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THEORETICAL ARTICLE

Healthy and Equitable Interpersonal Relationships, Health Inequalities and Socio-Educational Interventions: A Conceptual Framework for Action

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ABSTRACT

BACKGROUND: Interpersonal relationships undoubtedly have a bidirectional connection with the health of individuals and communities. Relational models based on equity contribute to well-being, while asymmetrical relationships based on hierarchies and differences of power negatively impact mental, physical, and social health.

METHODS: A conceptual framework for understanding the determinants of interpersonal relational models was developed.

RESULTS: Structural determinants were identified as the combined action of systems of oppression, the socio-historical context that normalizes violence, and social stratification and segregation, consequences which included inequitable access to power, resources, and opportunities. Intermediate determinants include individual, psychosocial, behavioral, and community aspects. Structural and intermediate determinants impact health and health inequalities through multiple relational patterns that are simultaneously established and sustained by individuals and communities. The health impact of inequitable relational patterns includes: Reduced self-esteem; anxiety, stress, and depression; acceptance of violence; physical and sexual harm; suicide; and murder.

CONCLUSIONS: This conceptual framework allows for the modification of relational models by influencing structural and intermediate determinants. Six areas of intervention have been identified: educative policies, school governance, physical and symbolic space, school curriculum, school-community relations, and socio-educative interventions to promote healthy and equitable relationships. Healthy and equitable relationships are associated with improved subjective well-being, health status and protection from violence. Socio-educational interventions that consider the elements of this conceptual framework may be effective in promoting healthy and equitable relational models.

Keywords: interpersonal relations; childhood; health education; conceptual framework; violence.

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Interpersonal relationships are an important social determinant of health which is central to individual and collective life, and development.[1,2] The interpersonal relationships established in any community are a network of widely heterogeneous simultaneous interactions. Thus, their study has often been fragmented into typologies and reduced to a dyad,[3] such as couple relationships and the mother-child relationship; or group dichotomy such as teachers-pupils or employer-employees. However, the interpersonal relations that are established within any community are a network of highly heterogeneous simultaneous interactions. As reported by Tajfel, elements such as the symbolic framework, norms, and social roles,[4] the distribution

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of power and the normalization of violence[5] are key to understanding which relational models predominate in a community and their impact, whether their impact is positive, negative, or both.

Therefore, relational models are social determinants of health. The social determinants of health are all those conditions in people's lives that influence health status.[6] These conditions explain most of the social inequalities in health, which are the systematic differences in health status between different groups of people, as defined by Whitehead.[7] From Antonovsky's salutogenic perspective,[8] we define healthy and equitable relationships as those safe and voluntary interactions that allow for positive individual and collective development, which address the different needs, realities and aspirations of people, and are a source of well-being. Maintaining such healthy and equitable relationships positively affects health, contributing to a state of physical, mental, emotional and social well-being.[9] However, the focus has been on understanding the negative health effects of particular relational patterns. Research corroborates the impact of discrimination on mental health including racism,[10] and of experiences of abuse and violence, such as intimate partner violence,[11] but there is little research of the impact of healthy and equitable models on health.

The link between interpersonal relationships and health is mediated by education. Mata defined educating as the process of transferring, acquiring and creating ways of life.[12] Through education, each person acquires the social and cultural meanings of the environment in which he or she develops.[13] Childhood and adolescence are crucial periods in which, through socialization, relational models are observed, learned, and tested.[14] They are the ideal period for building relationships based on respect and non-violence.[15] As reported earlier, some children and youth experience violence against themselves, in their homes, educational centers, in social networks or on public transport.[16,17] They reproduce the violence they experience, perpetrating it toward their peers.[18] Reports by Floods[15] have confirmed education is key to promoting healthy relational models. Socio-educational actions are effective in modifying behaviors related to interpersonal relationships, with a positive impact on health.[19] The World Health Organization recommends acting through socio-educational interventions that are sustainable over time,[20] as they allow learning to identify violence and to act against it.[21] Furthermore, action in the educational context enables both formal and behavioral aspects to be addressed, as well as the hidden curriculum, that is, all those symbolic knowledge, skills, attitudes, and values that are acquired implicitly and unintentionally.[22]

