

# Radically Good. Reformulating Healing and Care Practices in Times of Crisis

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Report on the international conference “Radical Health. Doing Medicine, Health Care, and Anthropology of the Good” organized by the Association for Anthropology and Medicine (AGEM), the Medical Anthropology Working Group (AGMA) of the German Anthropological Association (DGSKA), and the Institute of Social and Cultural Anthropology at Freie Universität Berlin, Online, June 24-27, 2021

Due to the safety measures imposed in response to the COVID-19 pandemic, about 130 anthropologists and other social scientists, medical professionals, health activists, and artists gathered virtually from June 24 to 27, 2021 to take part in an online conference organized by the Working Group Medical Anthropology of the German Anthropological Association (DGSKA) in collaboration with the Association for Anthropology and Medicine (AGEM) and the Institute of Social and Cultural Anthropology, Freie Universität Berlin. The conference was generously funded by the German Research Foundation (DFG). With the conference title “Radical Health: Doing Medicine, Health Care and Anthropology of the Good”, the conveners (Helmar Kurz (University of Münster), Claudia Lang, Caroline Meier zu Biesen (both at Leipzig University), Dominik Mattes, Nasima Selim (both at Freie Universität Berlin), and Ehler Voss (Siegen University)) asked the participants to explore how ‘healthy futures’ can be envisioned, theorized, and actually ‘done’ despite multiple constraints caused by proliferating neo-liberalization, augmenting socio-economic disparity, environmental degradation, and political struggles around identities and belonging. In other words, the conference revolved around questions of how and in what ways a (medical) “anthropology of the good” (Robbins 2013) can act in solidarity with radical notions and practices of medicine and healthcare that are oriented towards past and present issues as well as imagined futures.

The presenters were invited to reflect on how ordinary people, medical personnel, and activist groups respond to intimately entangled economic, ecological, social, cultural, and political challenges in order to achieve and shape novel forms of (health) care. Crucially, they were asked to engage with contemporary chronic crises as they affect people’s living environments, health, and healthcare provision and inform their capacities to conceive of (and realize) utopias of better futures. In line with the notion of the “anthropology of the good”, understood as a set of propositions and activist/academic advancements in light of previous anthropological research on suffering, the speakers presented and reflected on a wide range of practices of resistance and alternative care put in action by activists, artists and critical scientists to achieve health equity and fair medical treatment in an unequal globalized world. To discuss and represent these practices embedded within and beyond local and global healthcare systems and the academic world, the conference speakers referred to regionally and thematically diverse case studies from Asia (India, Indonesia, Iraq, South Korea, Syria), Africa (Sierra Leone,

Swaziland, Tanzania, Uganda), Europe (Austria, Finland, Germany, Italy, the Netherlands, Spain, UK), South America (Brazil, Chile, Colombia, Mexico, Venezuela), and North America (the US). The conference included a keynote address, seven thematic panels, one creative lab, two roundtable discussions, a World Café, and three documentary films. Endorsing the spirit of radical equality that informed the entire conference, the present conference report aims to critically summarize all of the manifold presentations as well as their research outcomes and political implications. In order to follow up on the applied and pragmatic guidelines set up by the conference organizers, we also decided to follow the original conference structure in laying out our report.

In her keynote address entitled “Good for what: radical health in the midst of an epidemic”, [Adia Benton](#) (Northwestern University) reflected on what constitutes 'the good' in the anthropology of health and medicine and on the potential of naming and unsettling 'the bad' in the practice of public health and medicine (and its anthropological critique). Benton outlined how, in the context of recent Ebola epidemics in West Africa, global health projects reinforce existing socio-economic inequalities between the Global North and South by extracting biological samples and knowledge of the disease without sharing these research results with local physicians and the population in Sierra Leone. Against this backdrop, Benton questioned the position of anthropology within this framework of inequality, emphasizing the ways in which the production of anthropological knowledge, in particular what she called the “politics of location”, ends up exacerbating divides between various world zones. Therefore, she argued that anthropology should position itself beyond simplistic notions such as ‘the good’ and ‘suffering’. Instead, Benton proposed a radical critique of the discipline and called for a serious reformation of anthropology in terms of thinking and reflecting more radically on its own colonial past and heteronormative attitude and perspectives. In Benton’s opinion, anthropologists and social scientists at large should address colonial, extractive, and paternalistic practices that are both (re)enacted by epidemiological and global health practices and reverberate in the anthropological critiques of these phenomena.

