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D.3.1 Protocol for NBSP Menu Development

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RECETAS

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1. Protocol outline

The present protocol contains the methodological guidelines for the co-creation of the menu for Nature-Based Social Prescription (NBSP) and its indicators. It results from the review of theoretical reflections, as well as the experience of the "hands-on" implementation of the participatory approach. It has been developed within the framework of the RECETAS project and is initially addressed to the research teams of the six pilot cities participating in the project: Barcelona, Cuenca, Helsinki, Marseille, Melbourne and Prague. In addition to contributing to the process of co-creation of the NBSP menu and indicators, the protocol aims to contribute more broadly to the following objectives:

1. To give continuity to the participatory process initiated by WP2,
2. To promote a greater global and local articulation of the various networks in each city,
3. To strengthen relationships between different actors in order to engage them throughout the project in each pilot city.

The protocol is structured in four sections: 1. Glossary, which aims to facilitate the common understanding and implementation of the protocol among the different cities. It is due to the variety of technical vocabulary used in this research and the possible trajectory of its use in each context; 2. Participation approach, where a brief theoretical framework is presented regarding the approach that we promote from WP3; 3. Proposal of the co-creation process of the NBSP Menu and indicators, which has been adjusted with respect to its first version, according to the general schedule of the RECETAS project; 4. A set of annexes that constitute a toolbox that we put to the consideration of the RECETAS research teams of each pilot city for the development of the proposed participatory process.

Broadly speaking, three phases are proposed to co-create the menu for NBSP and its indicators:

Phase 1: Elaboration of the diagnosis, listening and initial self-reflection.

The objective is to enrich the knowledge obtained in WP2 on loneliness, social isolation and NBSP, its actors, networks, structures, and experiences prior to the RECETAS project, based on individual listening to the various actors interested and/or who could have an impact on the materialization of the project in each pilot city.

Phase 2: Construction of the participatory diagnosis

The objective of the participatory diagnosis is to re-known and agree on starting elements, through a face-to-face meeting of the various RECETAS stakeholders, around the results obtained in the diagnosis (individual listening), as well as to identify criteria adapted to each context to prioritize the proposals that will be co-created in the next phase (phase 3).

Phase 3: Co-creation of the NBSP menu and indicators

The objective is to identify and co-create NBSP menu proposals adapted to each context and program them through participatory, sustainable, and articulated work planning that includes monitoring indicators.

Each phase presents four indications of the participatory co-creation process:

Methodological keys and ethical considerations. This section includes methodological recommendations to be taken into account when approaching the activities of each of the phases and the use of the work tools.

Activities. This section lists and synthetically describes the main activities suggested to be developed from the participatory approach to achieve the specific objectives of each phase.

Work tools. This section lists the work tools that will be extensively developed in the annexes, together with references to expand on the contents. Annexes can be modified or included according to the requirements of each local process.

Report of results. This section contains the minimum content structure to prepare the report for each phase.

Though the proposed phases to achieve the co-creation of the menu for NBSP are defined, they might be adapted considering the particularities of each territory, population, and available resources. One key recommendation is to keep the process of co-creation of the NBSP menu and indicators open to new actors that may join as the process progresses. These diverse actors may have different degrees of involvement, but they should always be involved in the process.

The menu for NBSP will be a list of options constructed and adapted to each pilot city. It may be different, but the methods used for its construction should allow for a comparative analysis between cities. Therefore, within the RECETAS project, the articulated work between the different cities will be fundamental. It will also allow the permanent enrichment towards the construction of proposals oriented to the solutions of common problems such as social isolation and loneliness.

2. Glossary

1. Social isolation and loneliness

We recognize that loneliness and social isolation are different but correlated concepts, both complex and multifaceted problems. Numerous studies developed around the world have demonstrated their association with chronic diseases. In addition, these are connected to low self-esteem, self-worth, and judgment of self and others.

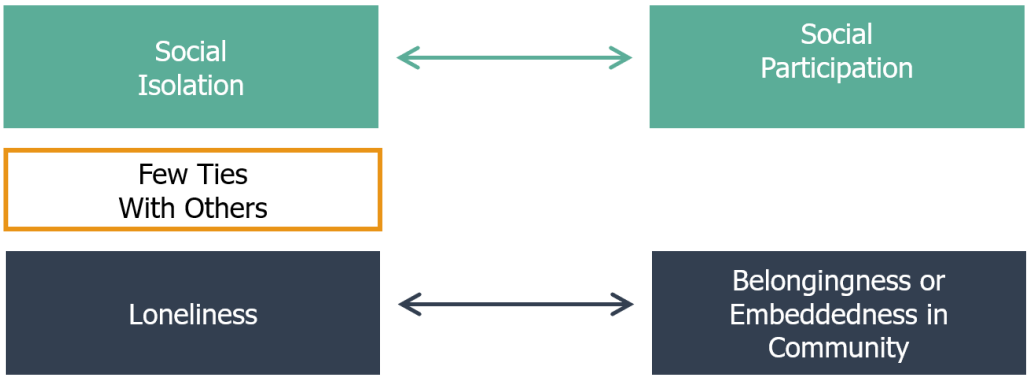


Fig. 1. Social isolation and loneliness
Source: Scan of literature RECETAS project (WP2)

Cattan et al. (2005) explain there is some agreement that social isolation refers to the lack of social integration, while in terms of Dickens et al. (2011), loneliness is related to the feelings a person has about the disparity in desired and actual social support. Both situations are present in every society. They know no geographical, economic, cultural, and social boundaries and affect all age groups. However, loneliness is a known risk factor for substance abuse, depression, cardiovascular disease and premature mortality (Holt-Lunstad, 2017) and it is also associated with chronic diseases such as cardiovascular disease, diabetes, cerebrovascular disease, and anxiety, depression, cognitive impairment and depression (Hawkley and Cacioppo, 2010; Luanaigh and Lawlor, 2008). In the European context, loneliness is more prevalent in southern countries (d´Hombres et al. 2019). Coll-Planas et al. (2015) state that loneliness increases with age (i.e. due to losses, diseases and/or disabilities), thus, the current aging trend leads to a greater number of older people suffering from loneliness. In the same vein, there are several groups at higher risk for loneliness and social isolation such as older adults, young adults, those identifying as LGBTQIA+, those in rural communities, and veterans (National Academies of Sciences, Engineering, and Medicine, 2020; Cuesta-Lozano, et al., 2020; Beam, et al., 2020; Leavell, et al., 2019; Teo et al., 2018; Mereish, et al., 2015; Rainer and Martin, 2015). Social isolation and loneliness are modifiable conditions. Unfortunately, they are not sufficiently addressed in traditional healthcare systems.

2. Health inequity

Health inequity refers to the concept that certain differences in health stem from broader social and economic inequalities. Such differences are "systematic, avoidable and unfair" and prevent individuals and communities from reaching their full health potential (Whitehead, 1992). Health equity is a multidimensional concept which includes aspects related to the achievement of health and the possibility of achieving good health, and not only to the distribution of health care; it also includes the fairness of processes and, therefore, must pay attention to the absence of discrimination in the provision of healthcare (Sen, 2002). In this sense, health inequities are systematic differences in health that could be avoided by reasonable means (Marmot et al., 2012). In general, differences in health between social groups, such as those based on race or religion, are considered health inequalities because they reflect an unfair distribution of health risks and resources (Kawachi et al., 2002). Latin America and the Caribbean is a region marked by vast social inequalities between people with high and low levels of education and wealth, rural and urban populations, and dominant and minority ethnicities (UNICEF, 2016).

3. Determinants of health

Marc Lalonde (1974) emphasized that health is the result of the interaction of different factors that interrelate with the individual. The determinants of the general health of the population can be conceptualized as rainbow-like layers of influence (see Fig. 1).

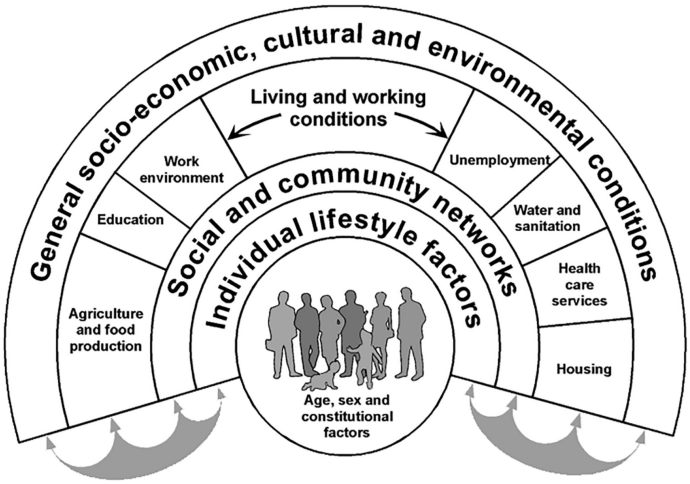


Figure: The main determinants of health from the “Rainbow model” (Dahlgren and Whitehead)
Source: Dahlgren and Whitehead, 2021 adapted from Dahlgren and Whitehead, 1991

In the centre of the figure, individuals possess age, sex and constitutional characteristics that influence their health and that are largely fixed. Surrounding them, however, are influences that are theoretically modifiable by policy. First, there are personal behaviour factors, such as smoking habits and physical activity. Second, individuals interact with their peers and immediate community and are influenced by them, which is represented in the second layer. Next, a person's ability to maintain their health (in the third layer) is influenced by their living and working conditions, food supply, and access to essential goods and services. Finally, as mediator of population health, economic, cultural and environmental influences prevail in the overall society. This model for describing health determinants emphasizes interactions: individual lifestyles are embedded in social norms and networks, and in living and working conditions, which in turn are related to the wider socioeconomic and cultural environment. The determinants of health that can be influenced by individual, commercial or political decisions can be positive health factors, protective factors, or risk factors (Dahlgren and Whitehead, 1991).

Subsequent research such as Calaza (2016) and those collected in the recent Guide to Prescription of Community Assets: Social Prescription and Health Program (PSS 2021), point out that these different factors have been translated as determinants of health, which can be individual, social, structural and socio-environmental.

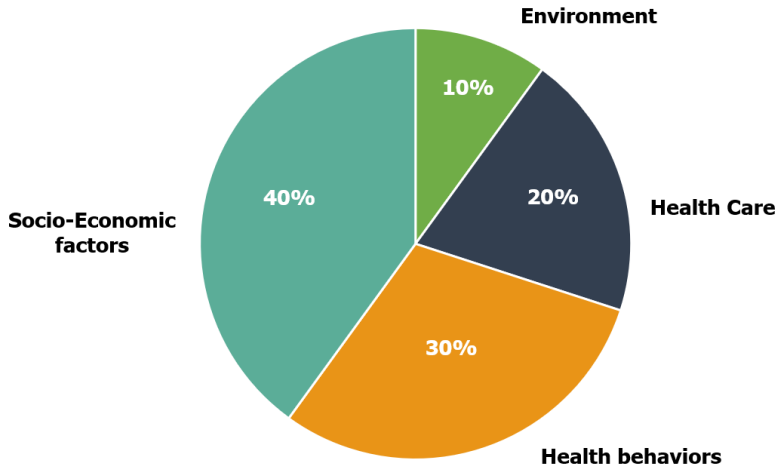


Fig. 2. Proportional influence of health determinants.
Source: Community asset prescription guide: Social Prescription and Health Program (PSS 2021).