In recent years, research on healthy and equitable relationships has become on the agenda. Socio-educational interventions have been designed and evaluated all over the world. However, as far as we know, evidence has been scarcely compiled. More specifically, before carrying out interventions, it is crucial to understand theoretically the relationship between health, its inequalities and determinants, and relational patterns, particularly in an educational context. There is a gap in the theoretical approach to the promotion to the healthy and equitable relationships from an equity and justice perspective.

This article has 2 purposes. First, it proposes a conceptual framework for understanding the relationship between health, relational models, and education, from the perspective of social determinants of health and centered on the principles of equity and justice. This is a theoretical exercise for which we conceive education in its holistic form. Secondly, it identifies implications of this theoretical framework for school policy, practice, and equity. Specifically, the main application is aimed at promotion of healthy and equitable relationships in formal education, based on the available evidence, throughout socio-educational interventions. These interventions can address early childhood as well as primary and secondary education.

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The considerations can be useful both for policy makers and school administration team.

METHODS

The city of Barcelona has 1.6 million inhabitants and is located in Catalonia, Spain. Compulsory schooling in Barcelona is from 6 to 16 years of age, divided into primary and secondary education. The school enrollment rate reached 93.7% in the 3-5 age group (kindergarten), and 89.2% in the 16-17 age group (post-compulsory education) in 2021-2022.[23] Health education is not part of the official curriculum in Barcelona, besides physical education. However, institutions offer schools a catalog of socio-educational health promotion interventions.

Barcelona has a long history of studying and addressing health inequalities.[24] Recently, childhood and adolescence have been established as a political priority.[25] One of the central points of action included the reproduction of power dynamics and violence among children. An educational approach was considered necessary. For this reason, a strategy to promote healthy and equitable relationships in the educational environment had been launched in the city in 2019.[26] The objectives of this strategy were defined by a core group. This group was composed of people with diverse professional backgrounds, spanning public health, psychology, education, gender studies, sociology, and anthropology; and the members were traversed by different axes of oppression. Three essential actions were identified by the core group: (a) The development of a conceptual framework, centered on the principles of equity and justice, to provide a theoretical basis for policy development, (b) The design and evaluation of socio-educational interventions to promote healthy and equitable relationships in educative environments, (c) The training of teachers in the promotion of healthy and equitable relationships.

Conceptual frameworks allow illustration of complex aspects of health and make the intentionality of public health action explicit.[27] The conceptual framework presented in this article was developed from the conceptual framework of social inequalities in health[2,28] and the conceptual framework for addressing intimate partner violence.[29] The core group conducted a literature review, which included sociological and psychological studies underlying interpersonal relationships.[19,30-32] This was followed by an analysis of the theoretical frameworks of different interventions promoting positive relationships[15,33-37] and their theoretical models of behavioral changes.[38] Finally, we interviewed key people in the educative field in the city of Barcelona: heads of the municipal departments of Education, Childhood and Adolescence, academics in health education and educators with experience in the implementation of socio-educational interventions for health promotion. All this information was worked on in the successive sessions of the core group, which selected and organized the available evidence in an iterative way to give rise to the present conceptual framework. At last, the explanatory text accompanying the conceptual framework was drafted.

RESULTS: A CONCEPTUAL FRAMEWORK OF DETERMINANTS OF HEALTHY AND EQUITABLE INTERPERSONAL RELATIONSHIPS

A proposed conceptual framework of determinants of healthy and equitable interpersonal relationships is presented in Figure 1.

