Title

Building communities of Health: The experience of European Social Clinics

Authors

Delia Da Mosto[1], Sara Vallerani[2], George Kokkinidis[3], Marco Checchi[4], Silvia Giaimo[1,5], Elisa Adami[1], Leonardo Mammana[1,5]

[1] Association Centre for International and Intercultural Health APS
[2] Roma Tre University
[3] University of Essex
[4] Northumbria University
[5] Centre for Research and Studies in International and Intercultural Health, University of Bologna

Corresponding author: deliadamosto@gmail.com

Abstract

Social clinics are grassroots health initiatives characterized by the development of mutualist practices of healthcare provision and the articulation of their action at territorial and community level. The present paper explores the development and implementation of community participation practices across three social clinics in Europe: social clinic of solidarity KIA in Greece, Village2Santé in France, and Microclinica Fatih in Italy. Drawing on findings collected through qualitative methods, our paper reflects on three overlapping themes of community participation highlighting its collective and eminently political character. Inspired by the frameworks of health promotion, comprehensive Primary Health Care and community development, we analyze three levels of community participation in the social clinics: participatory medical practices, the co-creation of health services, and the connection with broader social movements. Our paper contributes to the literature on community development by stressing the urge to reimagine the principles and practices of community participation through the creation of alternative forms of organizing and of radical empowerment. At the same time, it can inspire practitioners in experimenting with community participation initiatives from a more critical perspective, resisting the worst elements of neoliberalism.

Main Text

Introduction

As neoliberal policies induce the mass privatization of healthcare and commodification of health, while co-opting and depoliticizing community development and participatory practices (Gaynor, 2011; Lathouras *et al.*, 2021), a wave of grassroots initiatives guided by principles of social justice and equity, are attempting to reorient community participation and its development to its former collective and politicized dimension. In doing so, we examine the intersections between different community participation practices which are carried out by three social clinics in Europe and community development.

According to Breilh's (2021) theory of the 'Social Determination of Health', the distribution of health and disease reflect the impact of complex-multidimensional processes which organize society such as the forms of political economy, the organization of production and reproduction, and the accumulation of capital (Harvey *et. al*, 2022). Together with other phenomena (i.e. patriarchy, ableism, racism) these processes determine an unequal distribution of resources and power (Crenshaw, 1989), creating interlocking systems of oppression which produce and sustain inequalities, whilst marginalizing individuals (Collins, 2019). These frameworks emphasize how health promotion - a framework developed during the First International Conference on Health Promotion in Ottawa, in 1986 - cannot be limited to the health sector, but consists in a series of joint actions that could empower people to have greater control over the processes which determine their health (WHO, 2009). Similarly, community development has the objective of strengthening civil society in order to "enable people to organize and take action on the decisions and policies which affect their life" (Budapest Declaration, 2004, p.424). In this perspective,

both approaches are not limited to the actions of institutional actors, but recognize the central role of civil society and grassroots initiatives, such as the experiences of social health movements for access to public and universal healthcare, and mutualistic experiences of healthcare delivery (Brown and Zavestoski, 2004).

Another intersection between the two frameworks is the comprehensive Primary Health Care (PHC) model, developed in 1978 during the conference of Alma Ata (WHO, 1978). This healthcare approach is based on a social understanding of health, and promotes the development of channels between the health sector and broader social, political, economic and physical environmental components (WHO, 1978; WHO & UNICEF, 2022). Moreover, PHC model suggests the reorientation of health services through a wide range of strategies that can be implemented by different actors (individuals, communities, health professionals, health service institutions and governments) in order to lead to a change in the approaches and organization of health services by refocusing on the health promotion of individuals and communities. These include the development of policies and practices based on community participation that are operating at a *micro* (the healthcare professional-patient relationship), *meso* (the organization of the health service) and *macro* (the political environment) level. An example is the experimentation of co-production methodologies, both in healthcare provision and healthcare organization, which can be done by promoting the active role of the individual or group with similar issues, and redefining the power relations between the individual and the medical personnel.

Looking at the relationship between social organization and the distribution of health, we can discern how neoliberal policies have further increased social and economic inequalities that have both a direct and indirect impact on people's health. The unequal distribution of resources and the marginalization of deprived and oppressed communities is a result of the progressive corporatization and marketization of health and welfare services, favoring the definancing of healthcare and its exclusionary policies, whilst undermining the implementation of the community development and health promotion approaches advanced at the Alma Ata and Ottawa conferences.

