuclear family are also transferred to educational spaces.

Cultural structures refer to the symbolic dimension shared by a society, including social norms, beliefs, and values. These become, within capitalist, patriarchal, and colonialist systems, a dominant ideology, a set of ideals of behavior, depending on one's position, and what the consequences are of breaking or adhering to norms. For example, these structures establish who should perform caregiving tasks and behavioral guidelines for sex-affective relationships framed in romantic love (Simon et al., 1992). A central aspect of social and cultural structures deals with the legitimization of the use of violence: against whom, when, and how the use of violence is permitted. Today, social norms legitimize the use of violence by groups in dominant positions as structural violence. There is also symbolic violence, related to the cultural, that legitimizes structural violence (Galtung, 1990).

Institutions arise from the amalgamation of social and cultural structures with the aim of organizing social activities through symbolically imposed spaces as facts. Individuals assume roles based on their position within the institution, giving rise to processes of subjectivation and inscription within a symbolic order, thereby assuming an educational function (Foucault, 1975). The violence exerted by power is deemed necessary for the reproduction of institutions and the ensuing power relations.

In the third place, the structural determinant referring to social stratification involves the categorization of individuals into hierarchical groups based on axes of power such as gender, social class, race, functionality, age, desire orientation, gender identity, migratory status, and place of residence (Krieger et al., 1993; Palència et al., 2017). The intersectional perspective (Crenshaw, 1991), crucial for understanding relational models, posits that power axes combine differentially, resulting in a multiplier effect of power axes in generating inequities. These power axes define a particular position within systems of oppression and power hierarchies, determining personal experiences and a differential exposure to certain relational patterns (Krieger, 1999). These stratifications inherently lead to population segregations that enable phenomena such as school bullying and classist, sexist, racist, and LGBTQI-phobic violence, profoundly impacting health and its inequities (Perez et al., 2015; Vives-Cases et al., 2021).

2.2. Intermediate Determinants

Through social stratification, determinants unevenly distribute rights, opportunities, and resources among the population. Intermediate determinants refer to individuals' specific experiences influencing health processes, particularly material conditions and lifestyles. Firstly, material conditions, which vary according to axes of power, shaping differential realities from childhood onwards. Needs are socially constructed and satisfied through interpersonal interaction. The satisfaction of material needs will influence health and related behaviors (Hanson & Chen, 2007). Social stratification processes from childhood determine how and with whom interpersonal relationships are established. Family relationships, school relationships, friendships, and time use are key psychosocial factors during childhood, with adolescent relationships adding to these. All are affected by power axes and impact individuals' health (Piontak & Schulman, 2016). Experiences of material deprivation, social exclusion, violence, and discrimination, as well as other stressful events during childhood and adolescence, impact health through somatization (Krieger, 1999). Self-perception is an example of a psychosocial factor strongly influenced by the context that affects health through self-esteem. This occurs in individuals whose bodies do not conform to the norm, where discrimination strongly alters the self-perception and self-esteem of those who experience it, influencing the rejection of their own bodies (Leiva et al., 2013).

Secondly, behavioral determinants, i.e., lifestyles: individual and collective attitudes and behaviors closely linked to relational patterns. Ultimately, it is important to bear in mind that particular lifestyles are conditioned by both dominant ideology and material conditions. Multiple models identify behavioral determinants such as knowledge and beliefs, attitudes, subjective norms, skills and self-efficacy, and behavioral intention. Knowledge and beliefs refer to what an individual or group knows or perceives to know about an action, including perceived benefits and difficulties. It gives rise to the attitude towards a behavior (De Vries et al., 1988). In perpetrating

violence, a favorable or unfavorable attitude is crucial and depends on the perceived benefit/harm balance.

Subjective norm is an individual or group's perception of pressures to perform a behavior, perceived as thought or done by influential people in the environment. It is deeply influenced by social norms. In the case of caregiving tasks, the norm acts as an obligation for women, socially sanctioning those who do not comply and exempting men (Salvador-Piedrafita et al., 2017). In sexual-affective relationships, the subjective norm will facilitate behaviors that a person expects from others, based on myths of cis-heterosexual and monogamous romantic love. In this sense, in adolescence, the perpetration of violence is related to the perception that it will be approved by the group (Lipsey & Derzon, 2012).

Social skills are linked to self-efficacy, including expectations of success in performing a particular behavior. Perceiving oneself as capable of resolving conflicts, individually and in groups, is closely related to self-efficacy in terms of social and communicative skills, such as empathy and assertiveness, as well as emotional and affective management strategies (WHO, 2020).

Thirdly, community contexts where we find assets, factors, or resources for health recognized by a community as health promoters, well-being, and reducing inequities, as previously mentioned (Morgan and Ziglio, 2007), strengthening interpersonal and intergenerational relationships and building collective resilience to health stressors. It includes individual, community, and associative resources, as well as institutional ones (Pérez-Wilson et al., 2015); services and the physical environment, including green and leisure spaces (Borrell et al., 2013).