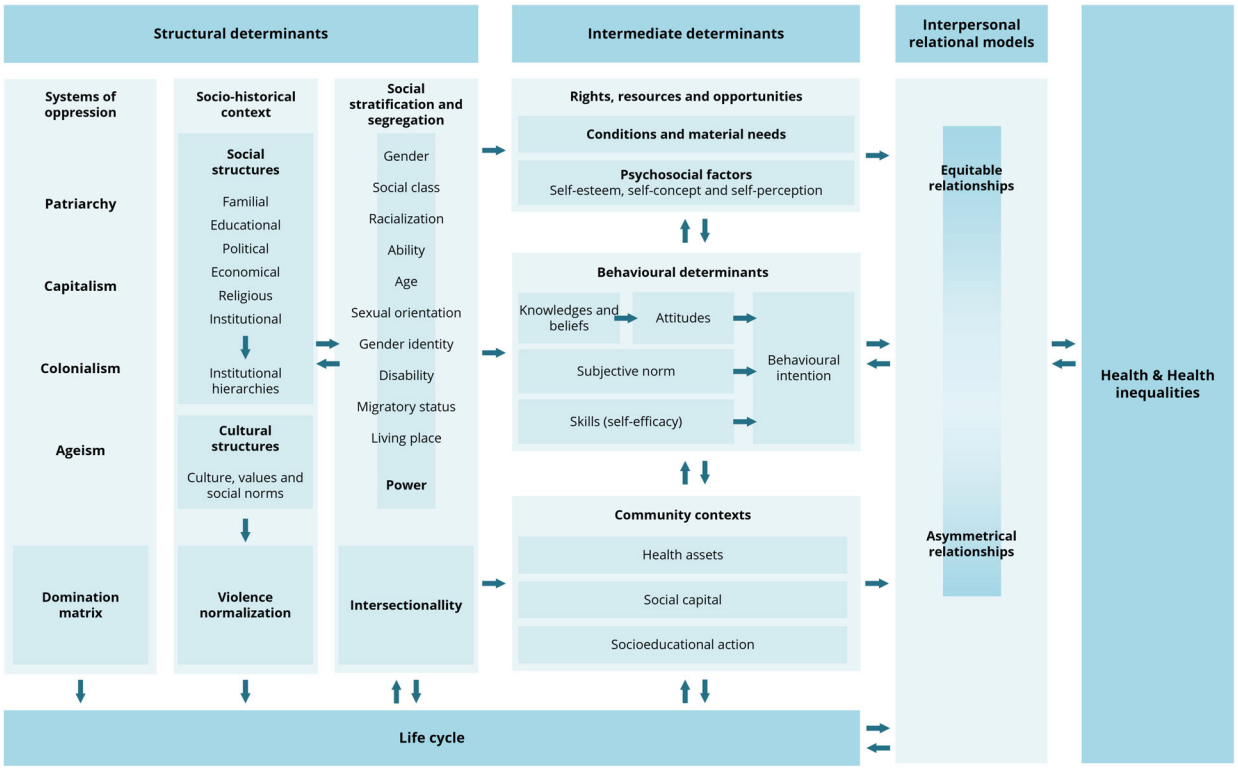
Structural Determinants

Structural determinants include the mechanisms generating and sustaining social hierarchies[2] and are the result of the unequal distribution of money, power, and resources on a global scale.[7] Power should be understood not as something that is held, but as something that is exercised discretionally, in the way Foucault stablished,[39] particularly in interpersonal relationships. Violence is understood as the use of power against individuals or groups, resulting in a high probability of injury, death, psychological harm or deprivation of their rights and freedoms.[40] We exclude from violence counter-violence, which is recognized in critical theories as legitimate uses of violence to subvert structural power relations between people or groups.