Thus, in addition to social factors (inter and intrapersonal), the territory and the landscape, its configuration, and its elements are fundamental since they have a decisive influence on the incidence of diseases. Further studies (Dahlgren & Whitehead 1991; Barton & Grant 2006; Coutts & Hahn 2015) confirm the importance of the natural environment for our health and well-being. Notwithstanding, the transition of environmental risks holds that factors increasing risk for infectious disease are largely at the household level (e.g., lack of access to clean water and basic sanitation) and these diminish with economic development (Smith,

1994). Meanwhile, more “modern” environmental risk factors, including exposures at the community (e.g., air pollution in cities) or global (e.g., increasing global levels of greenhouse emissions) scales are more likely to lead to non-communicable diseases. A third category of risk factors, injuries from accidents or violence, may not be directly linked with patterns of development. Risk transitions are also related to global urbanization patterns.

4. Social determinants of health and Social determination of Health

The World Health Organization (2004) defines the social determinants of health as the circumstances in which people are born, grow, work, live and age, including the broader set of forces and systems that influence the conditions of everyday life. Thus, two main categories of social determinants are identified: 1. Intermediate determinants of health: factors that directly influence health through health-related behaviors and biological and psychosocial factors (material or psychosocial circumstances, health-related habits or behaviors, health system, social cohesion, and social capital); 2. Structural determinants: socioeconomic position and socioeconomic and political context. Structural determinants influence health through the intermediate determinants, constituting the "causes of the causes" of health inequalities. The field of social determination is concerned with key aspects of people's living and working circumstances and with their lifestyles. It is concerned with the health implications of economic and social policies, as well as with the benefits that investing in health policies can bring (Wilkinson and Marmot, 2003).

The social determination of health is one of the three central categories of the proposal for a critical epidemiology, enunciated in the mid-1970s and later developed and complemented by other authors, especially from the Latin American current. Together with the categories of social reproduction and society-nature metabolism, they have formed the theoretical axis of a proposal to break with the dominant paradigm of public health. The starting point of this theoretical construction is based on a re-reading -from critical realism- of the two epistemological strands headed by Kuhn and Bourdieu (Breilh, 2013).

It is a category that develops a critique of the empirical-functionalist paradigm of epidemiology and proposes a tool to work on the relationship between social reproduction, ways of living and ways of getting sick and dying (Breilh, 1977). This theoretical-methodological tool nourished and encouraged the construction of Latin American critical epidemiology, forged in the debate and the break with the canon of classical epidemiology and its linear multicausalism, then against the empirical-functionalist model of ecological epidemiology, and now, against the epidemiology of the so-called "social determinants of health" (Breilh, 2013).

5. Assets for health

According to Morgan and Ziglio (2008), a health asset is any factor (or resource) that enhances the capacity of individuals, groups, communities, populations, social systems, or institutions to maintain and sustain health and well-being, as well as to help reduce health inequalities. People, environments, community activities, and facilities can be assets.

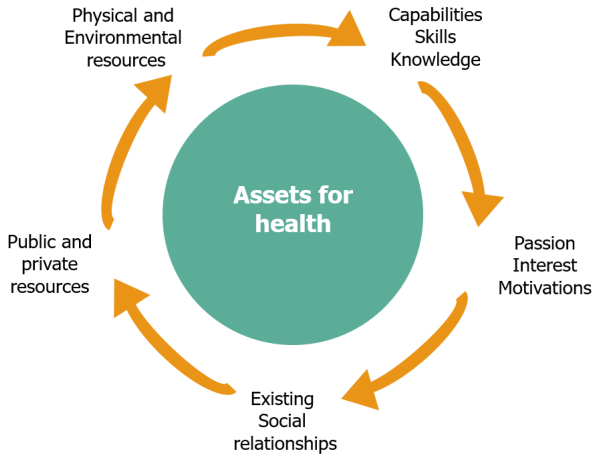


Fig. 3. Assets for health
Source: Fernández R (2013)

Closely linked to health assets is the definition of social capital. For Coleman (2000), social capital is the ability of people to work/cooperate in groups, organizations, or communities. However, Putnam (1999) expands its notion to include the positive contents of interactions between people: reciprocity, trust, cooperation, common and stable objectives.

Bonding social capital, the strong connections within a family, ethnic group, or community with a high sense of belonging; Bridging social capital, the weaker diffuse and extensive connections between different and more distant groups (i.e., networks of acquaintances or businesses), and 3. Vertical social capital (Linking), the connections between people with different levels of power or social status (i.e., connections between political representatives and groups of residents) (De Silva, 2005, Poortinga 2012); however, and from a sociological perspective, Pierre Bourdieu points out that the social capital is the set of actual or potential resources linked to the possession of a durable network of more or less institutionalized relations of inter-knowledge and inter-recognition; or, in other words, to belonging to a group, as a set of agents who are not only endowed with common properties (susceptible of being perceived by the observer, by others or by themselves), but who are also linked by permanent and useful ties. These links are irreducible to objective relations of closeness in physical (geographical) space or even in economic and social space because they are based on

indissolubly material and symbolic exchanges whose establishment and perpetuation presuppose the recognition of this closeness (Bourdieu, 2011: 221).

6. Social prescription

Leavell et al. (2019:4) state that "social prescribing is a structured therapeutic intervention that targets psychological processes. It requires direct involvement in everyday settings to activate processes that support social connectedness and promote and maintain health-promoting behaviors (e.g., physical activity and nutrition) and well-being." According to the Guide to Prescription of Community Assets (2021), this recommendation can also be informal, among the neighborhood, or formal, the recommendation made by professionals from primary care centers, municipal technicians, or other professionals from community entities.

The same source indicates that social prescription consists of promoting from the health system, access to community resources, to strengthen the social network or support of people with social or emotional problems; to improve health and well-being; and to formalize a link between people and the community. It is a formal way of establishing links between the person and his or her environment beyond simple counseling. Through social prescribing, a health professional and the person he or she cares for jointly identify community activities to improve the health and well-being of the person being cared for. It indicates that the aim is to offer alternatives to the medicalization of the discomforts of daily life to people for whom traditional medicine is of little benefit and who perceive a lack of social participation, a feeling of loneliness or are at risk of social isolation or exclusion.

In terms of Bertotti et al. (2017) in social prescribing, behavior change leads to improved mental and physical well-being in three key ways:
1. combined effect of one-to-one interaction between the patient and the social prescribing coordinator in the form of coaching, motivation, and listening;
2. social interaction between the patient and the group of people involved in the execution of community activities; and
3. social interaction within other community activities.
In this way, patients go through different stages through the support received from the social prescribing coordinator and social interaction in the community and finally find themselves empowered to change their own circumstances. Their research highlights that social prescribing appears to work for all those patients who need support and motivation to take action to improve their own health and well-being, especially if their needs are non-clinical or have a non-clinical component.

7. Nature based Social Prescribing (NBSP)

It is a recently coined concept. For van den Bosch & Ode Sangc (2017), NBSP refers to actions inspired by, supported by, or copied from nature, designed to address a range of environmental challenges. For Leavell et al. (2019), besides offering healthcare providers a

valuable opportunity to help adults and children find ways to feel more socially connected and part of their community, NBSP promotes a form of re-engagement with their natural environment in general. These prescriptions meet the need to focus on interventions that harness the beneficial impacts of nature and have a powerful effect on population health.

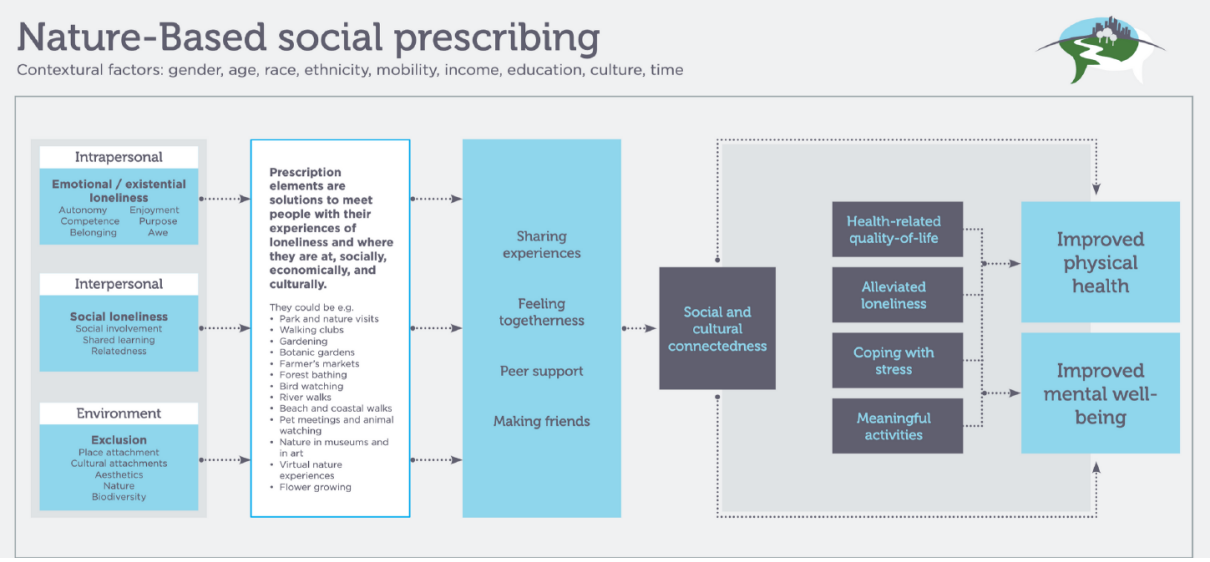


Fig. 5. Theoretical model describing the RECETAS proposal
Source: RECETAS project

3. Participatory approach

The participatory methodological approach proposed for the co-creation of the NBSP Menu will be referred to generically in this document as Participatory Action Research (PAR) or Sociopraxis. It is aligned with the biopsychosocial model of health which holds that: "If the causes of illness are social, the responses should include a social approach" (GAC 2021:19).

3.1. Participatory Action Research (PAR) - Sociopraxis: methodologies for social transformation

The proposal for this methodological process of co-creation of the menu for NBSP is participatory, understanding that this approach also includes the qualitative and quantitative approaches. Within the three perspectives in social research: distributive, structural, and dialectical, the latter emphasizes its attention not so much on the description/measurement or explanation of that reality that the first two assume from different ways, but on its transformation. As Martí (2005) points out, participatory methodologies do not renounce the methods and techniques traditionally used in social sciences (qualitative and quantitative) but integrate them with others more oriented to moments of dynamization and participation. Capturing the complexity of a social scenario leads them to inquire into its different levels; the descriptive (quantitative), discursive (qualitative), and mobilizing (participatory) dimensions of social reality. Their focus is on the discursive-participative. Both will centralize

the activity of the participatory workshop understood as the meta-technique of this type of process, inspired by being a reflection of the social world and life. It corresponds to the mobilizing dimension that the individual and society often show in their thinking and social action, along with describing it or trying to explain it. PAR-sociopraxis presents a multiple and plural character concerning techniques (Fig. 6).