Indeed, although in the past few years we have witnessed the incrementation of community participation initiatives (Palmer, 2020), many of these have raised criticisms and controversies. As participatory practices are being increasingly institutionalized in public governance, the process of depoliticization is affecting both the procedures and the outcomes of participation, resulting in the removal of the conflictual aspects of decision-making and the sidelining of power asymmetries (Esposto and Moini, 2020). In this perspective, participation initiatives which are not based on community control can be manipulative, passive and utilitarian (Wallerstein *et al.*, 2011) transforming them in a way in which governments shift the responsibility of solving problems of social injustice to communities (Popay *et al.* 2021), or limiting the engagement of community members as no more than informants (Wallerstein *et al.*, 2011). These same contradictions have been seen in the Community Development initiatives which remained enmeshed within dominant power structures, that instead of developing strategies which have the

objective of redistributing power and resources, consist in a series of actions that reflect the specific policies set by the dominant agents (Carpenter and Raj, 2012; Petersen, 1994).

Despite the expansion of these depoliticization dynamics, neoliberal policies are continuously contested by numerous grassroots organizations that propose mutualist and community participatory initiatives based on the contrast of social injustice and a critical and outward gaze at the processes of depoliticizing participation. Among them are social and cooperative clinics, grassroots initiatives, connected by the development of mutualist practices of healthcare provision and the broader social action in the neighborhoods in which they operate (Basson *et al.*, 2021; Cabot, 2016; Kokkinidis and Checchi, 2023). These clinics share the same governing structures (cooperative and democratic management), organizational principles (horizontal structures, inclusive decision-making processes, egalitarianism) and political aspirations (health as commons and developing communities of care). Indeed, although these clinics operate in different localities, and respond to context-specific challenges, they all represent buffering systems to the exclusionary health policies and the progressive erosion of the public service.

In the light of this, the aim of this paper is to discuss the ways in which these realities embody community development and participatory practices from a more radical tradition. In the sections that follow, we first describe our methodological approach, and then turn our attention to the community participation practices across three social clinics in Europe. Our data analysis turns around three overlapping themes of community participation, focusing on participatory medical practices, the process of co-creation, and the convergence of struggles. Doing so, helps us to reflect on the different levels of community participation, and to emphasize the eminently political dimension of community participation and development.

Methodology

This article's fieldwork focuses on the community participation initiatives at 3 Social Clinics as they are illustrative examples of micro, meso and macro-level of participation: Social Clinic of Solidarity (KIA) in Greece, Village2Santé in France and Microclinica Fatih in Italy, all members of the newly established European Network of Social Clinics that has 7 core members (social clinics) from 4 different countries (France, Germany, Greece and Italy) and a research team that consists of the authors of this paper.

Being academics and activists, demands a more reflective approach in terms of how we perform our identities and switch roles, and a recognition of the challenges associated with the ways in which we connect with wider political subjectivities and interact within and across different organizational spaces that we study and participate in (Chatterton, Hodkinson, and Pickerill, 2010; Daskalaki and Kokkinidis, 2017). As activists we have contributed to the creation of the European Network of Social Clinics and we have been involved in the organization of a range of networking initiatives, meetings and events (during which community participation initiatives have emerged as one of the main topics), helping to develop an infrastructure for knowledge sharing and support, as well as setting the agenda for future actions.

As researchers, we have used a range of qualitative methodologies from participant observations diaries to semi-structured interviews and from informal group discussions to documentation and photography. Specifically, we have conducted 16 interviews and 4 group discussions with members of the clinics that lasted between 1 to 2.5 hours and were recorded with the consent of our participants. During these interviews and group discussions we covered a range of themes and although the specific questions were designed solely by us (as researchers), the general themes were co-created with our participants in a collaborative process based on their needs. These themes covered a range of issues including (but not limited to) their mode of governance and organizational practices, where questions about the character and principles of their initiatives were raised as well as questions about their decision making processes, organizational culture and structure. We also investigated their perception on the relationship between doctors and medical practices, their community development initiatives and connection to the wider ecosystem and social struggles as well as a more general discussion around health care, such as the different national systems and the idea of health commons. Our data set also includes our individual observations during our 40 days fieldwork at the clinics and have been collated into a reflective diary (approx. 104 pages).

Our data analysis process had two main reiterated stages. In the first stage, we did a free coding of the transcripts from the recorded interviews and group discussions where a range of themes, not all related to the purpose of this paper, were identified. In the second stage, we identified themes from the transcripts and our reflective diaries that were more attuned to the issue of community participation initiatives which contribute to community development. We found this process particularly useful for revisiting our experience and initiating a reflective dialogue among the authors around the overarching subject of our research that consists in the development of communities of care through radical experimentation. The outcome of this process was the emergence of three overlapping themes that constitute the focus of this paper, community participation/development through: participatory medical practices, co-creation, and convergence of struggles.