Systems of oppression. The hegemonic social organization in place in the global north in the 21st century is governed by systems of oppression, including patriarchy, capitalism, colonialism, and ageism. Their effects are not independent, but act as a matrix of domination and resistance, distributing power, and resources inequitably.[41] This matrix of domination acts through 3 sets of mechanisms: first, it maintains the social structures; second, it proposes hegemonic models of behavior, language and ideology; and third, it establishes the disciplinary and punitive regime that underpins the systems.[42]

Patriarchy is a binary, sexist, and heteronormative model of social organization. It is binary because it is based on exclusionary dichotomies, such as female-male and feminine-masculine, as Fausto-Sterling reported.[43] It is sexist because it generates a hierarchy that stereotypes the masculine as superior and undervalues the feminine, objectifying it, or subjugating it. Patriarchy is heteronormative, as it reduces sexuality and affectivity to the complementarity of the female-male binomial.[44] The implications of this system include social norms,[45] institutional systems,[46] the nuclear monogamous family, the division between public and private spheres, the separation between

Figure 1. **A Proposed Conceptual Framework of Determinants of Healthy and Equitable Interpersonal Relationships**



productive and reproductive work,[47] and the canons of beauty. Individuals apprehend the foundations of the system through gender socialization,[48] such as the subordination of women, which is considered accepted and even attractive to men,[49] the legitimization of macho violence[29] and LGBTIphobia, a structural violence toward sexual and gender dissidence,[50] which has severe consequences on health.

Capitalism is a model of social and economic organization based on the privatization and unequal distribution of the means of production, leading to the progressive accumulation of capital and power in a minority of the world's population,[51] that is, the dominant social classes. Reports by Krieger[52] have confirmed the implications of the capitalist system on health and its inequalities, including in childhood.[53] The capitalist system gives rise to social norms, taking the possessing class as a moral and behavioral reference,[39] and social class stereotypes are generated from childhood onwards that maintain inequalities.[54]

Colonialism is a form of social organization of global and local scope, through which certain countries exercise a position of economic, military, political and cultural supremacy.[55] Furthermore, this form of oppression creates a hierarchy of human groups through physical attributes and stigmas,[56] which identify and socially disqualify their bearers through processes of social comparison, based on stereotypes and prejudices.[4] Fanon[57] reported that this is a violent phenomenon per se. It shapes racist imaginaries in colonizing states and processes of racialization, which impact on health and its inequalities from childhood onwards through social, psychological, and economic mechanisms, such as acculturation, segregation, discrimination, and deprivation.[58]

The last system of oppression discussed here is ageism, an organizing condition of society that allows adults to maintain a position of superiority over children, adolescents, and older people.[59] In addition, an idealization is built around youth, associated with beauty, energy and potentiality, which are perceived as a set of canons to aspire to and maintain.[60] An adult-centric dichotomy is produced between the young and the old, in which adults are socially required to place themselves. This dichotomy denies childhood, adolescence, and older people as subjects of the present and impacts negatively on self-perception during these stages.

Socio-historical context. The term socio-historical context refers to the social, political, and cultural mechanisms that shape and maintain social hierarchies at a particular historical moment.[2]

Social structures include the different systems that exist in a society and that are composed of patterns

of relationships between social groups. Examples are educational, political, economic, and religious systems. These support hierarchical relationships, as in the case of educator-educatees in a classroom. The hierarchies of political institutions, who chooses the curriculum and who executes it in the classroom, economic institutions, and their ability to determine what should be learned from a utilitarian perspective, and religious institutions, whose morality still permeates educational relations, are also transferred into educational spaces. The mononuclear family, with its characteristic asymmetrical relationships, is central in this context.

Cultural structures refer to the symbolic dimension shared by a society, including social norms, beliefs and values.[61] They propose ideals of behavior. What people, depending on their position, may or may not do, and what the consequences are of breaking or adhering to the norms. For example, these structures establish who should perform care work[62] and behavioral guidelines for sexual-affective relationships from adolescence onwards framed in romantic love.[63] A central aspect of social and cultural structures deals with the legitimization of the use of violence: against whom and when and how the use of violence is allowed. Nowadays, the social norm legitimizes the use of violence by groups in dominant positions as structural violence. There is also a symbolic violence, related to the cultural, which legitimizes structural violence.[64]

Institutions arise from the combination of social and cultural structures.[61] Their objective is the organization and normalization of social activities through symbolic spaces imposed as facts.[65] People assume roles according to their position in the institution, giving rise to processes of subjectivation and inscribing people in a symbolic order.[42] Thus, all institutions assume an educational function. Violence is inherent and necessary for the reproduction of institutions and is directed by power.[66] Of note, hierarchies and violence are also manifested in groups. In an educational institution, hierarchies will be found between educators and learners coexisting with hierarchies among educators and among educatees.