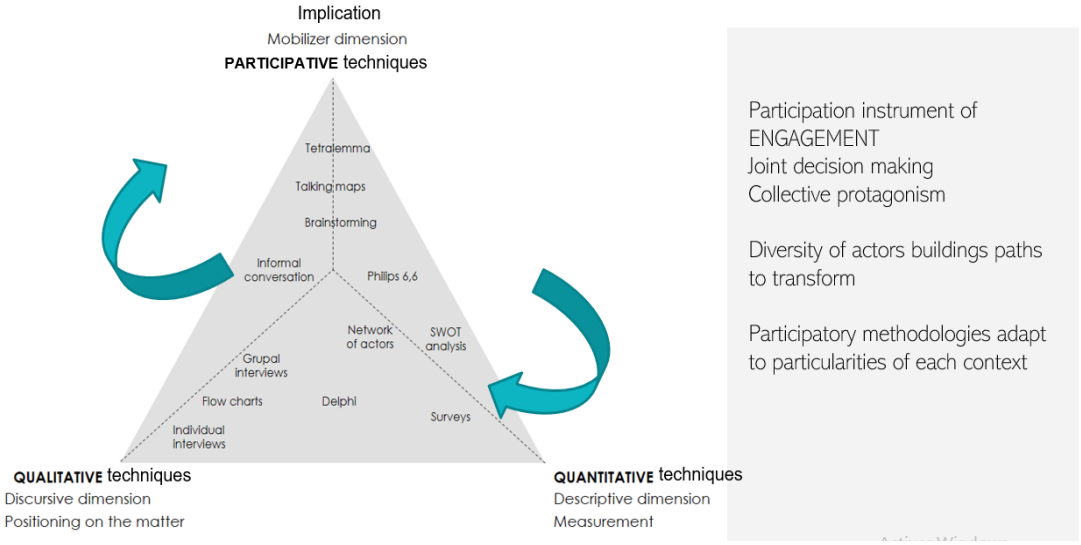


Fig. 6. Enfoque articulador de la IAP-sociopraxis
Fuente: Propia. Adaptado de Martí 2005.

As theory and practice constitute two inseparable parts of social and scientific research, nothing prevents, now that the link has been reconstructed, that research can be perfectly associated to intervene in the improvement of the investigated reality. Francés et al., (2015: 33) point out "the knowledge acquired through social research takes true meaning when is used by the population for its improvement, which should ultimately be the ultimate goal of scientific development" . Beyond using research to generate information and knowledge, participation adds the component of action to transform the reality that is being treated.

This link leads to praxis as a concept that, going beyond practice, brings together a whole series of innovative critical orientations linked to social action. F. Borda and Rahman (1991) will deal with praxeology to propose a concept of praxis that incorporates theory by adding objective and subjective elements of commitment, reflection, criticism, and self-criticism. From this nucleus will emerge the denomination of praxical methodologies or, later, socio-praxis that Villasante systematizes since the '90s, nourished by very varied practical and theoretical contributions for its construction, from the Participatory Action Research (PAR) as its central nucleus. Faced with a world that is witnessing increasingly complex societies and systems, he will deconstruct this positivist vision by contributing the components of complexity and uncertainty that, as corroborated by the current scientific paradigm, characterize all systems, and to a much greater extent social systems as directly hypercomplex: dynamic, inter-influencing, changing, performative and innovative. The reflexive analysis proposed for its participatory processes will seek the generation of knowledge and self-knowledge necessarily from collective construction.

Hence, from the perspective of PAR-sociopraxis, goals such as researching the problems of those affected, formulating interpretation and analysis on their situation, and elaborating plans to solve them (Francés et al., 2015: 57) will be jointly encompassed in the same proposal. In that sense, Fals Borda announced it as an experiential methodology that adds its methodological procedure, its pedagogical teaching capacity, and its political action as part of a whole. It is therefore not only a research method but also a "system-process of participation broader than that" (Villasante, 2014: 266).

The following diagram shows the levels of participation to which the different techniques correspond. Although there may be different paths to reach the co-creation of the NBSP menu, in each case the maximum level of participation -ideally combining the techniques of the three levels- should be sought. In this sense, the possibilities of combining these techniques should be evaluated in each pilot city according to the resources of each local project team.

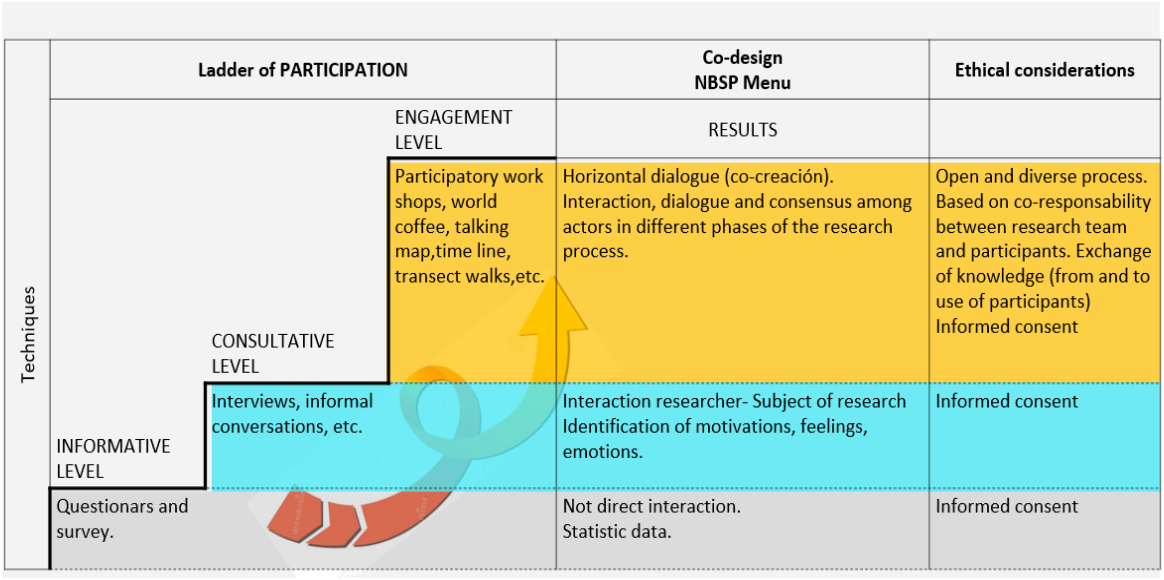


Fig. 7. Ladder of participation for co-creation process
Source: Authors. Adapted from Arnstein 1969

PRA-sociopraxis will promote the open, social, deliberative, and binding participation that those affected may have in the process. For this proposal, participatory adds to the methodological meaning of being part of the process, the more political meaning of contributing knowledge, action, and decision. And in the most extreme version of democracy, it has another fundamental meaning: it is executed democratically by listening to everyone and their knowledge for the construction of shared visions, and, at the same time, it is democratizing by proposing to carry out these processes in a plural and transparent way. In this way, it teaches how to build transformative democratic practices.

It implies visualizing and shaping the existing networks that appear in social spaces and the public sphere. As Martí (2005) points out, PRA can be understood as a methodology that should enable agents to "recreate social networks": to transform them through (self-) reflection on existing structures . Given the centrality of social relations for social understanding, networks will reflect those webs of interactions that this PRA-sociopraxis proposal aims to know, intervene and recreate from the reflection of its actors. Villasante

(2014) considers this aspect would correspond to detect, analyze and try to modify the existing relations between subjects rather than themselves or their ideologies . The aim is to find out how social relations are articulated in the instituted environment to, from an instituting dialectic oriented by the desires and needs of the subjects, achieve social transformations (Francés et al., 2015). In this sense, this type of participatory processes are intended to influence these networks of subjects concerning aspects such as reactivating the network, including the incorporation of new actors linked to the context under analysis, promoting critical, self-critical and proactive reflection through deliberative and democratic mechanisms.

Concerning the figure of the researcher/interventionist, the above-mentioned premises place him/her in a different role from the traditional one. The protagonism acquired by the collective subject with reflective capacity for knowledge, analysis and action, frees the researcher from the attribution of being the only thinking and directive figure in the process. From the specialists who study others (most of the time subaltern and treated as without knowledge), the flexibilization of their figure is proposed to take away their power and break the unidirectionality in search of collectively building a social process of change. Diverse citizens, from their multiple experiences and capacities, will assume the main tasks of the process, such as the definition of the problems to be dealt with from the beginning. Far from problems created by the academy, the issues to be addressed will be those that concern the community as needs in the search for improvements that embody desires and projections. In this change, the researcher has become a catalyst figure of the research-active process. This places him/her in multiple roles as problematizer, facilitator, systematizer, dynamizer, promoter of deliberation and democratization of procedures, coordinator of the process and information in different ways and to different extents. The positivist construction of the researcher as an expert due to his/her formal degree and institutional recognition, appears questioned and to the extent that he/she does not know experientially the territories and problems investigated, his/her expertise will only be thematic, theoretical or methodological to share with other experts as those who will be the protagonists of the relationships in the territory; it corresponds to the useful and democratizing differentiation between thematic and convivial experts (Villasante, 2006).

The approach of orienting research or knowledge generation towards a process of action-participation finds its meaning only in collective social frameworks of common work. The participatory workshop condenses, in methodological terms, that moment of encounter of different positions and perceptions aimed at a common reflection. We can synthesize these work meetings, which are agreed to be convened in a pluralistic manner with clear objectives and facilitator roles that allow them, have in themselves some relevant characteristics as a democratic exercise of debate and social deliberation. On the one hand, with their political character towards decision-making in public spheres, participatory workshops have an outwardly transforming dimension, beyond those who attend, to the extent that decisions are made that transcend their subjects and present time (Martí 2005). It should be clarified when it claims to be participatory does not mean that they necessarily guarantee participation in themselves. It will depend on how they are convened, carried out, their degrees of transparency, deliberation, forms of decision-making, etc. On the other hand, these workshops gain relevance in their pedagogical component of mutual learning, sharing

individual knowledge to enrich and enhance it. It also allows transparent participation in the collective construction of knowledge (Ganuza et al., 2011).

For each participatory workshop, depending on the objectives and moments of the process, we should combine diverse techniques. Those are spaces for the systematic return or restitution of information for communicative purposes. According to Fals Borda in 1997 (Herrera and López 2012), this is the exercise of returning to the subjects the information elaborated for further discussion towards the definition of the action, to facilitate the social appropriation of knowledge that constitutes a central practice for the PAR-MPs. "We return information to make it easier for people to listen to each other and go deeper into the causes so that they can feel that they are reflecting at another level and see the possibility of change" (Hernández et al., 2014: 135).

In fact, with the feedback sessions or participatory workshops we set out to cover several central objectives within the participatory process, which go beyond the validation of the information previously collected:

- To create a climate of collaboration between the participants and the local RECETAS group by returning the information that was given to us in the more individualized listening of the first phase,
- To verify the information covers a wide diversity of discourses, including those that are not related to our interests,
- To encourage a process of self-reflection in each participant to build deeper reasons to strengthen or correct pre-judgments,
- To open the way towards co-responsibility and involvement in the necessary processes of change,
- To build consensus and, based on it, strengthen or constitute working groups to follow up and materialize the traced paths.

These returns are also called creative returns because they aim to provoke social creativity. "The returns are to deepen, but not to wallow in the problems but to provoke reaction, to make it easier to see ways to change" (Hernández et al., 2014, p. 139).

4. Participatory Process of Co-Creation of the NBSP Menu and Indicators

This proposal seeks to make the PAR-Sociopraxis methodological approach an instrument of involvement, decision-making, and collective protagonism throughout the RECETAS project process in the different pilot cities. As indicated above, the participatory approach integrates contributions from quantitative and qualitative approaches to collect and build on information from various sources. Therefore, the information to be presented in each phase might be based on the literature review but necessarily contrasted and complemented with social information. It might be collected through surveys, individual interviews, and

participatory workshops, to learn, for example, people's perceptions and opinions regarding the interests of the RECETAS project and, particularly, to contribute to the process of co-creation of the menu for NBSP. The participatory workshops constitute a crucial tool to achieve in practical terms the participatory dimension. These participatory workshops allow us to generate spaces for face-to-face meetings among the stakeholders (the actors with the capacity of advocacy). For this process of co-creation of the NBSP menu and indicators, the following general phases are proposed as general guidelines:

1. Elaboration of the Diagnosis,
2. Construction of the participatory diagnosis, and
3. Co-creation of the menu for NBSP and social indicators.