### *Challenging Infrastructures of Care*

The presenters of this three-partite panel focused on the frictions, interactions, conflicts, and new possibilities between various conceptions of care in the context of rampant social and biomedical inequalities prevailing in many parts of the world. [Thandeka Dlamini-Simelane](#) (University of Amsterdam) presented findings from her research on so-called expert clients in Swaziland. While these people were conceived as volunteers in support of the country’s HIV response, Dlamini-Simelane witnessed over the course of her fieldwork that their workload doubled with the massive expansion of HIV treatment. This caused a significant shift in the role the expert clients played in the country’s healthcare system and the responsibilities they took on. They were no longer mere counsellors but also tested people for HIV, had to disclose the test results, enrolled patients in HIV care, scheduled appointments and follow ups, tracked patients, managed side effects, dispensed and packaged drugs, and provided reports for medical professionals. Given these responsibilities, which were similar to those of paid nurses, Dlamini-Simelane challenged the notion of ‘voluntarism’ and urged anthropologists to reflect on

the intertwinements of ethical practices and neoliberal tendencies in the production of this specific category of individuals at the intersection of local health systems and global health processes.

Drawing on his research with healthcare workers in clinics established by the Kurdish Liberation Movement (KLM) in Northern Syria (Rojava) and in Shingal (Iraq), Benjamin Garabedian (Berlin), an activist-physician trained in Germany, described how the KLM, a non-state transnational network in the Kurdish regions of Mesopotamia, unraveled the traditional physician-nurse hierarchy by training its own medical workers independent of the state licensing system. Garabedian argued that this type of experimental healthcare model from below disrupts the traditional hierarchy between physicians and nurses and provides the local healthcare system with new medical personnel after many physicians had fled the area during the recent war.

Anna Dowrick (Queen Mary University of London) investigated the implementation of structural changes in the provision of 'good' healthcare in the context of domestic violence and abuse (DVA) in two urban areas of the UK. In her presentation, she focused on the delivery of the Identification and Referral to Improve Safety (IRIS) program that officially aims at restructuring the interaction between healthcare workers and specialist community services. However, as she demonstrated, the program brought rampant austerity measures, which led to new obstacles and challenges for healthcare workers and specialists dealing with DVA. Considering these mismatches, Dowrick outlined that 'workarounds'—informal and often undocumented practices which keep activities on track—help practitioners to overcome difficulties in dealing with DVA. By making sense of these practices, she highlighted their creativity and flexibility despite budget cuts and other barriers.

Daniela Krüger (Humboldt Universität Berlin) focused on frontline personnel working in an ambulance service and three different emergency departments in a German metropolis. Ethnographically examining care practices enacted by nurses, doctors, and paramedics, Krüger compared these with institutionalized care and formalized medical protocols. Using the concept of the 'social safety net', Krüger showed how these frontline workers provide multiple types of care in close adaptation to the different situations and actors encountered during their service.

On a similar note, Lauren Nippoldt (University of California, San Diego) explored informal care practices in Delhi based on the principles of the 'Seva', a practice of voluntary social work among members of the Sikh faith. She argued that 'Seva' care practices constitute an important alternative to the institutionalized forms of care provided by government clinics, hospitals, and non-governmental medical services because they are not impeded by organizational politics and funding concerns. Furthermore, Seva groups provide a type of necessary triage for both acute and chronic conditions, non-life-threatening wound care and common viral or bacterial infections. Most importantly, Nippoldt underlined that based on the Sikh ideology that guide and inform practitioners, all patients are treated as equals, regardless of caste, gender, ethnicity, and religious affiliation.