Social capital refers to resources available to individuals and groups as a result of their participation in community networks and social movements, and emerging mutual knowledge and recognition. This is closely related to health (Trujillo-Alemán et al., 2022). In this regard, it has been demonstrated that the involvement of adolescents and young people in the community is key to reducing violence (O'Donnell et al., 1999). Agency, conceived as the collective capacity to counteract oppressions exercised by power, is key to transforming relational patterns through organization and resistance (Emirbayer & Mische, 1998). Thus, future interpersonal relationships, already real in the present, are imagined, tested, and disseminated in opposition to hegemonic models. The concept of agency goes beyond collective resilience and is understood as the ability to transform adverse realities.

Socio-educational interventions aim to improve the knowledge, beliefs, attitudes, and skills of a community. They usually rely on community strategies commonly used in education and health promotion. Over the past decade, interventions aimed at promoting healthy and equitable relationships, particularly addressing gender inequities, with diverse perspectives, have emerged. Among them, gender-transformative interventions grounded in critical pedagogies have been effective in transforming power relations based on gender (Arconada-Melero et al., 2019; Cahill et al., 2018; Emakunde-Instituto Vasco de la Mujer, 2015; Vives-Cases et al., 2019). The gender-transformative approach aspires to transform social relationships, putting an end to the perpetuation of social norms and attitudes that produce-reproduce gender inequities (Gupta, 2000).

2.3. Life Cycle

The life cycle perspective underscores the importance of life stages in understanding health phenomena and inequities at individual, population, and generational levels. Processes and experiences over time influence interpersonal relationships, as well as health and its determinants (Elder GH, 1995). The accumulation of advantageous and disadvantageous experiences is relevant, involving the adoption or rejection of specific individual and collective trajectories (Willson et al., 2007). The life cycle perspective is critical in childhood and adolescence: relationships established in these stages, facilitated by material conditions,

lifestyles, and community contexts, foster the subjugation and consolidation of relational patterns that will significantly influence health processes. Moreover, axes of power impact lived experiences, including interpersonal relationships. This is evident in the case of gender, which intertwines continuously during socialization in the construction of affectivities and sexualities (Carpenter, 2010).

2.4. Relational Models

Unlike other more general conceptual frameworks where relational models are considered an intermediate determinant of health, located in the section on social capital, social networks, or psychosocial aspects (Dahlgren and Whitehead, 1991; Solar and Irwin, 2010), in this conceptual framework, structural and intermediate determinants influence health and its inequalities through relational models.

Interpersonal relationships are central to the individual and collective life and development of individuals and are one of the main social determinants of health. The concept of healthy relationships, defined earlier, arises from the need to conceptualize relational models where interpersonal interactions are based on well-being. On the other hand, equitable relationships help promote gender equality in key economic, political, and social life activities, as well as in access to essential services (UNESCO, 2020). These factors enhance the health and well-being of individuals and societies. In contrast to this relational model are asymmetrical relational models, with hierarchical and dominant relationships between individuals and groups being their ultimate expression.

Violence operates on the basis of social norms that legitimize it and is systematically and directionally used for the control and subjugation of individuals affected by violence (Heise, 1998). Interpersonal relationships are a significant social determinant of health (Pietromonaco and Collins, 2017). It has been demonstrated that relational models based on violence, such as gender-based violence (Artazcoz et al., 2019), disproportionately affect the most disadvantaged population, generating greater health inequality (Krieger, 1999). It is established that in childhood and adolescence, the experience of violence is associated with lower self-esteem and higher levels of aggression (Pius Kamsu Moyo, 2020).

2.5. Health Inequity and Health

Health maintains a bidirectional link with interpersonal relationships, based on the characteristic gradients of relational models. This is because interpersonal interactions are diverse, ranging from affection, respect, and mutual support to discord, aggression, and boundary violations (Rook, 1989). As previously noted, healthy and equitable relationships contribute to the health and well-being of individuals and communities. Satisfaction with family, school, and friendship relationships is associated with subjective well-being from childhood and acts as a protective factor against violence (Iñiguez-Berrozpe et al., 2021).

Conversely, asymmetrical relationships negatively impact health in multiple ways. The main effects are associated with being a victim of violence in its various expressions: discrimination (Cave et al., 2020), gender-based violence (Eby et al., 1995), sexual abuse (Briere and Elliott, 1994), physical assaults (Norman et al., 2012), and bullying (Armitage, 2021). Specifically, these relationships are linked to decreased self-esteem and self-concept; increased feelings of guilt; anger, sadness, anxiety, stress, and depression; communication difficulties; reduced social problem-solving skills; normalization and justification of violence, aggression, and learned helplessness; and physical or sexual aggression, suicide, or homicide (Cornelius and Resseguie, 2007).