The following is a brief description of each phase, with its specific objectives, methodological keys and ethical considerations, proposed activities, work tools, and expected results. The methodological keys and ethical considerations aim to guide the development of the participatory process in an accessible manner for diverse actors. It should facilitate the inclusion of the opinions of vulnerable groups in the different pilot cities (elderly, migrants, undocumented, dependent persons, asylum seekers, and refugees, situations of poverty, lack of institutional language skills, members of the LGBTIQA+ group, among others, who may suffer discrimination). The suggested activities within each phase are presented sequentially to achieve diverse participation and progressively enrich the involvement of the actors in the process. At the same time, as the process progresses, the aim is to internalize ways of transforming the initial situation. The work tools include specific references to participatory methodologies (annexes) that might be adapted according to the particularities of each pilot city. Finally, the results reports refer to guidelines outlining the contents or results to be achieved in each phase.

This co-creation process demands a close interaction among the global and local actors. Thus, the following interaction scheme is proposed: the UCuenca team, as coordinator of WP3, will play a central role accompanying and fostering cross-fertilization during the process, in hand with each Local Research Team of RECETAS (LRT). LRT will promote the co-creation process in their respective city. Besides, LRT will consolidate a local working group (LWG). This group goes beyond the target group of intervention. It will articulate the LRT with a broad and diverse group of people from the local context (institutions, organized and unorganized actors) who share interests or could impact the RECETAS process. Progressively, within this LWG, two sub-groups will be formed: a Monitoring Commission (MC) whose objective is to ensure the information and monitoring of the process to all people, organizations, associations, entities, and institutions that feel they are representative of the community, and a Driving Group (DG), which will be the dynamic core of the process and is composed of people who are willing to get involved, discuss, share and implement the participatory process of the RECETAS project at the local level. The functioning of the (MC) CS is activated through informative assemblies, convened by the driving group.

Both groups should be as plural as possible, with people involved in different activities and open to the incorporation of new people. The DG will be the core of the process. Its members will participate according to their interest, availability, attitudes, capacities, and training, in the different phases of the co-creation process and the rest of the RECETAS project.

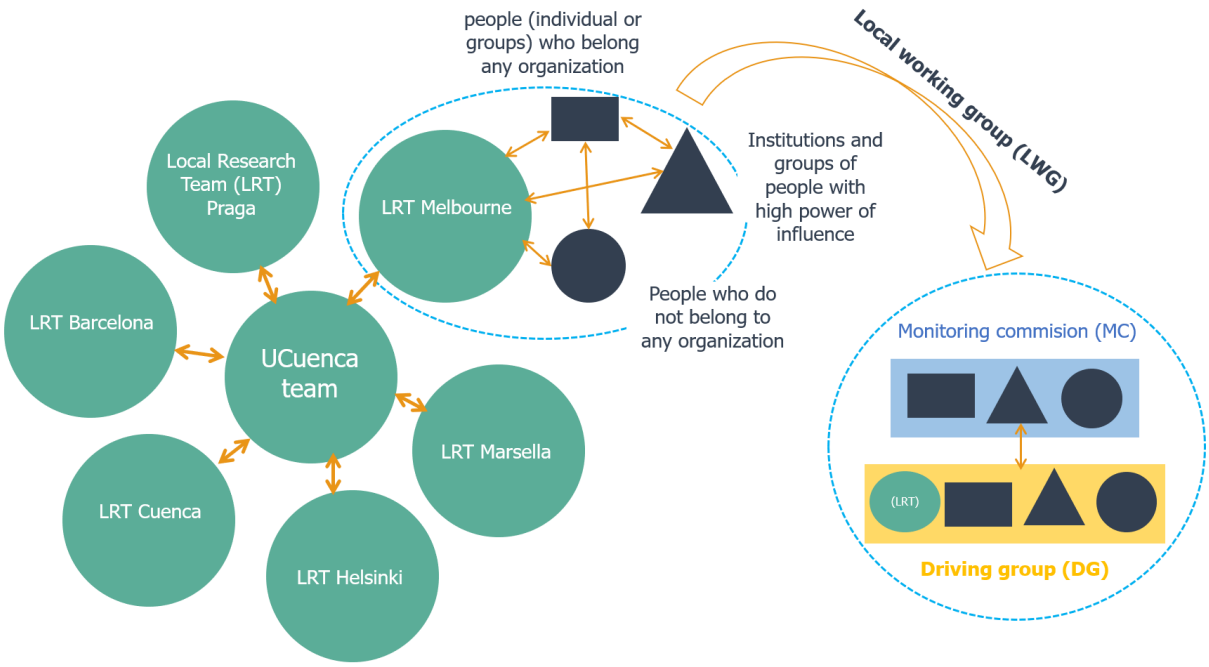


Fig. 8. Proposed interaction scheme for the co-creation process of the NBSP menu and indicators. Source: Authors.

The following is an indicative matrix of the succession of phases of the project concerning its objectives, activities, techniques, products, and deadlines:

Dimensions: Intrapersonal, Interpersonal, Environment	PHASE	OBJETIVE	GENERAL ACTIVITIES	TECHNIQUES	PRODUCTS	DEADLINE
	Preparation of the DIAGNOSTIC	1. To know the dimensions and characteristics of loneliness and social isolation.	Literature review-Analysis-Systematization	Bibliographic files Individual and group interviews Participatory workshops	PREDIAGNOSTIC (documental)	25-feb-22
		2. To have an approximation of the problem and those affected in each pilot city.	Gathering information (Listening)- walking transects - Analysis-Systematization	On-line/on-site surveys Household surveys Individual and group interviews Participant/non-participant observation Launching workshop Brainstorming SWOT	DIAGNOSTIC (Qualitative - Cuantitative - Participative)	15-apr-22
		3. To identify potential health assets.		Mapping of potential assets Transects	Mapping of potential assets prepared by each pilot city	
		4. To survey pre-existing NBSP experiences to RECETAS that serve the stakeholders of each pilot city.	Literature review-Listening-Analysis-Systematization	Bibliographic files Individual and group interviews	Audiovisual capsules elaborated on the inspiring experiences of pre-existing NBSP to RECETAS for each pilot city.	
		5. To know and influence networks that can propose solutions based on nature.	relational sample of actors-Listening-Analysis-Systematization	Sociogram or network of actors Stakeholder mapping sheet	Drivign Group and Monitoring Commission formed	
	Construction of the PARTICIPATORY DIAGNOSTIC	1. To socialize and return the results of the diagnosis	Listening-Analysis-Systematization-Return information	Participatory workshops for devolution of information	PARTICIPATIVE DIAGNOSTIC (Qualitative - Participative)	27-may-22
		2. To deep the diagnosis	Listening-Analysis-Systematization-Return information	Participatory workshops for devolution of information		
		3. To promote and/or consolidate the involvement of the various stakeholders, the driving group and the monitoring committee.	Signing of covenants/agreements between stakeholders	Individual interviews	Agreements signed	
		4. To identify relevance criteria for NBSP proposals.	Listening-Analysis-Systematization-Return information	Participatory workshops for construction of criteria	NBSP Menu Relevance Criteria Matrix developed	
	CO-CREATION MENU FOR NBS P & INDICATORS	1. To enrich local processes with the exchange of NBSP experiences among pilot cities.	Socialization of audiovisual capsules on the inspiring experiences of NBSP among pilot cities. Systematization of the proposals that have emerged throughout the process.	Participatory workshops for sharing inspiring experiences	Report on the selection of NBSP experiences applicable to the local context	31-aug-22
		2. To set a list of proposals for the NBSP Menu adapted to each context.	Propose initiatives that can be included in the NBSP Menu	Participatory workshops: construction of future scenarios. Brainstorming	NBSP menu(s) for each pilot city	
		3. Program the proposals selected for the NBSP Menu adapted to each context.	Prioritization of proposals for the Menu	Participatory workshop: flowcharts, weighted voting, programming matrix	Participatory action plan	

4.1. Phase 1 : Diagnostic

The specific objectives pursued in this phase are the following: to know the dimensions and characteristics of loneliness and social isolation; to have an approximation of the problem and those affected in each pilot city; to identify potential health assets; to survey pre-existing NBSP experiences to RECETAS that serve the interest groups of each pilot city.

The diagnosis will offer us a first approach to the experience of loneliness, social isolation (theoretical reflections and the state of the art, determinants, and patterns), and NBSP in each pilot city. It will also shed light on the actors involved (public, private, citizens) who address them and in what ways. The diagnosis allows us to know the relevance of institutional actions, conflicts, and contradictions present. A series of techniques (quantitative, qualitative, and participatory) will be used for this purpose, which may vary according to the context of each city; however, it will be very important to listen to and systematically analyze the information

gathered. For a process to be participatory, it must be open from the outset to the involvement of stakeholders in defining and addressing the problems that concern us. It is important to give the protagonists a voice and to listen. When we talk about listening, we refer to trying to transcend criticism, to those first reactions of judging, according to our own criteria, what we hear. That is why we say that listening is "looking for the reasons behind what is said" (Hernández et al., 2014: 6), an action that will be analyzed and reflected upon by the GLT where all opinions will be confronted in order to transcend them.

4.1.1. Methodological keys and ethical concerns

Prior to gathering information, it is suggested to develop an initial self-reflection among the members of the LRT that will lead to a micro-planning of the co-creation process. This initial self-reflection of the LRT will seek to understand the reality of the groups affected or threatened by loneliness and social isolation, health determinants, current and potential health assets, the institutional network, and the target population of each case study. Therefore, it must pay special attention to the various existing institutional and citizen backgrounds. Indeed, the LRT is called to go beyond the identification of these actors to deepen the understanding of their 'networks', i.e. relationships that the RECETAS process would like to strengthen in case of existing ones, or also to create from this new initiative. For this purpose, the use of the sociogram is proposed.

This tool (sociogram) will be fundamental for the micro-planning of the co-creation process, as it allows us to identify to whom and how to listen. Indeed, this tool reveals those "communicating" elements (people, groups, etc.) that acquire relevance in the connection of some levels with others: for example, the "bridges" between the associative, or with sectors of the population, or with some Institutions, etc., identifying which are the spaces of alliance or those of conflict (to be unblocked), to have an idea as close as possible of the actors involved in the proposals for action.

The sociogram might be read based on a matrix of positionings from which the relational or social network sample will derive. Actors will be intentionally selected from those who fulfill certain criteria of interest, in this case: variety, not quantity. That is to say, what is of interest in this case from this sample, more than large groups is to seek the opinions or discursive positions regarding social isolation, loneliness, and NBSP from different sectors. We look for a variety of opinions/ positions, not the subjects who speak about the opinions/positions.

From the point of view of PAR-socio-praxis, these nuances come from 3 variables (with which the sociograms are constructed): for being more or less organized (institutions, organizations, collectives), or by class or social power (being above or below the pyramid), or for being more similar or more opposed to transforming positions (similar, different, alien, opposed). We do not want to describe how many people there are in reality who think such a thing about the current state of loneliness, social isolation, and NBSP in each pilot city. Instead, we look to build a strategy with all the actors involved to do something together that contributes to

transforming the reality, taking into account the strategy or positions of all the groups involved.