Ruth Kutalek and Maren Jeleff (both University of Vienna) analyzed the care practices of healthcare workers in Vienna, Austria, during the COVID-19 pandemic. More specifically, they examined how the new protective technologies, the stressful physical working conditions, the

demands to apply new Standard Operation Procedures and Infection Prevention and Control guidelines, the mental burden of working with severely sick patients, and the expectations and fears of the patients' and professionals' relatives affected patient care and influenced the everyday working experiences of the healthcare personnel. In addition, Kutalek and Jeleff explored how the new technologies interfered in the communication among patients, relatives, and health care workers and how vulnerable patients were protected with respect to the concepts of 'good care' and principles of medical ethics.

Keira Pratt-Boyden (University of Kent) shed light on the formation of networks of relatedness and economies of care between mental health activists and patients experiencing numerous forms of mental distress in London. Faced with growing economic crisis and the implementation of austerity measures hitting the country, Pratt-Boyden argued that these types of relatedness and alliances made out of care and affects constitute a viable way of questioning the relationship between patients and caregivers. She further demonstrated that mental illness and vulnerability are not only potential conditions for social disruption but can also be crucial for personal transformation and social re-generation.

Melina Rutishauser (University of Basel) studied various socio-material infrastructures that her research participants with diabetes and/or hypertension in the Kilombero Valley in Tanzania are constructing to counter socio-economic structural barriers to their health within the country's health insurance landscape. Inspired by scholarly contributions from Critical Medical Anthropology, Rutishauser argued that patients with chronic conditions build their own networks of social health protection—networks that are constantly being shaped and reshaped in order to adapt to new forms of 'doing' and imagining a 'healthy future'. On a different note, Nora Wuttke (University of London) examined the architectural infrastructures of Myanmar's biggest and most prestigious hospital, Yangon General Hospital. She stressed the symbolic multiplicity of configurations of the hospital (understood, for instance, as workplace, healing space, training ground and marketplace), as well as the various entanglements between human and non-human actors such as people, places, and services.

### *Suffering and Wellbeing in Regimes of Subordination*

In this panel, three researchers from different institutional backgrounds offered an interdisciplinary perspective on health, suffering, and wellbeing in various regimes of subordination. The first contributor, Tyenne Claudia Pollmann (Universität der Künste Berlin), drew on the artistic research project [visions4people](#), conducted by the Clinic for Psychiatry and Psychotherapy Charité Berlin Mitte in collaboration with the Weißensee Kunsthochschule in Berlin in order to question structural roles in psychiatric practice. In her presentation, Pollmann demonstrated the importance of interdisciplinary and collaborative approaches as a way of better capturing the different dimensions of health, suffering, and wellbeing, particularly in relation to psychiatric practices. Subsequently, speaking from an academic context and addressing academic activism, Julia Nina Baumann (Freie Universität Berlin) analyzed the conditions for wellbeing in academic institutions working on the basis of a neoliberal rationale of productivity and efficiency. Drawing on her ethnographic research, Baumann provided a grim

insight into the emotional experiences of ethnographers in such work environments. Similarly, Thomas Stodulka (Freie Universität Berlin) emphasized the importance of remaining attentive to the researcher's emotional wellbeing. He argued that an engagement with methodological approaches that recognize the epistemological potential of the researcher's affects and emotions could be a crucial element to avoid "fieldwork blues and emotional turmoil".