Social stratification. Social stratification is the categorization of people into hierarchical groups according to axes of power, such as gender,[67] social class, racialization,[68] functionality, age,[59] desire orientation and gender identity,[50] migration status, and place of residence. The axes of power combine differentially in the same way that systems of oppression intertwine to form the matrix of domination. This view, known as intersectional,[69] is key to understanding relational models. We must recognize the multiplying impact of the axes of power in the generation of inequalities.[70] These axes of power define the individual position within systems of oppression and hierarchies of power. They determine personal experiences and generate a differential exposure to certain relational patterns; they will also determine vulnerability to certain events. This gives rise to phenomena such as bullying and sexist, racist and LGTBIphobic violence, whose serious impact on health has been repeatedly demonstrated.[17,18]

These stratifications inherently entail population segregations, which have a profound impact on health and its inequalities. Segregation is common in our socio-historical context, particularly in urban contexts.[24]

Intermediate Determinants

Living conditions. Structural determinants, through social stratification, unequally distribute resources, rights, and opportunities among the population. Living, material and psychosocial conditions differ according to place of birth, shaping different realities from childhood onwards. Needs are socially constructed and satisfied through interpersonal interaction.[71] Satisfaction of material needs will influence health and related behaviors.[72] Social stratification processes determine from childhood onwards how and with whom interpersonal relationships are established. School segregation at the community level on the basis of gender, race, or social class limits getting to know different people and different ways of relating to others than those existing—and predominant—in one's own context.[73]

Family relationships, school relationships, friendships, and the use of time are key psychosocial factors during childhood, and sexual-affective relationships are added in adolescence. All of these are affected by axes of power and have a positive impact on people's subjective well-being.[73] The continued experience of contexts of social exclusion and discrimination, as well as other stressful events, during childhood and adolescence, impacts on health through somatization.[70] Self-perception is an example of a psychosocial factor strongly influenced by context that affects health through self-esteem.[74] This happens in people whose bodies do not fit the norm, as in fatphobia, in which discrimination strongly alters the self-perception and self-esteem of persons experiencing it, influencing the rejection of a persons' own body.[75]

Behavioral determinants. Individual and collective attitudes and behaviors are closely linked to the relational patterns that are maintained. Multiple models identify behavioral determinants:[38] knowledge and beliefs (perceived susceptibility, severity, benefits, and barriers), attitudes, subjective norm, skills and self-efficacy, and behavioral intention.

The subjective norm is a person's or group's perception of the pressures to perform a behavior, which is perceived to be thought or done by influential people in the environment.[77] It is profoundly influenced by social norms. In the case of care tasks, the norm

acts as an obligation for women, socially sanctioning those who do not comply and liberating men.[78] In sexual-affective relationships, the subjective norm will facilitate behaviors expected by the person of the ''other sex'', according to the myths of heterosexual and monogamous romantic love.[79] Knowledge and beliefs refer to what the person or group knows, or perceives they know, about an action, including the perceived benefits and difficulties, and give rise to the attitude toward a behavior.[80] In violence perpetration, a favorable or unfavorable attitude is key and depends on the perceived benefit/harm balance. In this regard, among adolescents, perpetration of violence is related to the perception that it will be approved by the group.[81]

Social skills are linked to self-efficacy, which includes expectations of success in performing a certain behavior and outcomes.[82] Perceiving oneself as capable of resolving conflicts, individually and in groups, is closely related to self-efficacy in terms of social and communication skills,[83] such as empathy and assertiveness, as well as emotional and affective management strategies.[84]

Community contexts. In community contexts we find health assets, factors, or resources recognized by a community as promoting health, well-being, and reducing inequalities as reported earlier,[84,85] strengthening interpersonal and intergenerational relationships and building individual and community resilience to health stressors.[86] They include individual, community and associational, and institutional resources; the services;[87] and the physical environment, including green and leisure spaces.[24]