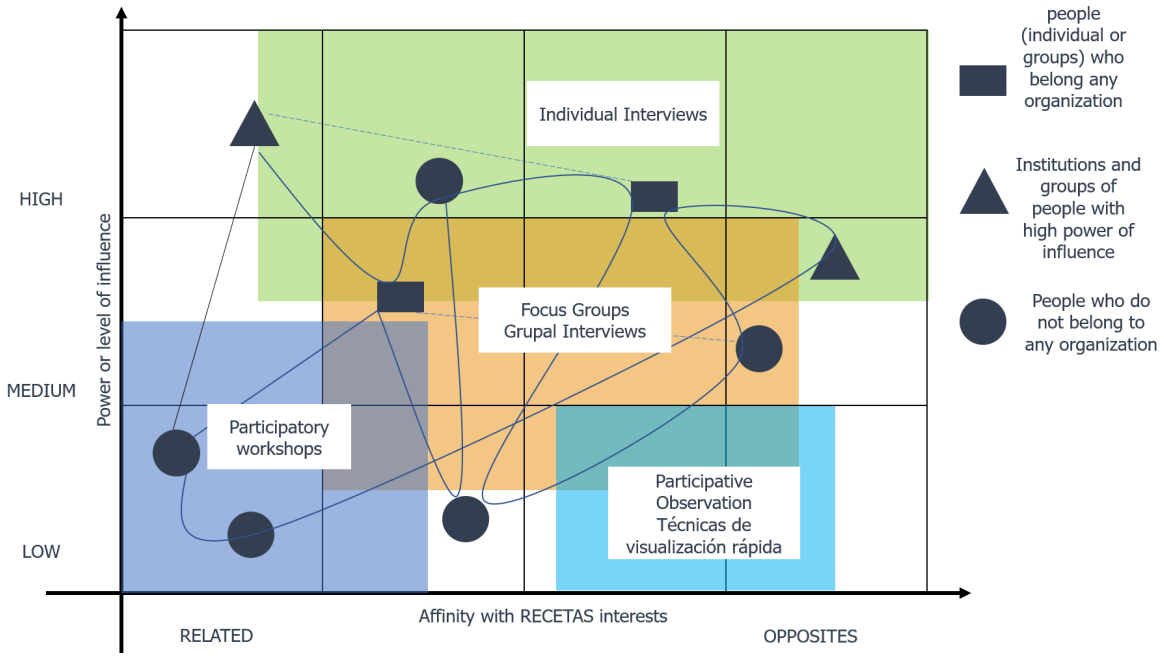


Fig. 9. Matrix for the determination of the relational sample and selection of listening techniques
Source: ANTIGONA procesos participativos.2010.

Concerning the limited time and economic resources available for the fieldwork of this first project of approaching social groups, we will include those people and groups to which we can have access from different work networks. The LRT will always try to generate trust and creative environments where people start to feel the protagonist, not only in formal spaces but also in informal spaces and those spaces where people meet daily.

Regardless of the technique used when LRT collects information (listening), it is essential to obtain the consent of the people we are working with. Besides, to guarantee the anonymity of the opinions collected. Moreover, being aware that our intervention at certain times may heighten the perception of the negative feelings of those affected must involve foreseeing and acting on the effects of our intervention. Continued work with them after interventions needs to be considered from the beginning as the key to mitigating these possible effects. We must be very receptive to adapting to the vulnerability profiles presented by the subjects, adjusting the actions to their needs and contexts. It goes hand in hand with intersectionality criteria that analyze in an articulated manner the different inequalities suffered by the participants while avoiding situations of victimization. In addition, when identifying current and potential health assets, we must bear in mind that age, sex, and other factors of the

individual influence the perception of nature and the appropriation of the natural environment in its broadest context.

When LRT listening with qualitative techniques should be considered: the duration of the conversation, less than an hour (depending on the degree of confidence), preferably; not issuing our opinions or judgments; directing as little as possible; and letting the topics arise spontaneously by the person or group according to their way and pace to express themselves; facilitate that the topics come up at the beginning and then enter into a climate of greater depth; say goodbye returning to more topical topics of easy consensus and emphasize anonymity, the objectives of this collection of information and calling for the return (even if dates cannot be specified).

When the face-to-face participatory workshops take place, it is recommended to initiate by recapitulating the different moments of the process, meetings, participants, and consensus with respect to previous diagnoses. For this purpose, we recommend the preparation of audiovisual material (video) with a duration of no more than 5 minutes. As far as possible, we should try to ensure that the groups are heterogeneous, both in terms of population sectors and age and gender groups. In turn, each group will debate, supported by a facilitator (LRT), who will remind the objectives of the work in this group, control the time and facilitate the synthesis for the presentation in the plenary. In order to encourage debate and deepening of the discussion, it is suggested that the workshops be designed in four different moments: 1. Opening, where the meeting objectives and methodology are presented; 2. During the meetings, the activities will allow each participant to choose the group that interests him/her the most, because what we want is commitment, not only in the debate.

4.1.2. Activities

a. Preparation of the project team that will energize the participatory process in each pilot city.

Based on the work developed by WP2 and the information gathered from the literature review and contained in the pre-diagnosis, the LRT is invited to generate spaces for self-reflection on the project's objectives, micro-planning, knowledge of the intervention area, the type of participation to be incorporated into the process, the position of the team within the process, etc

b. Determination of the relational sample

The results obtained in WP2 should be used as a starting point to deepen the actors and networks identified. Due to the limited resources and time to develop this WP3, we suggest a sample that combines a relational or social network sample and a structural sample. It will include those social groups that can be accessed from different networks of related groups, from the neighborhood or proximity, from groups with which we are working from other processes, etc., ensuring plurality. The participants in the listening activities could be people

with experience or knowledge of the topic, or simply those who feel directly or indirectly affected by it. From the first contact, invitations will be extended to participate voluntarily in the process in its different phases and not only in co-creation.

LRT should coordinate contact with key informants in the areas to be intervened. They might be local politicians, technical personnel from different services (health, social, cultural, educational, community, etc.) or research centers, people linked to the social fabric of the neighborhoods, and even the same groups to which RECETAS is interested in during the intervention.

c. Definition of the work strategy to implement the participatory process in each pilot city.

It refers to the detailed micro-planning of the listening. The intention is to incorporate to the previously existing information all the opinions (from the relational sample) about the topic. That is to say, to know from people, mainly what is their perception about loneliness and social isolation, as well as their prejudices regarding the social prescription based on nature. Likewise, opinions will be collected on those elements, spaces or situations of personal experiences that are recoverable or not concerning the menu to be developed.

d. Local Kick-off meeting of RECETAS in each pilot city.

A workshop with the stakeholders identified in WP2 and relational sample is proposed to present the co-creation process. During this session, collective reflection and understanding of the objectives and key elements of the RECETAS project will be facilitated, as well as the deepening of issues related to urban health, loneliness, social isolation, assets for health, gender equality, and NBSP. For this purpose, brainstorming, analysis of Strengths, Weaknesses, Opportunities, Opportunities and Threats, and community maps can be used, which will be addressed by the participants through group work. The presentation workshop should be used as an opportunity to start the development of meetings with people, organizations, associations, entities and institutions with whom the Monitoring Commission can be formed. It is in these informative sessions where the first results obtained are compared and where the attitudes and reactions that these awaken can be felt.

Tasks of the monitoring committee:

Active participation in the supervision and follow-up of the process

Maintain periodic working meetings.

Hold briefing sessions at the end of each phase.

Discussion of the diagnosis and negotiation of proposals

Availability and responsibility in the follow-up of the process

Reinforce its involvement in the negotiation and dissemination of the diagnosis and proposals.

Potential of the monitoring committee:

Promotes a healthy exercise of participatory democracy, since it involves political representatives.

It curbs the arrogance in which the driving group sometimes has the inertia to see itself as the protagonist of the process.

Provides an atmosphere of trust and transparency to the process.

In addition to this commission, there should be identified actors that could make up the Driving Group, above mentioned in 4.1.1. will be the dynamic core of the process.

Tasks of the driving group:

To co-design the process (organization of activities, times, and resources).

To take care of and follow up the methodological guidelines.

Design and carry out the pertinent techniques

Systematize the information gathered during the process.

Calling meetings

Have moments of self-reflection and self-learning.

Disseminate the information

To create bridges with other networks, entities, and institutions

To be, in short, the referent of the process.

Potentialities of the driving group:

Opportunity for mutual, collective learning.

Sharing a heterogeneous group work

Gain a way of understanding reality that goes beyond the project itself.

To create bonds of trust that facilitate a better understanding between different professional and population sectors.

To materialize a group capable of undertaking other projects and activities.

e. Analysis, systematization and report writing.

4.1.3. Work tools

Annex 1: Strategic network map or sociogram.

Annex 2: Micro-planning matrix for each phase.

Annex 3: Classification table of identified actors.

Annex 4: Interviews.

Annex 5: Participatory workshop planning instrument.

Annex 6: Systematization instrument for the participatory workshop.

Annex 7: SWOT matrix

4.1.4. **Results** Report

Elaboration of a diagnostic document, containing the deepening of the general framework of characterization of the local context for each pilot city, in order to have an approximation of the local situation regarding the study of the three key issues: loneliness, isolation and social prescription, from their different dimensions: intrapersonal, interpersonal and environmental. This document will be enriched as the participatory research process progresses.

The basic structure proposed for this diagnosis is as follows:

THEORETICAL AND TERRITORIAL FRAMEWORK

Health determinants linked to loneliness and social isolation.

Socio-territorial conditions that link the population suffering from loneliness and social isolation.

ACTORS, HEALTH POLICIES AND REGULATORY FRAMEWORK

METHODOLOGY

CONCLUSIVE ANALYSIS

When did loneliness and social isolation become a problematic situation in the pilot city? It would be necessary to reflect on how RECETAS would affect this situation.

4.2. Phase 2 : Participative Diagnosis

The objectives that we intend to achieve in this phase of construction of the participatory diagnosis are the following: to socialize and return the results of the diagnosis, to deepen the diagnosis, to promote the appropriation of the diagnosis by all participants, to promote and consolidate the involvement of the various stakeholders, driving group and monitoring committee and identify criteria of relevance for the NBSP proposals. For this it is essential to promote spaces to return, reflect and collectively integrate the information from the diagnosis in each pilot city.

Thus, the transition from the diagnosis to the participatory diagnosis is determined by the action of return of all the collected information produced during the diagnosis. This will be subject to interpretation and feedback from the actors involved in the RECETAS project through face-to-face meetings and collective, not individual, reflections. In this phase, the information will be appropriated by the actors who will begin to articulate it, to know other positions, to modify their initial points of view, to collectively construct the information on loneliness, isolation, and NBSP from different perspectives.

More than an ethical compromise, returning the information allows validating the information and better comprehension among participants. They reflect on the crossing of the different visions and positions. In addition, we seek in this step the appropriation and identification by each one of these diagnoses, now confirmed collectively and collaboratively. LRT should

prepare the material through the systematization to give an idea about what was said. In the return, we leave the interpretation in the hands of the participants, since they are the ones who can answer the question of why what was said, inviting a new, deeper, and more comprehensive reflection than the one generated in the first moment (diagnosis).

4.2.1. Methodological keys and ethical concerns

To guarantee to obtain people's consent for using their information in any format (written, audio, video, images). To be aware that our intervention at certain times may heighten the perception of negative feelings of those affected, which should involve foresight and action on the effects caused on the affected persons. Continued work with them after certain interventions should be taken into account from the beginning as the key to mitigating these possible effects.

4.2.2. Activities to develop

a. Return - Analysis - Systematization

With the participatory workshops of this phase, we aim to meet the following objectives: to encourage the appropriation of the information generated, to validate the systematized information, to facilitate an environment of deepening and creativity based on the first speeches made and to build a deeper collective interpretation. We return those elements that allow us to advance in the process of co-creation, which will allow us to glimpse horizons that enable and enhance the practice of NBSP.