### *Moving Migration*

Through ethnographic case studies from Italy, United States, and Brazil, this panel explored different facets and dimensions of mobility, from Deferred Action for Childhood Arrivals (DACA) recipients in the United States to the management and identification of migrants who died trying to reach Europe across the Mediterranean Sea. In her research on DACA recipients, Rachel Kingsley (University of South Florida) delved into the world of 'DACAmented' people to analyze the mental and emotional distress caused by everyday life and legal uncertainties in connection with this policy. Kingsley touched upon questions of discrimination—as well as resistance to it—and different mechanisms of coping with stressful circumstances. She asked, for instance, how DACA recipients maintain hope for the future given their complex and uncertain life circumstances. This can be asked similarly in the context of Venezuelan refugees in Brazil that were addressed by Fabiane Vinente dos Santos (Oswaldo Cruz Foundation). As she showed, these migrants, who leave their country as a consequence of socio-political and economic disruption, face substantial new challenges in being recognized by the state as they seek the 'real utopia' of Brazil's state-funded health care system. Sara Casartelli (Sapienza University of Rome), in turn, explored the processes of management and identification of migrants who died in their attempt to reach Europe by crossing the Mediterranean Sea. Casartelli conducted her fieldwork at the center of this 'epidemic of death', as she called it, at the southern external borders of the European Union. She outlined a complex intertwinement of various practices that ultimately create an infrastructure of death that facilitates the identification of deceased migrant bodies. Although they spoke about different contexts, all three contributions in this panel addressed human tragedies that unfold as byproducts of state violence and institutional injustice and have dramatic consequences for the everyday lives of people who have followed distinct routes of mobility.

### *Contesting Neoliberal Conditions*

The three papers of this panel engaged with numerous ways of how people and organizations conceive of alternatives to the existing neoliberally informed health care modes. Claudia Lang (University of Leipzig) and Jean-Paul Gaudillière (Cermes3, Paris) investigated the histories and social practices of primary health care in Kerala, an Indian region with de-centralized primary health care centers and community health workers struggling against the rise of private medical care. Lang and Gaudillière argued that primary health care in the region instigated "radical changes in healthcare" based on three main principles: universal access to healthcare, the entanglements between biomedical practice and Ayurvedic and homeopathic knowledge, and

shared management of healthcare in which communities take decisions on their health services based on their needs.

Drawing on ethnographic interviews with medical professionals, administrators, and academics in the city and state of San Luis Potosí and in Mexico City, [Mary Bugbee](#) (University of Connecticut) explored present-day popular critiques of a highly-contested reform of Mexico's healthcare system. The reform called 'Seguro Popular' went into effect in 2003 and was officially revoked in 2020 under the leftist government of President Andrés Manuel López Obrador. Based on a hegemonic and neoliberal model of universal health coverage, the reform had the explicit goal of allowing greater private sector participation in the public health sector. Although this scope has been fully achieved, Bugbee argued that supporters and opponents alike contested 'Seguro Popular'. On the one hand, the law has never fully implemented the changes originally promised to improve the national healthcare system through privatization. On the other hand, the reform introduced neoliberal measures into the public system, which emphasized notions and discourses of deservingness and health citizenship.

Reflecting on his ethnographic fieldwork with political activists, managers and politicians, [Piyush Pushkar](#) (University of Manchester) focused on multiple forms of accountability in the UK public healthcare system in the wake of fiscal cuts and austerity. He suggested that campaigners sought to mobilize the concept of political accountability against tax cuts and privatization by arguing that managers and politicians were not being honest about the potential consequences. Managers and politicians often sympathized with activists' views but felt constrained by "the reality" of limited funds. However, managers felt unable to speak honestly in public about the financial rationale of the reforms or possible negative consequences, as they feared losing their jobs. Accountability to one's employer thus became a means for enforcing reforms that were necessary to "balance the books" according to budgets set by the central government. Pushkar argued that these multiple and divergent forms of accountability among politicians, managers, and activists interweaved and overlapped, therefore indirectly producing an increase of power centralization as well as shaping healthcare reforms.