Social capital refers to the resources available to individuals and groups as a result of their participation in community networks, and the emerging mutual knowledge and recognition.[89,90] This is closely related to health.[91] In this regard, the involvement of adolescents in the community has been shown to be key in reducing violence.[92]

Socio-educational actions are contextualized primary prevention actions aimed at improving the knowledge, beliefs, attitudes, and skills of a community. They are usually based on community strategies that are commonly used in health education and promotion. Emotional education programs of the previous decade, mainly designed and evaluated in the United States and the United Kingdom, were effective in influencing individual capacities for emotional regulation.[93] However, an important limitation was the lack of a critical perspective.[32] Several socio-educational actions have recently been aimed at promoting positive relational models in childhood and adolescence from a holistic view of relationships and critical appraisal of inequalities, particularly gender inequalities, and their results on health and its inequalities are promising.[33-35,94]

Finally, important factors are the role of agency, which is the capacity of individuals and communities to counter oppressions exercised by power, to transform relational patterns through collective organization and resistance.[95] Through collective agency, the interpersonal relations of the future, already real in the present, are imagined, tested, and disseminated in opposition to hegemonic models. The concept of agency goes beyond collective resilience in the face of adversity but also about the ability to transform realities that are adverse. Fostering resilience through socio-educational interventions promotes social cohesion but can remain at the individual level. Socio-educational action aiming to have an impact on relational models must necessarily involve awareness of learners as subjects with transformative potential.

Life Cycle

The life cycle perspective supports the importance of life stage in understanding health phenomena and inequalities at the individual, population, and generational levels.[2] The processes and experiences experienced by people over time influence interpersonal relationships, as well as health and its determinants.[14] Also important is the accumulation of advantageous and disadvantageous experiences, involving the adoption or rejection of certain scripts, conditions, and individual and collective trajectories.[96] A life cycle perspective is critical in childhood and adolescence, as the decisions, behaviors and relationships established during these stages will significantly influence health later in life.[97] In addition, axes of power influence lived experiences, including interpersonal relationships. This is the case of gender, which is continuously intertwined in the construction of affectivities and sexualities, as reported by Carpenter.[98]

Relational Models

Structural and intermediate determinants impact on health and its inequalities through the relational models that are established and sustained. Other more general conceptual frameworks view these relational models as an intermediate determinant of health, as a psychosocial factor and close to social capital.[2] Recently, however, interpersonal relationships and violence have been at the center of much of the debate on health and health inequalities.[1] Relational models should be approached from a polyhedral view, considering gradients and nuances, as well as the socio-historical context, avoiding first and foremost dichotomizing into ''good'' and ''bad.''

The concept of healthy relationships, defined above, arises from the need to conceptualize relational models in which interpersonal interactions are based

on well-being. Importantly, healthy and equitable relationships are not only an individual matter, insofar as they are the relationships maintained by a person but have a collective dimension: they constitute the network of interactions established in a group of people, and individual and collective well-being depends on them.

In contrast to these models are asymmetrical models, whose maximum expression is the hierarchical and domineering relationships between individuals and groups. Violence acts on the basis of social norms that legitimize it, and it is used in a systematic and directional way for the control and subjugation of these people.[99] There is a need to approach relational models from a polyhedral view, considering gradients and nuances, as well as the socio-historical context, avoiding above all dichotomizing into ''good'' and ''bad.''

We must also bear in mind that established relational models have a reciprocal impact on intermediate determinants: a clear example of this is how, in childhood and adolescence, the experience of violence is associated with lower self-esteem and higher levels of aggression.[100] Life trajectories will thus also be influenced by the experiences of one or other relational models.