As mentioned in 4.2.1. In this phase, listening and information gathering (qualitative) will be combined with feedback, creating micro cycles of learning that are repeated among the participants. The starting point will always be the revision and updating of the analysis of the actors' networks (sociogram) with the possibility of registering new actors and relationships within the map, which are dynamic and which, in the light of the relational matrix, will make it possible to derive the listening techniques to be used. Semi-structured interviews, both individual and group, or discussion groups, will be used, and as a priority, participatory workshops or creative feedback workshops with various techniques such as: tetralemes, construction of asset cartographies in the city, tours through the territory explained by local experts (transects or drifts), among others.

Creative feedback meetings to validate and to exchange socio-natural solutions to the loneliness of the target groups in each city with the interaction of a diversity of actors (institutions, associations, informal groups, people concerned, etc.), using visualization techniques such as talking maps, discourse analysis such as multi-problems, group work, and sharing. We will work collectively on the construction of criteria that will allow us to evaluate the relevance of the proposals for the NBSP Menu considering the different dimensions of loneliness and social isolation, such as those indicated in the following table:

DIMENSIONS OF SOCIAL ISOLATION AND LONELINESS		
Interpersonal	**Intrapersonal**	**Environmental**
Preferably under our control Incorporate proposals with a gender perspective Promote social cohesion Be intergenerational …	Preferably under our control To favor the autonomy of the participants… …	walkability The menu should be oriented towards open air and natural spaces …

b. Signing of agreements between stakeholders

The information systematized will provide a clear view of the actors and their capacity and resources to influence the RECETAS project. The signing of agreements and accords will contribute to consolidating the process through a series of solid commitments and actions. In the same vein, reinforce the process to consolidate the work of the driving group and the follow-up commission.

4.2.3. Work tools

In addition to the instruments detailed in Annexes 1, 2, 5, and 6, updated according to the activities of this phase, it is recommended to carry out:

Annex 8: mapping of assets and potential health assets in each pilot city,

Annex 9: transects walks or drifts.

Annex 10: multiphrase

Annex 11: Workshop for criteria definition

4.2.4. Results Report

This report will integrate the contents of the diagnostic and the results of the present participatory diagnostic, highlighting the prioritization techniques and criteria for the elaboration of the NBSP menu. The report will then deliver the participatory diagnosis and its construction process.

4.3. Phase 3 : Co-creation of the Menu for NBSP and indicators

Based on the participatory diagnosis, the NBSP menu will be co-designed with the various local actors in each pilot area, including a list of interventions, programs, and indicators best adapted to each context. In addition, the aim is to characterize the menu of each territory and enrich it in light of the NBSP menu proposals constructed in the other pilot cities. At this point, it will be crucial the interaction between the LRT with the driving group and the monitoring commission. It will determine possible budgets and actions to be implemented during the intervention and after the end of the RECETAS project. The local results of the different phases will be shared among the pilot cities to refine and improve both the NBSP menu and the indicators. The participatory selection of menu items can then be compared across cities against this list of all NBSP initiatives available in each city. Once the Menus have been agreed and harmonized, interventions can be implemented.

4.3.1. Methodological keys and ethical concerns

Following a bottom-up planning approach, this phase should serve to build consensus and decide jointly and horizontally on criteria, proposals, and indicators, which can also be carried out in a co-managed manner. Therefore, in this co-creation phase, the methodology will prioritize participatory workshops, always open to incorporate opinions and actors that may not have been collected/identified beforehand, respectively. It is recommended that after the socialization of the existing (previous local and international NBSP experiences) we define shared interests (desired scenario) and that each action proposed has positive repercussions to achieve it and does not contradict the relevance criteria elaborated in the participatory diagnosis.

It is recommended that working groups or commissions be organized to deepen the socialization of previous local and international proposals or experiences that have been identified throughout the process. In this way, each commission will be able to open a space for consultation and debate in order to gather more elements to be presented at the next meeting or workshop, where the adapted proposals will be presented and prioritized. The prioritization of the proposals does not mean that some are better than others, but rather that they are more appropriate in the current scenario. After prioritization, and depending on the number of proposals selected, a comprehensive action plan should be drawn up detailing a programmatic matrix indicating the activities responsible, dates, and evaluation indicators. The proposals will be identified with specific NBS for each city that can be detailed according to their characteristics, preferences and to the profiles and needs of the affected persons, as well as establishing certain typologies according to the type of proposals.

4.3.2. Activities to develop

In the second quarter of WP3 development (Jun to Aug) participatory workshops will be developed to build with stakeholders an NBSP Menu adapted to each context. It is suggested at least one meeting per month and preferably two. The meetings in this phase will be based on the socialization of previous local and international proposals or experiences that have been identified throughout the process. The next step will be the proposal of new viable ones from the previously existing possibilities and networks. In this regard, Hernandez et al., (2014) point out that in participatory processes, from the moment we start listening to the participants, in addition to an attitude of complaint or uneasiness, "people always have a propositional attitude that must be valued". Therefore each group of local researchers RECETAS should collect these ideas throughout the process and take them up again in the co-creation phase.

From the review of inspiring or innovative experiences, we will work together with the actors involved in the construction of the NBSP menu to be implemented, highlighting the commitments of each of the actors (community, SMEs, institutions, and others) working at the intersection of mental health, wellness, natural resources, healthy and active living. The construction of multi-sectoral, multi-level proposals based on the particularities of each context, especially the profile and needs of the stakeholders, will be sought.

Finally, it is proposed to prioritize in a participatory manner among the set of proposals for the Menu, to determine the programming of short, medium and long term actions, as well as a basic typology that emphasizes their main positive effects and for whom they may be more appropriate and useful (for example: massive/small groups, in the city/outside the city, with natural/social emphasis, etc.). In addition, this co-creation process will be used to collectively define those indicators (both quantitative and qualitative) that are most appropriate for each local context and that from a social, cultural and environmental point of view will allow monitoring their impact.

4.3.3. Work tools

Annex 12: Weighted voting

Annex 13: Construction of future scenarios

Annex 14: Flow chart

Annex 15: Programming Matrix

4.3.4. Results Report

With the co-creation of the NBSP Menu and indicators, the project team shall deliver a document with the following minimum structure :

DESCRIPTION OF THE LOCAL CO-CREATION PROCESS

Actors involved

Methodology (including the annexes of the participatory workshops)

MENU OF THE PNSB

List of initiatives for the Menu and Indicators

Results of the criteria evaluation

Participatory Action Plan

Annexes

The annexes presented in this section are referential and may be adjusted according to the particular process of each territory.

Annex 1

Sociogram or network cartography or relationship map.

What is it? It is an instrument that allows to visualize the actors and networks present in the territory, or that have great influence on it, and to trace the existing connections between them.

What is it for? It helps to understand the relationships between the actors, their power of influence and their potential interest in the RECETAS project. One of the first functions of this map is that it helps us to realize how isolated or not we may be in the tasks we propose, and the alliances we need and should make; and in this sense, which elements or "bridge" groups we should interview in order to know how to collaborate in common tasks. It also allows us to agree on the extent of the networks in which we are working. The sociogram allows us to identify which antagonisms are likely to appear and the driving group can determine a strategy to counteract them. All this is done by weighing not only the number of people who may be in each situation, but also their real socio-political weights and strengths and their capacity to help in the strategies of the driving group.

How to use it? There are several ways to perform a network mapping, a possible application of the technique in a manual way and accessible to groups with different characteristics, would be the following:

Hand out blank cards: some **triangular** in shape to represent actors with a lot of symbolic or convening power (and possibly external to the specific place), e.g. political authorities, the most influential media, economic powers, etc. Other **rectangular** ones to represent organized and local social actors, e.g. NGOs, associations of all kinds, political parties, trade unions, sports clubs, etc. And other **circular** ones to represent sectors of the population that are not organized but that carry out some activity in common or have a common interest, which are usually the majority, or to represent individuals who are considered to be relevant to the process.

Each significant social agent is placed on a card, either triangular, rectangular or circular, or with the shapes previously agreed upon. On a large piece of paper (for example, 1 meter high and 2 meters long), depending on the number of agents that have been identified, two axes are drawn, one vertical and the other horizontal.

The vertical axis can be divided into three to represent three sectors of social class according to their power of intervention:

high (economic, political, social power),

medium (permanent workers, specialists, professionals, etc.) and low (economic or social precariousness).

low (economic or social precariousness).

The horizontal axis will be divided into four according to the ideological position in relation to the subject:

The one closest to the vertical axis will be reserved to place the organizations, groups, collectives and individuals that we consider to be related to the project we want to carry out, separated vertically according to their degree of power. These related people constitute our greatest strengths, we have enough trust and we understand each other in the way we work.

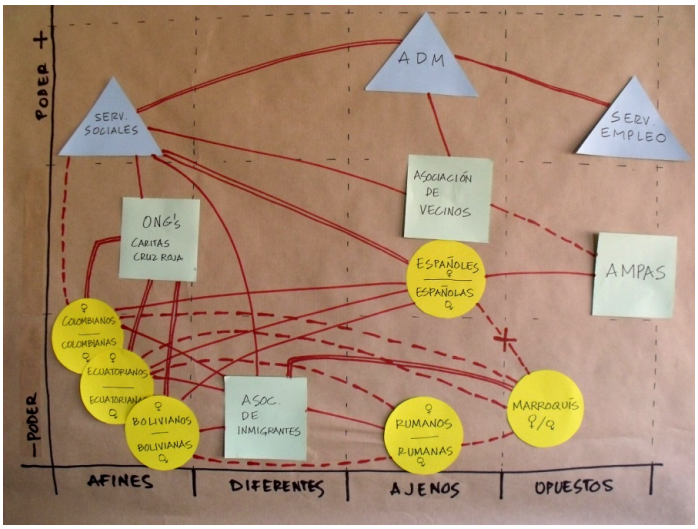
In the second horizontal segment we will put the actors that we consider different, that is to say, that would not oppose the project because they work in the same direction, but they have different ways of doing it, they have other ideologies. With these people and collectives we can negotiate concrete things, we can carry out common actions, but we should not try to make them share the whole process with us.

The third segment, undoubtedly the largest by far, is reserved for those who are alien or indifferent, that is, those who move in other fields of activity, people, collectives, groups, authorities, etc. who, beforehand, are alien to the project. This large percentage of the population is the challenge ahead of us to listen, they are "in their own business", but it is very important to know their opinions.

In the rectangle farthest from the vertical axis, we will put the opposites (who are very different from the Differents). They are the antagonists, the ones who are watching what we do to try to boycott it, to put stones in the way. Normally they are social agents who do not want things to change because they are making a profit from the current situation. A benefit that may be economic, the use of authority and power, or they may even oppose it because they understand that they would have to work harder.

Once all the cards have been placed in the boxes where they have been decided by consensus, the next step is to indicate the type of relationships that exist between all of them. Arrows are used to link the different actors in terms of strong relationships (dependence,

collaboration, etc.), weak relationships (isolation, disinterest, temporality, etc.), conflict, no relationship, indirect relationships (one actor with another through a third party), etc.



Strong line, strong relationship.

Normal line, normal relationship.

Crossed line, weak relationship

--x—x—x— crossed line, conflicting relationship.