### *Research and/as Social Change. Methodological Openings*

When it comes to radical approaches to health, it is crucial to address novel methodological openings that support the role of research as a driver of social change. Along these lines, [Caroline Contentin El Masri](#) (Freie Universität Berlin) discussed the possibilities and limits of ethnographic methods such as participant observation and interviews in the dissemination of information based on her experience in the project *Stadtteilmütter* (Neighborhood Mothers) and a workshop series on the circulation of health knowledge for migrant women in the district of Neukölln, Berlin, which resulted in a collaboratively written [publication](#). [Nasima Selim](#) (Freie Universität Berlin) instigated a reflection on why public anthropology matters in the context of planetary health. How can anthropology overcome internal controversies, for instance, about whether the discipline is theoretical or applied, carried out elsewhere or at-home, in order to respond to the challenges of planetary health? Selim suggested that one way of effectively achieving this is by reconceptualizing notions of the field and fieldwork and pushing

anthropologists to think of their own work as located in the so-called “field of engagement”. Here, the mere representation of medicine, health, and healing of more-than-human lives becomes replaced by radical practices, vocabularies, and epistemologies that target efforts to live well.

Christiane Falge (Hochschule für Gesundheit Bochum), Annika Strauss (Verein für multikulturelle Kinder- und Jugendhilfe – Migrationsarbeit, IFAK e.V. Bochum), and Silke Betscher (University of Bremen) followed up on this pursuit of radical openings by presenting their collaborative approach to analyze structural discrimination and access to health in the project ‘QUERgesund’. This project aims at developing health-promoting facilities together with the residents of the Hustadt in Bochum, an area of high-rise buildings where over 3.000 people from over 40 nationalities and various socio-cultural backgrounds live and experience everyday challenges of discrimination, health access, and unemployment. In close conversation with other governmental and civil society actors, ‘QUERgesund’ reflects on alternatives to improve living conditions and well-being at Hustadt and actually implementing such changes.

While this contribution focused on the potential of integrating different actors into a collaborative research endeavor, Sangyoub Lee (Freie Universität Berlin) and Young-Su Park (University College of London) explored the possibility of cafés becoming spaces of (health) care. They highlighted the prominent place occupied by cafés in the everyday lives of South Koreans and suggested to make use of them in order to more effectively “share health” and promote health knowledge. Vivian Laurens (University of Connecticut), in turn, explored how notions of health were built up from below in the context of transition justice and peace-making processes in Colombia. She shared how the 2016 peace agreements between the Colombian government and the FARC (*Fuerzas Armada Revolucionarias de Colombia* - Revolutionary Armed Forces of Colombia) outlined the need to implement rural health provision guided by *Buen Vivir*, an indigenous notion in the Andean region that favors a harmonious relationship between human and non-human actors. The inclusion of such forms of healthcare in the transitional justice plan, coupled with notions of *Buen Vivir*, is a novel approach as it highlights the importance of indigenous groups in terms of political representation, environmental protection, and recognition of cultural and gender equalities—which are crucial to the peace-building process.

### *Pharmaceuticalized | Technologized Subjectivities*

In this panel three researchers contributed to a discussion on pharmaceuticalized and technologized subjectivities. Based on her research on psychoneuroimmunology, Rebecca Blome (Freie Universität Berlin) argued that new ways of understanding and promoting health and healing, such as psychoneuroimmunology, could open up a path to overcome the traditional mind-body dualism by offering a perspective that stresses the relational dynamics between psychosocial aspects and physical systems. While biomedical approaches focus on how diseases affect people, a biopsychosocial approach highlights how people affect illnesses. That is, physical problems are considered to have social and psychological aspects and origins. Therefore, the main challenge consists in finding effective ways to integrate the biopsychosocial