Health and Health Inequalities

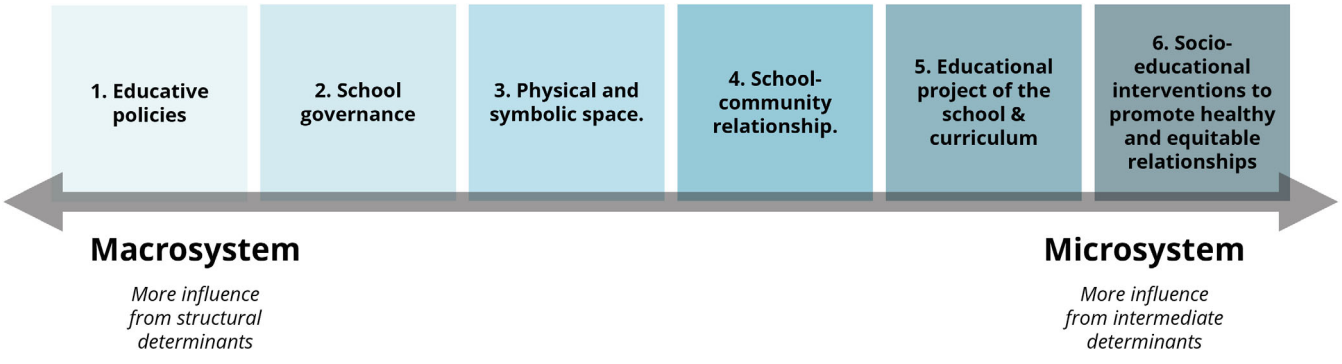
Health maintains, with interpersonal relationships, a bidirectional link, based on the gradients characteristic of relational models. This is because interpersonal interactions are diverse, ranging from affection, respect and mutual support to discord, aggression, and boundary violations.[101] Healthy and equitable relationships contribute to the health of individuals and communities. Satisfaction with family, school and friendship relationships is associated with subjective well-being from childhood onwards[73,102] and act as a protective factor against violence.[103]

In contrast, asymmetrical relationships negatively impact health in multiple ways. The main effects are associated with being a victim of violence, in its multiple expressions: discrimination,[104] gender-based violence,[105] sexual abuse,[106] physical aggression,[107] and bullying.[108] Specifically, these relationships are associated with reduced 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;[109] and physical or sexual aggression, suicide, or murder.

IMPLICATIONS FOR PRACTICE: PROMOTION OF HEALTHY AND EQUITABLE RELATIONSHIPS IN FORMAL EDUCATION SETTINGS

The proposed conceptual framework allows the identification of areas of intervention for the promotion of healthy and educational relationships in formal educational contexts. These proposals arise from the application of Bronfenbrenner's ecological model,[110] which identifies levels of concentric educational structures, from the distal macrosystem to the proximal microsystem. In this way, the elements of the conceptual framework are arranged in response to the different levels of educational and school structures: the structural determinants could be modified by influencing the elements of the macrosystem (the clearest example would be educational policies). On the other hand, intermediate determinants could be modified by influencing the microsystem, particularly through specific socio-educational interventions. In total, 6 areas of intervention in formal education settings have been identified, which follow a gradient in Brofenbrenner's ecological model[110] (Figure 2). In order to introduce changes from the perspective of equity and justice, it must be noted that all educational efforts start from a political position that must be explicitly stated.[111]

Figure 2. **The Proposed Areas of Intervention for the Promotion of Healthy and Educational Relationships in Formal Education Contexts**