Analysis of Findings

In the following sections we focus our discussion on ongoing processes of building health communities through a range of initiatives that involve the active participation of community members. The analysis includes participatory medical practices (KIA), the co-creation of services (Village2Santé) and the active engagement with the wider ecosystem and social struggles (Microclinica Fatih) that constitute complementary trajectories for experimenting with community participation across social clinics with a clear politically committed and morally engaged stance.

Community engagement through participatory medical practices

In this section, we focus on the case of KIA, reflecting on their distinctive discursive practices and experimentation with more inclusive and egalitarian medical processes to illustrate their community engagement initiatives through participatory medical practices. We look at how a

social clinic is evolving from a healthcare initiative to a health community driven by social experimentation that is questioning the traditional hierarchical structure of the medical apparatus.

One of the practices to create an inclusive and participatory healthcare space is the adoption of the word ‘incomers’ to indicate an equitable and horizontal relationship between anybody entering the clinic, irrespective of their role, purpose of visit or affiliation (i.e. being a doctor, patient, visitor, researcher, activist). Becoming an ‘incomer’ is crucial for creating and strengthening a strong sense of shared identity that instigates relationships of mutuality towards the collective development of a health community. As Kokkinidis and Checchi (2023) have more extensively articulated in their work, at a discursive level, the use of the term ‘incomers’ further brings forth the plasticity of a co-created egalitarian space, where boundaries between different medical professionals as well as between the expertise of a medical professional and the passivity of the patient are altered. In this perspective, the simple use of this vocabulary permits the deconstruction of power relations deriving from conventional (material and discursive) medical and organizational practices, driven by the hierarchical relations subscribed to different roles and expertise, and the passivity often associated with the notion of been a ‘patient’ or the transactional relations associated with having a ‘client’.

Drawing on our findings, we noticed that engaging the wider community of medical professionals and patients under the banner of ‘incomers’ and attempting to create an egalitarian environment is far from easy. This was particularly evident during the designing and implementation of alternative modes of organizing, from participation in the decision-making processes to strengthening cooperation and collaboration between doctor-incomers or between doctor-incomers and patient-incomers. An interesting story on this matter was shared by a psychotherapist at KIA about the first meetings during the Diabetes group session:

> “When we first ran the diabetes sessions, our idea and intention was to go there not as doctors or patients, but as incomers who are interested to participate in these sessions and share our experiences. Without the power that is associated with our professional identities. One of the things however that I found interesting was how people navigated in the space, and it was very visible during the first session that people were grouping in accordance to their professional identity and affiliation. This changed over time" (KIA Psychotherapist)

Despite KIA’s rejection of this model, tensions between their intention to build a health community that is guided by participatory practices and egalitarian relationships vs the traditional hierarchical models of healthcare remain apparent. This, in turn, requires strong commitment and a collective effort by all incomers in building structures and processes that can effectively resist ongoing hierarchical tendencies. For example, the doctor who defies cooperation or the patient-incomer who remains passive and is reluctant to engage provide some interesting insights on the persistence of hierarchy that characterizes medical practices but at the same time it nicely illustrates the messiness of mundane practices, “particularly cogent for alternative organizations that experimentally engage with novel reconfigurings of power” (Kokkinidis and Checchi, 2023, p.297). Boundaries were then disrupted when people disengaged from traditionally ascribed roles (being doctors or being patients) when new initiatives challenged the meaning of being a caretaker or a caregiver, or when cooperative processes

opened up new possibilities in professional and personal relationships as well as the interaction with material objects (e.g. the sharing of dental tools). Indeed, these events lead to a re-evaluation of medical approaches and a questioning of common-sense and hegemonic assumptions associated with their professional identities.

Looking more closely at some of their initiatives designed to provide a more holistic approach to medical care, we witness how new ways of 'knowing' about healthcare were gradually produced, boundaries altered, assumed identities questioned and relationships problematized. Our participants emphasized the idea of building a health community, as a mean and as an end,

> "...finding different ways to operate the social clinic. To involve everyone in all our processes irrespective of whether they are health professionals or not. We need to put the community at the heart of everything we do." (KIA General Practitioner)

This is evident in a range of everyday practices and experimental medical initiatives that aimed at strengthening incomers' participation and involvement irrespective of role or expertise. An example of these are the diabetes group sessions to the integrative medicine initiatives, the inclusive and non-hierarchical design of these processes and relationships between all 'incomers', gradually cultivated a strong sense of community that encouraged more cooperation in terms of sharing personal experiences and co-creating knowledge that "had unanticipated effects for all [incomers], prompting them to invent new ways of connecting with each other, encouraging doctors to reflect more critically on the conventional practices of their specialization and patients to reflect more on their own experiences living with a health condition and become more active/enabled/empowered in dealing with it" (Kokkinidis and Checchi, 2023, p.299). Indicative was a reflection of a member of KIA on the transformative impact of these initiatives and for building community ties that are based on more egalitarian relationships,

> "KIA Pharmacy Operator: In the diabetes sessions, we did not distinguish between doctors and patients. Some had degrees and specialized knowledge, but the idea was that the initiative will consist of a support team and the processes would be collectively agreed so that everyone involved will have an equal role. Who was the 'healer' in that context?
>
> Researcher: Are you implying that you were all patients and healers at the same time?
>
> KIA Pharmacy Operator: Exactly….they both change in terms of how they perceive themselves and their role in all that."