approach into the biomedical model. Stefan Reinsch (University of Lübeck) contributed to the discussion by shedding light on the everyday lives and hurdles of people with rare genetic diseases such as cystic fibrosis (CF). He focused on situated practices of producing hope amidst prevailing anxieties, doubts, and fears of patients who are waiting for an organ transplantation. As Reinsch argued, due to the progress made in therapy, the fate of such patients, their living conditions and wellbeing no longer rely solely on their “faulty gene” but also on their own initiative and adherence to treatment. While the latter can significantly slow down the progression of the disease, they simultaneously trigger emotions such as hope and exhaustion. Yet, waiting in line for a transplant may involve a coupling of this self-management of emotions and treatment with the need to be a “good candidate for transplantation”, which can lead to emotional exhaustion. In the third contribution to the panel, William Schlesinger (University of California, Los Angeles) analyzed the impact of pre-exposure prophylaxis (PrEP), a biopharmaceutical technology that drastically reduces the risk of HIV transmission, on the interplay of HIV, safety, and risk. Based on fieldwork conducted in Los Angeles, Schlesinger explored the long history of medicalizing homosexuality, including the stigma in relation to sexually transmitted diseases, in general, and HIV against the backdrop of the development of PrEP, which holds the potential to radically reshape the landscape of HIV. However, as Schlesinger argued, access to PrEP remains restricted for many gay men. While, on the one hand, PrEP has the potential to redefine “good” sexual health by breaking up the link between HIV, risk, and safety, on the other hand, unequal patterns of accessibility to this technology risk to reinforce the pathologization and marginalization of vulnerable gay men.

### *Enhancing Ways of Knowing*

In this panel, two presentations established a conversation on the ways in which meaningful and relevant ways of knowing patients’ cultural background and social experiences can improve their active involvement in healing practices and enhance the efficacy of the healthcare system as a whole. Roberta Baer and Jason Wilson (both University of South Florida) discussed how they succeeded in incorporating medical anthropology theories into medical training and clinical settings in the US. One of their primary goals was to explain biomedical practices around direct patient care to anthropology students. In doing so, they intended to establish a productive dialogue between the two disciplines and reduce their pragmatic and epistemological distance. By creating a patient-centered care pathway in partnership with physicians, Baer and Wilson realized that paying attention to and understanding patients’ experiences posed a great challenge to physicians. In order to contrast what they termed as “patient shadowing”, they emphasized patient experiences, differences between disease and illness, as well as possible methods for addressing social determinants of health in their various courses for both medical and pre-medical students, as well as medical anthropology graduate students.

Shelley Lees and Luisa Enria (both London School of Hygiene and Tropical Medicine) dealt with the identities, relations, and political imaginations that were brought to life by clinical trials of microbicides against HIV in Tanzania and the Ebola vaccine clinical trials in Sierra Leone. By unearthing global and local power dynamics and giving space to the voices and imaginaries of trial participants and their communities, the two scholars aimed to problematize biomedical

parameters and standards of medical research. On the one hand, they showed that medical trials and analyses were rooted in colonial relations and in the functioning of global capitalism in both Eastern and Western Africa. On the other hand, they demonstrated the importance of participants' understanding and involvement in medical research as well as the relevance of knowledge of social relations and moral economies that challenged the trials' research ethics. Finally, they argued that being critical of clinical trials constituted a way for these participants to express both disaffection and disillusionment with the political status quo whilst at the same time setting the foundations for emancipatory visions of global and local citizenship.

### *Imaginative Futures of Care: Laboratories, roundtables, and documentary films*

In addition to individual presentations and panel discussions, a series of laboratories and roundtables enriched the four-day conference. These formats allowed the speakers and audience to continue thinking on positive radical practices in opposition to 'conventional' models of healthcare provision. During the two-day laboratory held on the first and third day of the conference, entitled "What is Feminist Intersectional Community Care? A Creative Lab", the Alaska Studio for Feelings, a duo composed by [Anne-Sophie Reichert](#) (University of Chicago) and [Esther Vorwerk](#) (Berlin), created a utopian clinic and information center for comprehending female corporeality and the embodied emotions that human bodies are enduring in times of COVID-19. The laboratory's participants not only had the opportunity to problematize female corporeality in a patriarchal world but also to critically question the interrelations of healthcare systems and particular power structures, gender rights and health policies. The laboratory further encouraged participants to imagine different 'healthy' futures and outline their vision of ideal health care provision.