Once the network cartography or sociogram has been drawn up, the group discusses it until a certain consensus is reached. Reflection is made on the areas where the map is denser in its relationships, where these are more intense, the existing blockages, the articulating elements (dynamizers) and the empty spaces of actors or relationships. In fact, we can begin to define those "communicating" elements (people, groups, etc.) that acquire an important weight in the connection of some levels with others: for example, the "bridges" between associations, or with sectors of the population, or with some institutions, etc. It is also very interesting to try to define which are the spaces of alliance and those of conflict (to be unblocked) in order to have an idea as close as possible of the actors involved in the proposals for action. This will become much more concrete in a subsequent phase of feedback and negotiation.

The initial list of actors as well as the relationships are dynamic and therefore can and should be enriched with the help of key informants to identify other groups or persons that could be relevant to the present research.

Annex 2

Micro-planning plan and timetable (example Diagnosis phase)

Listening to different actors will be organized, considering the different territorial scales of analysis, and combining quantitative (orange) and qualitative (red) techniques. Subsequently, a space for returning the information will be organized to close the pre-diagnosis with participatory techniques (green).

28	01	02	03	04	CONSTRUCTION OF THE SOCIOGRAM	05
INITIAL SELF-REFLECTION						
February 28 to March 04 // REVISION OF PRELIMINARY REPORT AND ADJUSTMENTS TO CONTENT STRUCTURE						
06	07 LAUNCHING WORKSHOP	08	09 OPEN SURVEY ON-LINE	10	11	12
13 INTERVIEW Actor 2	14	15	16	17 INTERVIEW Actor 3	18	19
20	21	22 INTERVIEW Actor 4	23 INTERVIEW Actor 5	24 INTERVIEW Actor 6	25	26
27	28	29	30 INTERVIEW Actor N	31	01	02
March 05 to April 02 // INDIVIDUAL LISTENING AND ANALYSIS AND ORGANIZATION OF THE INFORMATION						

03	04 FEEDBACK WORKSHOP	05	06	07	08	09
10	11	12	13	14 DELIVERY DIAGNOSTIC REPORT	15	
PREPARATION OF DIAGNOSTIC REPORT						

Annex 3

Name of the technique/tool: Stakeholder Ranking Table

SECTOR	ACTOR(S)	RELATIONSHIP WITH THE RECETAS PROJCT
INSTITUTIONAL		
ASSOCIATIVE NETWORK		
SOCIAL BASE		

Annex 4

Name of the technique/tool:: Individual and/or group interviews

It is preferable to design a semi-structured interview script and schedule each meeting indicating the place, day and time established by both parties.

For the organization of the interviews, it is necessary to consider the following in advance:

If the interview will be conducted in person, prepare the material for the interview: tape recorder(s), the script (or several just in case), notepad and pen, in case it is virtual, make sure that the interviewee has access to electronic media and a stable internet connection. Organize the team according to their functions. One person to conduct the interview, another to observe, take notes and photos (in group interviews). Think about the characteristics of the person to be interviewed to adapt the language so that it is clear and close, and prepare our attitude of listening and empathy. In group interviews, do not forget the gender approach not only in the language, inclusive and inclusive, but also in the taking of the floor, encouraging

that all people can give their opinion in the same way, etc. Confirm the time and place. Arrive on time.

DEVELOPMENT OF THE INTERVIEW

(~3min) Why and what for this interview? Who does the interview should always make a small formal introduction, who we are, the objectives of the project and the work done so far. FOR EXAMPLE: "Good morning, we are X and Y, and we are part of a group of researchers interested in the city, in this case we have been interested in this neighborhood for its undeniable historical and cultural value. We have been investigating from various points of view (the anthropologist, the architect, the economist...) but we need to know what is the view and perception of those who live or work in the neighborhood about what things you believe that enhance or detract from the quality of the habitat in (San Roque/El Vado). And that is the objective that brings us now, to be able to talk with you about it, we will not take much of your time"...After the introduction, we let the person ask the questions he/she needs to ask, we asked him/her at that moment if he/she would not mind if we recorded the interview because we need to keep a record, but it will be exclusively for the team's internal work.

(~1min) Introduction of the interviewee and date of the interview. Very briefly and for our record: FOR EXAMPLE: "Today is August 3, 2017 and we are with Mr... or Mrs... or Ing.....etc. who is so and so.....". Request for authorization to record or use the information provided by the informant for research purposes.

(~40min) Interview:

FOR EXAMPLE: "Jorge, a pleasure. As I explained to you, our interest is in everything that unites people to their neighborhood, what gives them the sense of belonging to the neighborhood and all that. The first question has to do with history....." In the group interviews add: "As it is a group interview, we are going to ask the questions and whoever wants to answer can raise their hand, and then if anyone wants to add something, they can do so. We ask you to please keep your interventions concrete and brief. Thank you very much in advance".

Annex 5

Name of the Technique/Tool: Participatory Workshop Planning Instrument

1. Investigator(s):.

2. Place, date and time: Try to hold the meetings in neutral and used places or in attractive places that are out of the ordinary. d

3. Phase of the process:

4. Activity and objectives:

General Objective: Specific Objectives (SO): S.O.1: S.O.2: S.O.3:

5. Background: Brief description of the previous moment.

6. 1 Call: Preferably open by all possible means. If possible, take advantage of the contact with some people, entities or organizations to support the call, since facilitating and encouraging their participation in the start-up, could encourage their involvement during the rest of the process. [However, care should be taken that it is not seen as something that only involves some people.] Each local RECETAS researcher will contact their interlocutors to see the feasibility of date, time and place, and the respective call will be made taking into account mainly the people who participated and/or were invited to the previous workshop and any other person or group interested in the process. Remember that the call should be made 6 days before and, if possible, also on the same day of the event.

Table of participants who have confirmed their attendance and contact information:

SECTOR	ACTOR(S)	CONTACT	RELATIONSHIPS WITH THE RECETAS PROJECT
INSTITUTIONAL			
ASSOCIATIVE NETWORK			
SOCIAL BASE			

6.2. Invitation

Insert the invitation template

7. Plan of activities: Present the details of the planned activities indicating sequence, intervention times and persons in charge.

Example of Agenda for Participatory Planning Workshops

TIME	ACTIVITY	PERSON IN CHARGE
	Preliminary Activities	
	OPENING	
	First part:	X min
	Second part:	Xmin
	CLOSING AND LUNCH	Xmin
	Closing Present thanks for the work done and brief explanation of what is intended to be done next. Dates of the next workshop.	

8. Logistics and content tools: Detail the logistical activities and tools necessary for the development of the workshop:

Activity	Maximum date to have the activity ready	Person in charge
LOGISTICS		
Requests for the place where the workshop will be held.		
UPDATED list of actors in each territory (identifying those who have participated in previous workshops).		
INVITATION DESIGN		
Delivery of invitations (at least 6 days before the workshop).		
Attendance registration lists.		
Equipment: computer, projector, sound and microphone equipment, extensions.		
Triptychs (includes project information)		
Roll-up (RECETAS)		
Bio-safety supplies		
Presentations (ppt) Videos of previous workshop Workshop devices Printed handouts, poster board and post-it		

Refreshments		
Transportation		

9. Expected results

EXPECTED RESULTS	CONTRIBUTION TO THE STATED OBJECTIVES

Annex 6

Name of the Technique/Tool: Systematization instrument for participatory workshops.

1. ORGANIZATION

1.1. Researcher(s):.

Place, date and time. 1.3:

1.3. Background: This is a brief description that integrates the information from the planning of the workshop referring to the phase of the process in which the workshop is inserted, the objectives and background, plus the general elements of learning that emerged from the meeting.

1.4. Call for participants: This section describes how the call for participants was received and explains in general terms the number of participants and their diversity.

2. DEVELOPMENT: This section aims to describe the development of the different parts of the workshop, including digitized devices with some explanatory notes if necessary.

It is recommended to start by presenting the details of the activities developed by adjusting the agenda that was initially planned: sequence, intervention times and persons in charge, followed by the digitalization of the results.

Sample Agenda for Participatory Planning Workshops

TIME	ACTIVITY	PERSON IN CHARGE
	Preliminary Activities	

	OPENING	
	First part:	X min
	Second part:	Xmin
	CLOSING AND LUNCH	Xmin

3. ANALYSIS AND RESULTS This section will present an analysis of the data/information collected, re-organizing it if necessary and determining possible findings in light of previously existing information.

4. SELF EVALUATION: Based on the premise that processes can be refined and improved on an ongoing basis, it is suggested that at the end of each meeting an exercise of self-evaluation of the activity be carried out. This can include the opinion of the participants or can be developed within the local RECETAS group.

Participants' perception of the workshop developed
Progress in the process
Aspects to consider for future meetings (to be improved or enhanced).

5. ANNEXES: It is recommended to support as an annex a photographic and video record of the workshop, a register of attendees that should include signature and contact information, presentations or videos generated for the activity.

Annex 7

Name of the technique/tool: SWOT (Strengths, Weaknesses, Opportunities and Threats)

What is it? It is an analysis tool that combines the assessment of a current situation and an analysis of the main environmental factors that influence that situation.

What is it for? It is useful at the initial stage of the diagnosis. This tool is useful to know both the positive aspects (strengths) and the negative aspects (weaknesses) in which we assess a given topic, distinguishing whether we are referring to internal conditions (within our scope) or to situations arising from the environment and its evolution (outside our scope). Thus, weaknesses and threats refer to limitations or shortcomings of various kinds that we value as weaknesses, and over which we may or may not have influence. Strengths and opportunities refer to situations and factors of various kinds (socioeconomic, political, cultural, organizational, etc.) that are valued as strengths and positive points that we may or may not be able to influence.

How to use it? Depending on the number of participants in the workshop, it is possible to work in plenary session from the beginning, with the matrix drawn on a support (flipchart, blackboard, etc.); after explaining the technique, the participants are asked (either individually or in pairs) to start contributing ideas to complete the matrix. If it is decided to distribute the participants in pairs, a time margin should be given so that they can discuss the topic (about 15 minutes). It is important that at this stage the exercise is not collective so that all the existing opinions flow and there is no influence of some people over others; in fact, it is a stage where the objective is to collect all the opinions and initial views of the participants in the least crystallized way possible. The role of the facilitator is fundamental, both in the distribution of the floor and in encouraging everyone to participate.