These practices share a degree of intentionality in terms of creating the possibilities for more collaborative relations and building a health community, yet other participatory initiatives, such as the cooperative dentistry, were far from intentional and had gradually emerged through a process of contestation and deliberation. Reflecting on the cooperative dentistry initiative, members of KIA emphasized how the material realities of offering dental support in the context of a social clinic opened up unanticipated possibilities. Dentistry, one of our participants explained, is a very individualistic medical profession,

> "our education, the training we receive, our private practice, all cultivates an individualistic culture…sometimes you feel you are like an 'artist' and your patient is your 'canvas'." (KIA Dentist)

Thus, working cooperatively at a setting of a social clinic created a range of tensions as their implicit sense of 'ownership' and 'control' over patients was challenged. Everyday practices such as the collective use and sterilization of equipment, choices about what products to be used or what procedures to be followed, were all contested matters that required ongoing negotiation and collective agreement. As mentioned earlier, this process was far from smooth and as two dentists had on several occasions reiterated, the cooperative dentistry initiative at KIA was at first received with strong skepticism by most of the dentists:

> "You normally work alone or with your assistant but here [KIA] you had to work with other 50 dentists. We managed to cooperate well, but this is not something easy, it is actually very difficult because you begin a treatment and somebody else would finish it. I mean you start working on a patient and then you finish the session but the next time they visit they will continue with another dentist; and they must continue from where you stopped." (KIA Dentist)

The deconstruction of power relations, whether intentional or not, was not without tensions in the initiatives discussed in this paper. Yet, the cooperativization of dentistry, a medical practice which is otherwise hyper specialized, individualistic and hierarchical, offers further insights into our understanding of community engagement and community development through participatory practices that are shaped within a context of tensions, temporal contestations and ongoing deliberation.

In this section we have tried to further progress our analysis by looking at community engagement through participatory medical practices. Our intention was to illustrate the process of community engagement through the active participation of the users in the organization and management of the medical practices. In the following two sections of our analysis, we will focus more explicitly on the process of co-creating healthcare services and initiatives that aim at engaging with the wider ecosystem that social clinics operate in.

Community engagement through co-creation

The case of Village2santé, presents a trajectory of cooperation between various stakeholders (medical and social workers and community members) that starts with the co-creation of health provision and develops through a number of initiatives that reinforce and sustain an ongoing process of community engagement. This emerges through a participatory process where community members were directly involved in the co-creation and the development of services which were then implemented in the social clinic. The purpose of this process was to tailor the services, and subsequently the activities of the clinic, to better address the specific needs of the local community. At the outset of the process, a needs analysis was carried out by healthcare professionals working with community members to map existing provisions and develop a health center to address local needs. This participatory research process involved a range of engagement methods: interviews, focus groups and public meetings with the residents of Echirolles Village.

This allowed the members of the clinic to simultaneously collect valuable information related to the needs and lived experiences of the local community as well as to build and strengthen their relationship with local residents. A process that was also valued by community members as we can see in the following testimony taken from a film realized by Village2Santé:

> "...we thought it was great that you came to meet us and asked us what we would like to have as a doctor in the neighborhood, that you were interested in our requests, rather than just showing up with everything already decided. That was a good thing." (Village2Santé Resident)

What is more, this process of involving community members in the co-designing of services is not a one-off exercise but a well-established and continuous process of collaboration resulting in the reformulation of practices and activities. This reflects a dynamic understanding of community as an open and ever-changing entity and so are its needs.

One of the initiatives is 'Le place du Village', a monthly meeting between community members and workers of the clinic to review the activities of the health center as well as to make suggestions and put forward action plans for addressing emerging community needs. These meetings are also animated by community peer mediators, which are also implicated in outreach activities and in the co-design of specific health interventions. Within this context, the idea of community participation takes a very different form, fostering greater inclusion and direct engagement from community members as well as ongoing opportunities to co-create the very process and practices that could address their localized health-related needs. Reflecting on their core approach to community-based healthcare (*Santé Communautaire*), one of our participants explained that the idea is to create processes where,

> "...patients have real power and a say in how they are treated. It is about creating spaces where they can do stuff with us, organize themselves, and also do healthcare differently." (Village2Santé Social Worker)

As mentioned by Village2Santé members, these community-based health practices aim to question the instrumental and depoliticized understanding of participation in healthcare that has been abused by institutions and to bring forth its collective and political dimension.