On the second day of the conference, [Andrea Buhl](#) and [Sandra Staudacher](#) (both University of Basel) convened the World Café "Radical Health in Professional Care". The participants were invited to provide empirical insights and to theoretically discuss ideas about new approaches in the field of care. The aim of the format was to think about how new developments in the field of care provision in contexts of rising socio-economic inequalities can be translated into practice in order to improve the care of individuals.

Furthermore, the conference participants had the opportunity to watch and discuss the documentary "The Fever" (Austria/Germany/ Switzerland, 2019), directed by [Katharina Weingartner](#). The film highlights the multiple frictions between global health measures and the local production of a tea based on the Chinese medical plant *Artemisia annua L.* in both Kenya and Uganda. Given that the tea effectively reduces the incidence of infantile death for Malaria, "The Fever" is an invitation to problematize biomedical truth claims and reflect on alternative medicine to mitigate health-related and socio-economic inequalities. By showing the many difficulties that Kenyan and Ugandan doctors, malaria specialists, and scientists encounter in establishing a local production of drugs based on *Artemisia annua*, the documentary illustrates how various legal and political instruments are put in place by countries and pharmaceutical companies in the Global North to hinder the spread of these effective medications.

## *Health as Right to the City*

How do structural conditions make people sick in uneven ways and how can these structures be changed through collective and grassroots action? Addressing these questions, the roundtable “Health as Right to the City”, convened by [Richard B?žek](#), [Iris Dzudzek](#), and [Susanne Hübl](#) (University of Münster) discussed the manifold ways right-to-the-city movements can contribute to health justice, including the possibility of collective transformation of disease-causing structural conditions, such as inadequate housing, discrimination, and exploitation. In his initial statement, roundtable participant [Andreas Exner](#) (RCE Centre for Sustainable Social Transformation Graz) discussed lessons that one can learn from grassroots health activists in Austria, where recent budget cuts decreased social spending by 25 percent. He highlighted the importance of building alliances across a wide range of relevant actors in order to contribute more effectively to shifting the parameters within which public policies are discussed. [Anke Strüver](#) (University of Graz) contributed to this discussion by reflecting on the relation between social and spatial inequalities that are associated with economic, cultural, and environmental processes. According to her, understanding this relation is crucial to address the complexity of socio-economic inequality as well as the systematic exclusion of people from healthcare systems. [Vasilis Tsapas](#) (Social Solidarity Clinic Thessaloniki) provided an insight into how inequalities are addressed on a daily basis at the solidarity clinic in Thessaloniki. Following principles of direct democracy and the absence of hierarchy, the clinic was founded during the economic crisis. It strives against the exclusion of a large part of society by radically rethinking health, offering medical, dental, and psychological services free of charge, and facilitating access through an inclusive approach that does not require patients to provide legal documents such as proof of income or citizenship. Similarly, [Bettina Franke](#) (Poliklinik Leipzig) explored radical alternatives to overcome health exclusion, particularly in the context of primary care in a district of Leipzig, Germany, where health professionals, academics, and artists came together to improve health services and empower community members to work together in issues that affect their health.

## *Community Health Care Interventions as Real Utopias to Transform Society*

On the third day, the roundtable “Community Health Care Interventions as Real Utopias to Transform Society” involved activists, public health researchers, and primary health care physicians. [Philipp Dickel](#) (Poliklinik Veddel/Hamburg), [Jonas Fiedler](#) (Poliklinik Veddel/Hamburg), and [Angela Schuster](#) (Gesundheitskollektiv Berlin) presented the work of the Berlin Health Collective and the Poliklinik Veddel in Hamburg. Both community health care centers aim to establish integrated, community based, participatory and truly interdisciplinary care to serve the needs of structurally disadvantaged people. By conceiving healthcare as a modality to connect people and organize communities, the activists and physicians working at the health centers intend to implement utopian models of community-based healthcare, reinforce social solidarity and demonstrate valid alternatives to neoliberal economization of society.