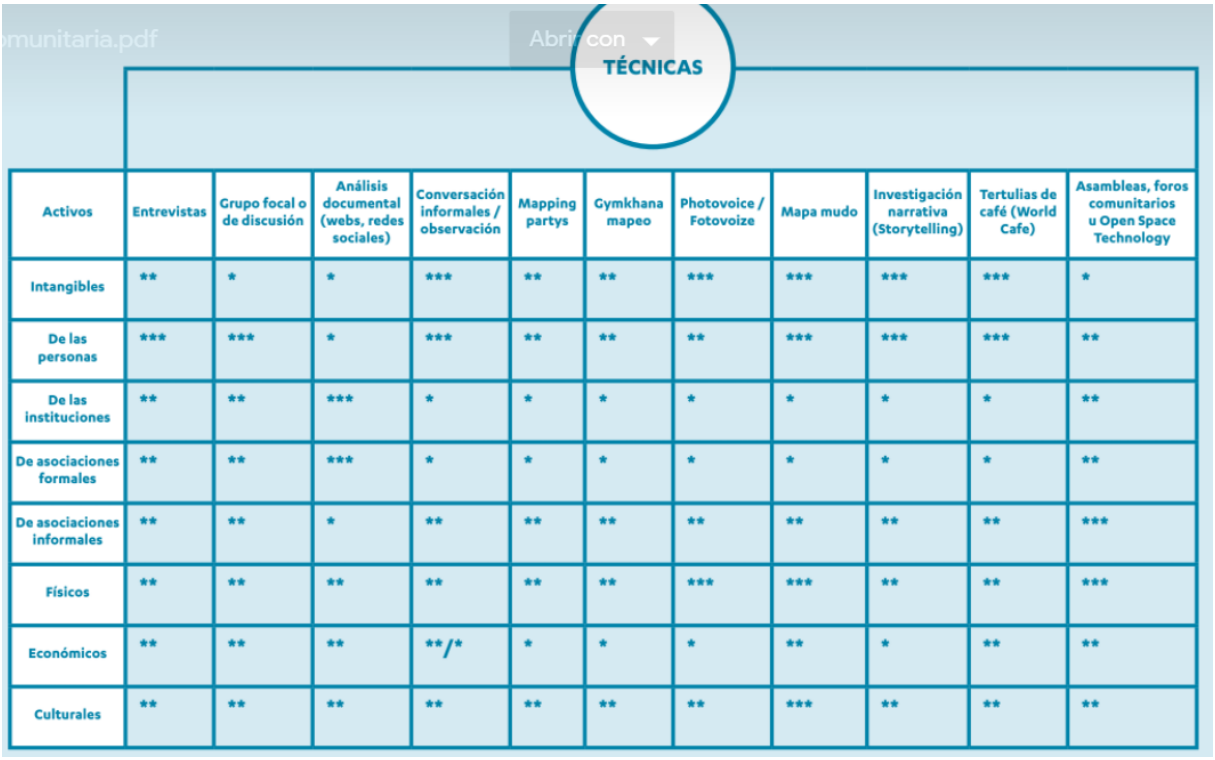
If we are clear that this type of workshop is an initial diagnostic workshop, its strength would be that in a short time (about two hours, two and a half hours) a diagnosis of the problem can be made in a graph (matrix), addressing internal and external factors that influence it. Another strength is the possibility of converting the matrix obtained (if we are working on a broader process) into an important input that allows us to deepen the diagnosis based on the aspects that have already been decanted in the matrix, for example, we can then work on a flowchart workshop.

	Strength points	Weak points
Internal analysis (is under our scope)	STRENGTHS	WEAKNESS

External analysis (outside our influence)	OPPORTUNITIES	THREATS

Annex 8:

Name of the Technique/Tool: Asset Mapping



TÉCNICAS

Activos	Entrevistas	Grupo focal o de discusión	Análisis documental (webs, redes sociales)	Conversación informales / observación	Mapping partys	Gymkhana mapeo	Photovoice / Fotovoize	Mapa mudo	Investigación narrativa (Storytelling)	Tertulias de café (World Cafe)	Asambleas, foros comunitarios u Open Space Technology
Intangibles	**	*	*	***	**	**	***	***	***	***	*
De las personas	***	***	*	***	**	**	**	***	***	***	**
De las instituciones	**	**	***	*	*	*	*	*	*	*	**
De asociaciones formales	**	**	***	*	*	*	*	*	*	*	**
De asociaciones informales	**	**	*	**	**	**	**	**	**	**	***
Físicos	**	**	**	**	**	**	***	***	**	**	***
Económicos	**	**	**	**/*	*	*	*	**	*	**	**
Culturales	**	**	**	**	**	**	**	***	**	**	**

Annex 9:

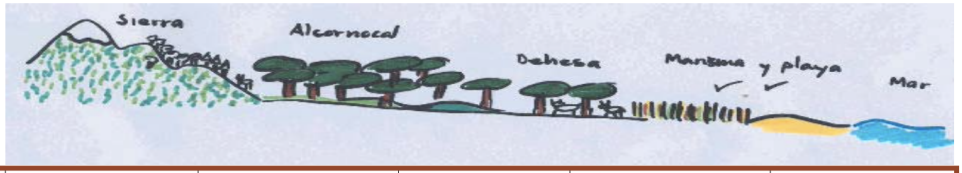
Name of Technique/Tool: Transect

What is it? It is a geographic-spatial visualization technique that consists in the graphic representation of a field reconnaissance route. It is usually one of the first techniques used to make contact with the reality of the territory.

What is it for? To jointly (technical team and participants) approach participant observation, insofar as the group carries out tours in stops (places that represent an asset in health) from which topics, opinions, emotions are suggested, which are collectively nuanced and collected to then build the graphic representation of the tour carried out jointly. It is very useful at the beginning of the fieldwork to identify the health assets for the proposals of the PSBN menu.

How to use it? For the organization of the transects it will be necessary to previously consider: prepare the material: blank sheets of paper, map of the area to be covered and pencil. Organize the team in groups of two and one person, who will record the identification of activities, places and people that could be relevant to this study. In this case, there will be more listening than asking questions, and with a map in hand, indicative notes will be taken.

TRANSECTO 1 (Noroeste-Sureste, Manolo –técnico del parque- y Rosa –educadora ambiental-)



Características ecológicas	Sierra: Monte	Bosque: Alcornocal, algo de encinar y olivar.	Dehesa	Marisma y playa	Mar
Recursos naturales y culturales, actividad económica	- Ganadería caprina, en declive (Queserías tradicionales) - Aprovechamiento del monte - Artesanías tradicionales (barro) - Senderismo y educación ambiental - Caza	- Aprovechamiento del corcho, - Olivares y otros cultivos, -Paseos interpretativos (Educación ambiental)	- Ganadería: cerdo ecológico. - Corcho - Huerta - Educación ambiental	- Artesanía tradicional del mimbre. - Turismo incipiente. - Posibilidades de ecoturismo (visitas ornitológicas en épocas migratorias) - Posibilidades turismo de calidad (balneario asociado a aguas y barros de la marisma, etc)	- Pesca y marisqueo.
Zonificación Parque Natural (autorización)	Zona A (Máxima protección) - Restricciones al pastoreo en zonas con especies vegetales vulnerables, - Aprovechamiento autoriza exige solicitud de autorización	Zona B1 - Descorche requiere autorización (restricciones en época de cría de algunas especies de fauna). - Permitidas actividades tradicionales. - No edificable.	Zona B2 - Permitidas actividades tradicionales, y actividades agroganaderas. - Normativa para la adecuación de las construcciones asociadas a explotaciones agroganaderas.	Zona B1 y C - Protección con barreras de algunas zonas con vegetación para la fijación de dunas,	Zona A2 - En el área de Reserva Marina sólo se permite la pesca con artes tradicionales. - Restricciones submarinismo y deportes acuáticos.
Problemas	- Envejecimiento de las masas forestales, - Abandono del caprino (gran rejuvenecedor de las masas forestales) - Sobrepastoreo de Calendus populues, planta en peligro de extinción. - Abandono y pérdida de caminos rurales tradicionales.	- Incumplimiento restricciones época de descorche. - Descenso de la rentabilidad de los olivares, - Bajada precio corcho: alta competitividad en precios, - Edificaciones no permitidas.	- Sobreexplotación de pastos, - Contaminación por purines, - Abandono de la huerta tradicional con productos de alto valor.	- Turismo de pocos recursos, - Población local desea otro turismo: turismo más impactante. - Abandono progresivo de las artesanías tradicionales de mimbre (se pierden las técnicas)	-Incumplimiento restricciones, -Entrada de barcos industriales.
Oportunidades	- Ecoturismo, - Educación ambiental visitantes (para reducir el impacto) - Educación ambiental locales (recuperación y transmisión saberes tradicionales, reconducción sobrepastoreo), - Recuperación caprino: queso de alta calidad, - Recuperación artesanías	- Recuperación técnicas descorche tradicional (búsqueda de calidad frente a competitividad en precio), - Aceite de oliva ecológico, - Ecoturismo y educación ambiental. Turismo cultural asociado a explotación tradicional del corcho.	- Recuperación de la huerta - Control de purines, y etiqueta de calidad para las explotaciones de porcino, - Ecoturismo y turismo cultural, asociado a venta de hortalizas, embutidos, y artesanías locales).	- Recuperación artesanía del mimbre. - Turismo de calidad: no sólo de playa sino asociado también a zona interior del parque natural. - Creación Balneario - Recuperación de fiestas tradicionales asociadas a la mar.	- Pesca tradicional, - Ecoturismo.

Annex 10:

Name of the Technique/Tool: Multilems or sets of phrases

What is it? It is a way of grouping the phrases to prepare the return, placing them along axes, highlighting those phrases that are more representative, some that seem clearer and more graphic, regardless of which value considerations are more or less recurrent.

What is it for? The methodological objective of these tetra, penta or multilemas is that around each set of different opinions or positions (not only the extreme or the majority ones), people value the reflected positions, reconsider them, deepen them or complete them.

How to use it? At first, the set of selected expressions should be presented for people to complete if something is missing. Subsequently, they are asked to express in a single sentence the answer to the question that generated the multilema.

Annex 11:

Name of the Technique/Tool: Criteria Building Workshop

What is it? It is a technique that aims to offer an alternative to the prioritization of proposals.

What is it for? It is used to facilitate the prioritization and discussion of heterogeneous proposals.

How to use it? This workshop is designed for the participation of all the actors involved in the process of co-creation of the PSBN menu or those interested in participating in it. It starts by explaining the meaning, the objective and the product we hope to obtain. We will insist that it is a technique to make operational the positive horizon that we seek through the PSBN menu, and that for this, the process and product will focus on the construction of criteria. The workshop is divided into two stages in which we will work, first, in subgroups, to end in a plenary sharing. It will last between two and two and a half hours. Emphasis is placed on issues such as: the criteria must be operational, different criteria must appear, and the criteria must be presented both positively (what the criteria should have or meet) and negatively (what they should not have or meet). After the presentations of the results of each group, and verifying that these definitive results are applicable, a debate is promoted to reach a consensual agreement on the following: a. The definitive characteristics of the common criteria to be adopted. b. The total number of criteria to be established. c. A nominal evaluation that will later allow to assess compliance and prioritize the proposals. Conclusions: the workshop will be closed by indicating the number of criteria achieved, what aspects they cover, what they consist of, among others. Likewise, it will be emphasized that with this, concrete guidelines have been obtained to build (and, to the extent that they are weighted, to evaluate) future proposals.

Annex 12:

Name of Technique/Tool: Weighted Voting or Method European Awareness Scenario Workshop (EASW)

What is it? This technique is derived from the EASW (European Awareness Scenario Workshop) method; however, in this technique it is not a matter of scoring each element but of distributing a certain number of points to be awarded to each participant among the different options to be prioritized.

What is it for? To prioritize some elements over others.

How to use it? The technique is simple: a number X of points (tokens, seeds, stickers,...) are distributed among the participants to be distributed among the proposals presented. When we have proposals elaborated by different groups, it is usual to prevent voting on the group's

own proposals. The points accumulated for each proposal are counted and a list of prioritized proposals is drawn up. In closing, emphasis is placed on the most voted criteria and the extent to which they can be articulated and constitute the most comprehensive action possible.

Anexo 13:

Name of the Technique/Tool: Flow Chart

What is it? This is another relevant technique in the framework of the feedback workshops, especially to order, relate and, thus, prioritize the problems that emerged during the participatory diagnosis stage.

What is it for? Seeks to identify cause-effect relationships, either by starting from the selected phrases or by directly formulating the elements that the participants consider to be influencing a central theme on which they are going to work. It also helps to distribute the problems according to the different responsibilities for their solution.

How to use it? It consists of collectively drawing up a graph visualizing the cause-effect relationships between the various elements related to the topic under discussion, in order to establish the "critical knots", the main factors that need to be addressed.

Anexo 14:

Name of the Technique/Tool: Programmatic Matrix

Positions - Proposals	Aspects (can be 9 issues						
	What to do	Why	When	Where	With what	With who	Etc.
A							
B							
C							
D							

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