3. Applicability of Promoting Healthy and Equitable Relationships in Formal Education

The proposed conceptual framework allows for the identification of five areas of intervention for promoting healthy and educational relationships in formal education contexts, derived from the application of Bronfenbrenner's ecological model (Bronfenbrenner and Ceci, 1994). In this way,

the elements of the conceptual framework are organized in response to different levels of educational and school structure: structural determinants could be modified by influencing elements of the macrosystem, such as educational policies. Intermediate determinants could be modified by influencing the microsystem, particularly through specific socio-educational interventions.

1) Actions on Educational Policies. Educational policies regulate educational institutions and are closely linked to social structures and dominant ideology, norms, and social values. Modifications in legislative texts can introduce changes in governance, educational curricula, and school spaces, impacting the promotion of healthier and more equitable educational models. For example, the United Kingdom has enacted laws to include the promotion of healthy and equitable relationships, as well as emotional and sex education, in educational curricula (United Kingdom, 2017).

2) Actions on the School's Educational Project, Organization, and Governance. These elements shape a dominant school culture and enable the hegemony of certain models. To transform relational models, it will be necessary to favor social norms and values that promote equity, critical thinking, and cooperation. Actions include rethinking the school's organizational structure, the educational project (Bernstein, 1982), school regulations, the use of spaces and playgrounds, architecture and accessibility, signage, images and graphics, materials used, celebrations, arrangement of elements in classrooms, and developing protocols for preventing and addressing violence. Involving and engaging children in decision-making processes at the school and classroom levels is essential (Agud et al., 2014). Care must be taken, however, to ensure diversity and avoid exacerbating inequities.

3) Training Actions for Educators. Within educational relationships, educators give meaning to discourses and practices, becoming positive or negative reinforcements for certain relational models. Training educators will contribute to their critical awareness of their impact on students and enable the effective promotion of healthy and equitable relationships (Forcadell-Díez, Bosch-Arís, et al., 2023). It will also enhance the effectiveness of school actions.

4) Socio-Educational Interventions to Promote Healthy and Equitable Relationships among Students. Socio-educational action aimed at influencing relational models must necessarily involve the critical awareness of both educators and students as subjects with transformative potential. Starting from a holistic transformative approach and grounded in critical pedagogies, collective critical reflection and dialogue promote the development of knowledge, skills, and attitudes that foster prosocial behaviors, reduce acceptance and perpetration of violence, and encourage collective organization (Luna and Rubio-Martín, 2022). These interventions should be evidence-based and have an equity and justice perspective. Such socio-educational interventions not only promote changes in relational models but also lead to the reduction of social inequities in health.

5) Actions on the Community. The involvement of the educational community in school practices from a cooperative perspective ensures the continuity of promoted educational actions, guaranteeing coherence and promoting social capital (Martínez-Odría, 2007). Additionally, the school community should be considered in decision-making processes: cooperation with families, entities, and associations, as well as the involvement of the school in community life, facilitate the dissemination of healthy and equitable relational models.

4. Strengths and Limitations

As a strength, the evidence gathered by this conceptual framework allows considering interpersonal relationships as a social determinant of health, enabling the understanding and addressing of social inequities in health.

Furthermore, this conceptual framework helps identify areas of intervention, and in this regard, socio-educational interventions, whether in formal educational contexts or beyond, involve group relationships. This perspective, which extends beyond the individual, is crucial when discussing the promotion of healthy and equitable relationships.

On the other hand, positivism in education has favored the cognitive-behavioral perspective, making it challenging to find evidence from a critical or community-oriented standpoint. Finally, concerning systems of oppression, we have not referred to ableism as one of them. The limited evidence we have found on this topic approaches it from a segregational or paternalistic perspective. Additionally, the diversity of bodies, functionalities, and abilities must be taken into account in future interventions aimed at promoting healthier and more equitable relationships.

5. Conclusion

The proposed conceptual framework, based on existing evidence, can facilitate the design of effective socio-educational interventions to promote healthier and more equitable relational models. The framework identifies structural and intermediate determinants, as well as areas that need addressing, particularly systems of oppression and social stratification based on power axes, as well as affective and emotional aspects, social skills, and social problem-solving. Additionally, five areas of intervention have been identified to promote healthy and equitable relationships in formal educational settings: educational policies, the school's educational project, organization, and governance, training for educators, socio-educational interventions to promote healthy relationships among students, and community relationships.

6. Recommendations

The promotion of healthy and equitable relationships through socio-educational interventions in formal education is a growing field, and it is essential to anticipate the emergence of new innovative socio-educational interventions. A theoretical model facilitating the design of socio-educational interventions for promoting healthy and equitable relationships with a transformative focus, directed at students, educators, educational contexts, school organization, physical and symbolic spaces of schools, norms and social values, educational community, and educational policies, is necessary.

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