1. **Educative policies**. Educational policies regulate all aspects of educational institutions. Policies are intimately linked to social structures and social norms and values.[2] Thus, modifications in legislative texts to introduce changes in governance, curricula and school spaces can have a great impact on promoting healthier and more equitable models of education. Recently, countries such as the United Kingdom have passed laws to include in their educational curricula the promotion of healthy and equitable relationships,[112] as well as emotional and sex-affective education.
2. **School governance**. Structural determinants shape the governance of educational institutions and hierarchies. Children's involvement and participation in center and classroom decisions[113] favors healthy and equitable relationships. However, care must be taken to ensure diversity, so as not to exacerbate inequalities.
3. **Physical and symbolic space**. School architecture, symbolic elements and school norms and values are conditioned by structural determinants, particularly social values, the normalization of violence and the matrix of domination.[42,114] that is, football as a central element at play at schoolyard and the existence of platforms for teachers, both combine these 3 elements. The physical and symbolic space must be analyzed in order to identify the activities, behaviors and opportunities it offers. The physical and symbolic space must favor healthy and equitable relationships, avoiding the reproduction of social inequalities. Rethinking the images on signage, the languages used, the symbols and logos that appear is key in this regard.[115]
4. **School-community relationship**. The involvement of the educational community in the school's practices from a cooperative perspective gives continuity to the educational actions promoted, guaranteeing coherence, and promoting social capital.[88,116] In addition, the school's educational community must be considered. It is necessary to build educational environment projects that take it into account.
5. **Educational project of the school and the school curriculum**, consisting of contents, methodologies, practices, timetables, forms of assessment, and student feedback. All of these are influenced by structural determinants and act at the level of intermediate determinants, producing and reproducing certain relational models.[117] It is central to analyze what is taught and from what point of view, but also to make explicit what is left out of the curriculum and why.[118]
6. **Socio-educational interventions** to promote healthy and equitable relationships based on evidence, explicitly and through a perspective of equity and justice. These interventions must address the intermediate determinants identified in order to be effective. Understanding interpersonal relationships as part of networks, on which power and inequalities act, opens the door to developing interventions explicitly aimed not only at changing relational models, but also at reducing social inequalities. Successive evaluations of programs to promote healthy and equitable relationships will identify the most effective ways to carry out this mandate.

Strengths and Limitations

We have identified several limitations in this proposed conceptual framework that should be areas for future research:

In this conceptual framework, concepts from pedagogy, psychology, public health, and sociology, with insights from gender studies, are brought up. It is very difficult to find common ground between such disparate, and in some respects even contradictory, disciplines. Fortunately, the team that drafted the conceptual framework has diverse backgrounds in these fields and has tried to bring together the richness of each area of knowledge, reaching the necessary consensus and agreements in this area.

Another important limitation is the positivist and individualistic paradigm in which we are immersed. Most of this evidence is drawn from traditions centered on the individual, rather than the community. Pedagogical traditions have for centuries spoken of ''the child'' in the singular, as if the educational act were centered on an exclusive educator-educated dyad. However, socio-educational interventions, whether in the school context or outside it, involve group relations. This view that goes beyond the individual is fundamental when we talk about promoting healthy and equitable relationships. On the other hand, positivism in education has favored the cognitive-behavioral perspective, which makes it difficult to find evidence from a critical or community perspective.

Finally, in relation to systems of oppression, we have not referred to ableism as one of them. The little evidence we have found on this subject approaches the issue from a segregationist or paternalistic perspective. Likewise, the diversity of bodies, functionalities and capacities should be considered in future interventions that aim to promote healthier and more equitable relationships.

Conclusions

The conceptual framework proposed here, which is based on existing evidence, can enable the design of effective socio-educational interventions to promote healthier and more equitable relational models. The

framework establishes the structural, intermediate and behavioral determinants that should be addressed, as well as the areas and dimensions that need to be addressed, particularly systems of oppression and social stratification according to axes of power, as well as affective and emotional aspects, social skills, and social problem solving. In addition, 6 areas of intervention have been identified to promote healthy and equitable relationships in formal educational settings: educative policies, school governance, physical and symbolic space, educational project of the school and the school curriculum, school-community relations, and socio-educative interventions.

Author Contribution

L.L.F.D., O.J.M., and G.P. conceived the project. All authors participated in the conceptual framework development sessions. L.L.F.D. prepared the first version of the manuscript, which was critically reviewed and discussed by all authors. D.G.A., M.J.L., F.S.M., and M.B.A. drafted paragraphs on their areas of expertise. G.P. and O.J.M. supervised the drafting and were responsible for the funding of the project. All authors have approved the latest version of the manuscript.

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