Subsequently, the participants were invited to watch the documentary “This is my face” (Chile, 2019) by Angélica Cabezas Pino (University of Manchester). The film masterfully shows how people living with HIV in Chile cope with their experiences of fear and stigma through the production of artistic photographic portraits that poetically depict their memories and feelings. Through such collaborative storytelling, Cabezas Pino outlines how these people are able to make sense of their past, reflect on their present, and imagine their future lives with the disease.

The last documentary screened at the conference was “Los Cuidados” (Spain, 2019) by Antonio Girón and Raquel Congosto to which a discussion about “New Forms of Social Medicine in Spain”, convened by Beatriz Aragon (Universidad Complutense de Madrid) and Janina Kehr (University of Vienna), followed. The discussants were Spanish activists and members of various organizations: Ana Zamora, Rosa Bajo (Red Promotoras Salud Lavapies), Marta Pérez (Yo Sí Sanidad Universal, Madrid), Adrián Carrasco Munera (La Cabecera, Madrid), and Daniel García (Centro de Salud Vicente Soldevilla). “Los Cuidados” portrayed the importance of health care activities for the community of Vallecas, a working-class neighborhood in Madrid. In so doing, the documentary displays an insightful way to bring together representatives of several Spanish health initiatives that interrogate the intrinsic ethical values of Social Medicine practices in the post-Francoist national healthcare system. By recounting their activist and applied experiences, they outlined the multiple ruptures caused by rampant economization, precarity, and austerity measures in post-2008 economic crisis Spain and stressed the importance of maintaining Social Medicine practices and organizations for the health and wellbeing of poor communities in face of these constraints.

### *Final Remarks*

In the conference wrap up, various participants and presenters reflected on the entanglements of practice and theory in the endeavor of radically transforming healthcare systems while emphasizing the productive impetus of collaboration across the fields of medical anthropology, critical global health, activism, social movement, and arts. As one participant noted, academia can be a venue through which activists and other groups involved in this endeavor can gain socio-political visibility. In terms of the practical organization of the conference, the interrelations and mixing of various formats, from more conventional individual paper presentations to film screenings and artistic workshops, constituted a viable way to not only envision and discuss radical and utopian ideas but also to experience them. Other ways through which the conference created transformative potentials was by criticizing colonialism, paternalism, homophobia, ableism, sexism, and racism as moral attitudes that produce inequalities, as well as by bringing together activists and distinct disciplines such as critical geography, medicine, critical global health, architecture, and arts.

In sum, the entire digital conference and the various presentations significantly underlined the social, political and economic nature of diseases and maladies and highlighted multiple intertwined themes and difficulties in the wider access to and equal utilization of health care systems and structures. On the one hand, it emerged that anthropological analysis, activism involvements as well as artistic productions envisioned radical and imaginative alternatives to

specific and well-established forms of power, privilege and inequality within existing health care systems at local and global levels as well as in both the Global North and South. On the other hand, the conference presentations showed that health problems do not only require the simple and direct use of medical and technological interventions to be solved but concern the critical consideration of a wider spectrum of intersectional political, economic, social and ecological issues.

Social scientists, medical professionals and health practitioners have cogently proposed in their presentations in direct and indirect ways that collaboration, solidarity, sharing, networks of care among people and medical professionals constitute viable solutions to varying forms of hierarchy, exclusion and privilege that impede equal access to health care. As a leitmotif throughout the conference, these attitudes and behaviours constitute tangible avenues to conceive of 'good' medicine and assure 'good' health in politically, economically, ecologically or otherwise difficult living contexts. The mutual and fertile convergence of theoretical and applied anthropological, medical, and health epistemologies and practices in the conference also emphasized the relevance and meaningfulness of deep collaborations among social scientists, medical professionals, public health experts, health activists, and other professionals in the health care system. In other words, such forms of action and types of connection displayed and fleshed out the 'radicality' of good health and offered evident solutions to present-day catastrophic times.

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