Furthermore, through these initiatives of participation and mapping of community needs, a range of processes emerged, some of which extended beyond medical practices. Strong emphasis is placed in finding new ways to strengthen the communal character of the clinic through reconfiguring the relationships between workers and residents. In order to face the absence of places and opportunities for socialization in the neighborhood, the Village2santé promoted two different initiatives aimed to facilitate community socialization. The first one is the 'Cafe du mardi', a weekly meeting to promote more informal interactions, knowledge sharing and relation building between members of the clinic and the wider neighborhood. The second is the 'Café accueil', a physical space designed to provide a welcoming area in Village2santé for people who are waiting for their appointment but it is also used as an open meeting space for people of the wider local community to socialize.

This idea of creating welcoming and inclusive spaces was a recurrent theme in our findings across all the clinics of the network. In the case of Village2santé our participants had explicitly reflected on the designing of the physical space as a medium for community engagement: on the outside is a green open area with benches and seats, on the inside a bright colored room with tea, coffee and books. The cafe is managed by three employees who are also assigned with several tasks from acting as socio-medical coordinators, collaborate with other professionals in setting the agenda and coordinating activities as well as helping to build interpersonal relationships between residents and with workers to ensure that community members feel welcomed. This is in line with our observations in other settings such as KIA, where the organization and layout of space has been central in developing non-hierarchical relations and participatory practices that are blurring the apparatuses and exclusionary boundaries of the traditional clinic (Kokkinidis and Checchi, 2023).

Community engagement through the convergence of social struggles

Following from the discussion around participatory medical practices and co-creation of community health services, this final section focuses on how social clinics can develop political actions which go beyond the health sector, addressing a broader set of social issues. In order to analyze these aspects, we present some of the practices which are carried out by Microclinica Fatih. We specifically concentrate on the community engagement practices and collective processes that are articulated outside the clinic's walls and in collaboration with other social actors. Although Microclinica Fatih primarily focuses on medical activities, the clinic's objectives are the construction of participatory and revindication processes, which, starting from the right to health, can extend towards a broader perspective of social struggles. Microclinica Fatih's conception of health is eminently political, and adopts a social justice perspective. As a member of the clinic says:

> "Health is a political matter. Too often, when you are in the health field, this aspect is consumed by technicalities, bureaucracy or something else...instead it is a political matter and also a matter of social justice" (Microclinica Fatih Psychiatrist)

This critical and holistic approach to health is also reflected in the name of the clinic. The term 'Microclinica' refers to the practices of resistance and community life of inspired by the Zapatista communities in Chiapas, where the microclinics are part of the autonomous health system of the 'Caracol' (the municipalities) and are open and inclusive spaces of welcome and care for all (Warfield, 2014). 'Fatih', on the other hand, was a 38-year-old adult who died after being denied medical assistance at the detention center of Turin. This reveals both the tension of wanting to build community health practices in response to the exclusionary mechanisms of the health system and the connection with an anti-racist perspective and struggles.

The construction of intersections with different social struggles, particularly housing ones, is central to the activities of the clinic and the associated self-managed center from the start. Indeed, the clinic is located within a community and self-managed center called 'CSOA Gabrio',

located in the historically working-class neighborhood of San Paolo, in Turin. As a member of the Clinic stressed,

> “2009/2010 was a time when there were many housing occupations in the city of Turin. In particular, there was a large housing occupation in Corso Peschiera in which Gabrio was also involved. After a short time, numerous health problems began to emerge among the occupants of the housing occupation, as the place was not warmed up and was unhealthy. The occupants were mostly asylum seekers but abandoned from a medical point of view [...], and it was in this context that the idea of setting up a clinic in the social center was born. [...] The origin of the clinic was in response to two exigencies: to follow up and treat people who could not access services and who could not afford medicine and to build a plan to demand and claim rights for these people and everyone.” (Microclinica Fatih Emergency doctor)

Carrying out the activities within a community center not only permits an action on other social struggles but it also facilitates connections with other experiences which take place within and across the space of the clinic. In the room next to the clinic is the self-managed legal clinic, where free legal assistance is provided, and anti-racist and anti-detention center initiatives are organized. Similarly, during the pandemic, the Microclinica Fatih worked in synergy with the 'SOS spesa' solidarity group, which was formed during the lockdown to support people and families in the neighborhood through food distribution. In a pamphlet the 'SOS spesa' solidarity group, stated:

> “We organized ourselves while the municipality was looking away. We found a way to resist together, demonstrating that outside capitalist logic, it is possible to create an inclusive and mestizo community that takes care of everyone and can express proposals for mutual aid and struggle together. [...] The SOS Spesa solidarity group was formed during the lockdown months to organize a network of neighborhood solidarity to resist this crisis together and leave no one behind.” (SOS spesa pamphlet)

Another example of the construction of participatory practices "within and beyond" the Microclinica Fatih, concerns the collaboration with an experience based in the self-managed center CSOA Gabrio born this year following a co-construction process: the "Consultoria FAM", a self-managed initiative aiming to provide counseling for sexual and gynecological health promoted by the transfeminist group 'Non una di Meno', the 'Sei Trans?' collective and Microclinic Fatih itself. The Consultoria organizes gynecological consultations, mutual aid, and self-exploration groups and implements practices of proximity and participation alongside political and public initiatives for women, trans and non-binary people assigned female at birth. The Microclinic and the Consultoria meet periodically in shared assemblies, and many incomers address both the Microclinic Fatih and the Consultoria. Outreach community engagement initiatives are regularly organized with a recent example being a public festival open to the neighborhood, organized jointly by the Consultoria FAM and the Microclinica Fatih, focusing on topics related to the community engagement perspective: ‘Health as a community wellbeing’;

‘Health as a collective struggle against inequalities’; ‘Art as a cure’; ‘Let's re-appropriate our bodies’. The activities include theoretical and practical workshops concerning the relationship between health and nutrition, mutual aid groups for those who share illnesses that are difficult to diagnose, bringing related social, economic and relational difficulties, workshops designed with the women who pass through the Microclinica Fatih to define their health and social needs, and finally, a public and communicative walk in the neighborhood.

Initiatives such as that of the aforementioned festival aim to address a range of objectives from: strengthening the engagement with the local neighborhood, to raise community members’ awareness of the impact of different social aspects on health; and, map community resources required to address inequalities and to tackle social exclusion and marginalization. In this case, the practices of the Microclinic intersect with those of the broader transfeminist social movement that carries out various struggles and public campaigns against the restriction of the right to abortion, obstetrical violence and medical gaslighting (Quéré, 2019).

Alongside the initiatives targeting the wider ecosystem of the social clinic, the Microclinica Fatih has built other strategies for participation and engagement. For example, social dinners for self-funding are organized collectively, together with some of the incomers and neighborhood residents.

The participation and shared construction of this vast range of initiatives help to focus more clearly on how the investment in the construction of community engagement processes does not only concern medical practices but the issue of health as a whole. The common thread of these community processes is the construction of a (re)taking of voice on health, both individual in medical consultations and collective in public and shared initiatives.

Discussion

At first glance, community participation represents a red thread that emerges from the declaration to Alma Ata (1978) and seemingly survives throughout decades of neoliberalism to arrive at contemporary approaches to healthcare provision from a participatory perspective. Interestingly, participation and the more general reference to communities are celebrated as the contemporary zeitgeist in healthcare (Palmer, 2020; Weavell *et al.*, 2019). But is this contemporary celebration of participation a radical implementation of the principles and values expressed by the declaration of Alma Ata? Or is it a form of co-optation where the original meaning of participation is twisted in a guise that serves the opposite of its original goal? As Rifkin (2009, p.1) puts it, “[community participation reflects] the underlying value of social justice, confirming the view that all people have the right to be involved in decisions that affect their lives”. Yet, in contemporary discourses on community participation in healthcare especially at the level of public policy and planning, social justice seems either sidelined or reproposed in an extremely diluted version which is little more than a pale copy of what its potential might imply. Popay *et al.* (2021) rightly notes how discourse on participation have progressively been depoliticized, privileging a focus on the psycho-social characteristics of communities that

ultimately ignores the wider social and economic circumstances that determine inequalities. Despite the growing evidence on the benefits of community empowerment, Popay *et al.* (2021, p.1259) remark that: "paradoxically as the role of governments shrink and inequalities widen, this outward gaze is neglected in many contemporary community initiatives".

As expressed in the introduction, we argue that this is not a paradox but a direct consequence of a wider neoliberal strategy of depoliticization that attempts to reduce all social and economic dynamics to the natural effects of the market whilst increasing inequalities. This was one of the starting points that oriented the research towards social clinics, namely social realities that deploy community and participatory practices with the explicit intention of repoliticizing them. Indeed, the three case studies we present in our paper represent the attempt to target political inequality with a radical antagonistic stance. Within this eminently political tension towards social justice, the provision of healthcare becomes one of the many interconnected sites of struggle towards a radical emancipatory horizon. In our research, we explored how clinics with an explicit militant and political outlook address the idea of community participation in healthcare and promote community health. Throughout our discussion, we tried to identify the distinctive approach of social clinics in designing and implementing participatory practices. The participatory zeitgeist seems to reproduce an instrumental conceptualization of community participation where participation is more effective either in terms of health benefits or in terms of costs (and savings) for the wider healthcare system. Even in the most progressive version, participation seems to be subordinated to effective health provision. For social clinics instead, community participation seems to be subordinated to a wider radical political orientation: social justice comes first and even healthcare provision needs to reflect the founding values of equality, self-determination and solidarity that framed the PHC and health promotion frameworks. These healthcare initiatives are therefore embedded in a wider tradition of social and political movements that emerges either in the personal histories of the activists that run the clinics or directly in the spaces where these clinics operate (as in the case of Microclinica Fatih). In these social clinics, we see community participation through the prism of the primacy of resistance (Checchi, 2021), antagonistic practices that create alternative forms of organizing and of radical empowerment. In particular, our three case studies offer different and, to some extent, complementary trajectories for experimenting with community participation from this radical stance of resistance.

Village2Santé shows the efforts of co-constructing a clinic through the active involvement of the neighborhood. Rather than an external intervention on a target group (Rifkin 2009), the foundation of the Village2Santé offers an interesting repertoire of practices where the community emerges through an active and meaningful attempt of involving the inhabitants of the neighborhood in the planning of the health center. The community is co-created through an encounter that generates trust, alliances and social bonds. As such, rather than a one-off intervention, community participation becomes an ongoing process that passes through moments of informality and everyday practices.

The case of KIA, offers interesting perspectives on how these ongoing processes of community participation and radical empowerment can be experimentally extended to medical practices,

challenging traditional power relations at stake between doctors and patients. This is evident especially in relation to how expert knowledge is reoriented in a more horizontal way directly influencing the orientation of the healthcare service. Experimenting with the idea of incomers as a linguistic attempt to eliminate the divide between medical personnel and patients is also another example of not only co-creating a community, but developing it in terms of radical equality and solidarity. If the creation of a (health) community is an ongoing process, it is in its everyday practices that we find experimental attempts to exert power differently in a more horizontal way through forms of radical empowerment that aim to neutralize or explicitly target the persistence of traditional power relations. Yet, these forms of empowerment and radical experimentation with alternative forms of exerting power have to be conceived in direct continuity or as a direct consequence of an explicit resistant stance based on social justice. This is what distinguishes social clinics from other examples of community participation in healthcare.

The example of Microclinica Fatih is a good illustration of this point. It is already from the choice of the name that this history of resistance and this horizon of struggle emerges. The reference to the Zapatista movement displays a radical political stance, an alternative model of organizing and a direct opposition to any form of hierarchy and exclusion. This stance is not only limited to the way they understand health and healthcare provision, but it is radically embedded in an encompassing political view. As the clinic operates within a social center, the political link with other struggles makes the reference to social determinants of health a material concern of struggle, rather than a mere theoretical reflection, expanding its actions towards the same processes that Breilh (2021) recognizes as the cause of the unequal distribution of health and disease.

Conclusion

Social clinics offer some critical perspectives that tackle well known issues in community participation in healthcare. Community participation here is not an instrument, but a necessary political principle dictated by an explicit political understanding of healthcare and, even more importantly, a more general radical stance of resistance against inequality. These practices of resistance need to be understood in their ongoingness and in the context of antagonistic struggles, where neoliberal societies progressively attempt to erode social infrastructures and widen inequality (Harvey *et al.*, 2022; Collins, 2019). This terrain of confrontation is explicitly assumed also as the antagonistic context that makes community participation problematic. We deliberately chose to observe the practices of these social clinics and to present them as experimental without attempting to measure their efficacy or their outcomes. It is the same inequalities that their practices aim to address that constitute the barriers to their success: unemployment, precarity, evictions and poverty are the biggest challenges to community participation. Yet, an explicitly political stance has the advantage to clearly identify what determines social and economic inequalities, while imagining a radical horizon of emancipation.

References

Basson, J-C., Haschar-Noé, N., Lang, T., Maguin, F., Boulaghaf, L. (2021) Recherche interventionnelle en santé des populations et lutte contre les inégalités sociales de santé : les partenariats « en train de se faire » de la Case de Santé de Toulouse, France. *Global Health Promotion*, 28(1), 24-30.

Breilh, J. (2021) *Critical Epidemiology and the People's Health*. Oxford: Oxford University Press.

Brown, P., Zavestoski, S. (2004) Social movements in health: an introduction. *Sociology of Health & Illness*, 26(6), 679-694.

Cabot, H. (2016) 'Contagious' solidarity: reconfiguring care and citizenship in Greece's social clinics, *Social Anthropology*, 24(2), 152-166.

Carpenter, M., Raj, T. (2012) Editorial introduction: towards a paradigm shift from community care to community development in mental health, *Community Development Journal*, 47(4), 457–472.

Chatterton, P., Hodkinson, S., Pickerill, J. (2010) Beyond Scholar Activism: Making Strategic Interventions Inside and Outside the Neoliberal University, *ACME* 9, 245–75.

Checchi, M. (2021) *The primacy of resistance: power, opposition and becoming*. London: Bloomsbury Publishing.

Collins P. H. (2019) *Intersectionality as Critical Social Theory.* Durham: Duke University Press.

Crenshaw, K. (1989) Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics, *The University of Chicago Legal Forum*, 1, 139-167.

Daskalaki, M., Kokkinidis, G. (2017) Organizing Solidarity Initiatives: A Socio-spatial Conceptualization of Resistance, *Organization Studies*, 38(9), 1303-1325.

Esposto, E., Moini, G. (2020) Participatory Governance and Healthcare. Opportunities and Perils, in A. Battisti, M. Marceca and Iorio, S. (eds) *Urban Health*, *Green Energy and Technology*. Cham: Springer. 9-18.

Gaynor, N. (2011) In-Active citizenship and the depolitization of community development in Ireland, *Community Development Journal*, 46(1), 27-41.

Harvey, M., Piñones-Rivera, C., Holmes, S.M. (2022) Thinking with and Against the Social Determinants of Health: The Latin American Social Medicine (Collective Health) Critique from Jaime Breilh, *International Journal of Health Services*, 52(4), 433-441.

Kokkinidis G., Checchi, M. (2023) Power matters: Posthuman entanglements in a social solidarity clinic, *Organization*, 32(2), 288-306.

Lathouras, A., Westoby, P., Shevellar, L. (2021) Reimagining and radicalizing community development practice in south-east Queensland through popular education action research, *Community Development Journal*, 56(2), 283-299.

Palmer, V. J. (2020) The participatory zeitgeist in healthcare: it is time for a science of participation, *Journal of Participatory Medicine*, 12(1), e15101.

Petersen, A. (1994) Community development in health promotion: empowerment or regulation?, *Australian Journal of Public Health*, 18(2), 213-217.

Popay, J., Whitehead, M., Ponsford, R., Egan, M., Mead, R. (2021) Power, control, communities and health inequalities I: theories, concepts and analytical frameworks, *Health promotion international*, 36(5), 1253-1263.

Quéré, L. (2019) Intersectionality or unity? Attempts to address privilege in the gynecological self-help movement, in Evans, E and Lépinard, E. (eds) *Intersectionality in Feminist and Queer Movements*. London: Routledge, pp. 121-139.

Rifkin, S. B. (2009) Lessons from community participation in health programmes: a review of the post Alma-Ata experience, *International Health*, 1(1), 31-36.

The Budapest declaration: Building European civil society through community development (2004) *Community Development Journal*, *39*(4), 423–429.

Village2Santé, *Le diagnostique Communautaire*. Available at: https://owncloud.levillage2sante.fr/index.php/s/Xanj2O9DiNmR0nE (Accessed 29/11/2022)

Wallerstein, N., Rosilda, M., Minkler, M., Akerman, M. (2011) Reclaiming the social in community movements: perspectives from the USA and Brazil/South America: 25 years after Ottawa, *Health Promotion International*, 26 (2), 226–236.

Warfield, C. (2014) *Understanding Zapatista autonomy: An analysis of healthcare and education*, Doctoral dissertation, National University of Ireland.

Weavell, W., Palmer, V. J., Callander, R., Piper, D., Richard, L., Maher, L., Boyd, H., Herrman, H., Furler, J., Gunn, J., Iedema, R., Robert, G. (2019) The Participatory Zeitgeist: an explanatory theoretical model of change in an era of coproduction and codesign in healthcare improvement, *Medical humanities*, 45(3), 247-257.

WHO. (1978) *Declaration of Alma-Ata*. Available at: https://cdn.who.int/media/docs/default-source/documents/almaata-declaration-en.pdf?sfvrsn=7b3c2167_2 (Accessed 29/11/2022)

WHO. (2009) *Milestones in health promotion: statements from global conferences*. World Health Organization. Available at: https://apps.who.int/iris/handle/10665/70578 (Accessed 29/11/2022)

WHO, UNICEF. (2022) *Primary Health Care measurement framework and indicators: monitoring health systems through a Primary Health Care lens.* Available at: https://www.who.int/publications/i/item/9789240044210 (Accessed 29/11/2022)