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RESEARCH ARTICLE

From Availability to Accessibility. Vaccination Proximity in a Social Clinic in Palermo

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ABSTRACT: The present paper explores protests and initiatives in the vaccination field carried out by organisations developed within social movements, specifically focusing on the collective social actors involved in the Covid-19 vaccination campaign by proposing differentiated intervention strategies to ensure equity in access to the vaccine. The case study is the social clinic of Borgovecchio (Palermo) which developed a vaccination centre that responds to the principles of Primary Health Care (accessible, proactive and inspired by a spirit of 'proximity'). The social clinic is located in the community centre Anomalia. Data collection was carried out through observation and semi-structured interviews. The so-called 'proximity vaccine centre' project results from the radical criticism of the official vaccination campaign. The paper analyses the distinctive elements between this grassroots initiative and the official vaccination campaign, the initiative's guiding principles and goals, the organisational aspects and the ambivalences of the relationship with institutions. The results suggest that the primary goal of the "grassroots vaccine centre" was to safeguard the inhabitants of the district through a 're-territorialisation' of the intervention and the valorisation of different elements such as relation, spatial proximity and "trust". Additionally, the involvement of the social clinic in the vaccination campaigns represents an unprecedented collaboration between the National Health System and an informal organisation. Consequently, this case study represents a privileged observation point for analysing the relationships and conflicts between a self-organised experience and governmental institutions. Finally, this contribution suggests a broad reflection on the processes of politicisation in the healthcare domain and on the risk that initiatives implemented in an emergency logic produce or reinforce further inequalities in access to services.

KEYWORDS: Vaccination campaign, Covid-19, Primary Health Care, Health social movements, vaccine hesitancy
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1. Introduction

The outbreak of the Covid-19 pandemic has led several researchers to investigate some of the main causes of vaccine hesitancy, acceptance and rejection (Aw et al. 2021; Dubé et al. 2021; Gallé et al. 2021; Reno et al. 2021, Troiano and Nardi 2021, Sorell and Butler 2022).

This paper aims to contribute to the research on public health campaigns for vaccination, particularly by referring to the vaccination campaign for Covid-19, which has some notable aspects: the emergency context, the rapid vaccination trial, the need to vaccinate the entire population as swiftly as possible, and the concomitant organisational issues associated with a vaccination programme of unprecedented scale. In response to the extent of the intervention required, health authorities in many countries deployed a mass vaccination programme, focusing on equipping large centres capable of administering many doses (Chiolero et al. 2021). Especially during the first phases of the vaccination campaigns, the interventions were characterized by an emergency-led top-down approach, uniformally delivered throughout the countries and often managed by national authorities (Burgess et al. 2021).

Implementing a public health program of this magnitude presents challenges related to equity in vaccine distribution, access, and the level of engagement of services to marginalised communities and people with disabilities (Burky 2021; Strully et al. 2021; Roozen et al. 2022).

There are still few studies considering a multi-actor perspective and focusing on the role of different collective social actors of civil society. This paper aims to contribute to the existing literature by analysing how collective social actors are involved in the vaccination campaign and how they propose differentiated intervention strategies to ensure more significant equity in access to vaccination pathways.

The contribution focuses on a social solidarity clinic[1] (hereafter social clinic) in Borgo Vecchio, a working-class district in Palermo, Italy, which set up a grassroots vaccination centre. Activists and health professionals run the clinic. In general terms, social clinics can be defined as grassroots and informal organisations administering primary care without being affiliated with the NHS and promoting the right to health before and during the Covid-19 pandemic, both in Italy and in other European countries (Borrelli and Sparano 2021; Brenner and Lock 2022; Cabot 2016; Ghiglione 2018; Kokkinidis and Checchi 2021). Finally, this paper aims to report the complexity of positions, attitudes and factors that underlie vaccination hesitancy, as outlined by a collective social actor - the social clinic in Borgo Vecchio - and the strategies implemented to facilitate/promote vaccination programmes in an equitable way, namely the grassroots and self-managed vaccination centre.

The paper addresses four questions: (1) What are the proximity vaccination centre's main organisational characteristics and motivations? (2) What differentiates this centre from official vaccine centres? (3) How are PHC principles promoted in vaccination? (4) How are the relationships between this self-managed centre and public health institutions structured?

The research answers these questions through the analysis of qualitative data collected through observation of organisational meetings and the first days of vaccination and semi-structured interviews conducted with health workers and activists involved in the vaccination centre of the social clinic.

The investigation is based on two theoretical premises to observe how this self-organised form of local

[1] In the literature, the designations of these experiences vary: self-governed medical cabinet (Pecile 2017); social solidarity clinic (Kokkinidis and Checchi 2021); social clinic (Cabot 2016).

medicine offered vaccine services and how it exemplified certain principles underlying the initiative (proximity, community, relation, trust).

The first premise relates to the connection between the scientific literature on vaccine hesitancy/acceptance and the literature on comprehensive Primary Health Care (PHC) principles, as expressed in the Alma-Ata Declaration (WHO 1978), and echoed through many social health movements. These issues are relevant in explaining the concept of proximity, grassroots, and community-involved vaccination campaigns for two reasons. First, the PHC approach is essential in achieving more significant equity in health (Starfield 2009). Second, the research explores the extent to which the vaccination campaign has applied the PHC principles through a close study of the Borgo Vecchio social clinic example.

The second premise concerns the Italian vaccination campaign and the more recent studies on vaccine hesitancy/refusal, as well as the necessity of going beyond the issue of vaccine availability to consider the substantial problem of accessibility, taking into account the logistical and organisational aspects of the vaccination campaign.

The paper is structured as follows. The following section is dedicated to the theoretical framework, referencing studies on vaccine hesitancy and the principles of comprehensive PHC. The third section addresses the contextual elements of the vaccination campaign in Italy and the methodology. The fourth section presents the results as they answer the research questions. Finally, the last section contains the summary and the conclusion.

2. Theoretical Framework

In recent years, healthcare systems have come under strain because of the sudden outbreak of the Covid-19 pandemic and the necessity of instigating plans, infrastructure, and health responses within a short timeframe. The recent vaccination campaign against Covid-19 that began in 2021 is one of the most significant public health interventions to date. Even before the pandemic, vaccination hesitancy was already one of the ten most important issues in global health (WHO 2019). According to the SAGE Working Group, vaccination hesitancy refers to a «delay in the acceptance or refusal of vaccination despite the availability of vaccination services. Vaccine hesitancy is complex and context-specific, varying across time, place, and vaccines. It is influenced by factors such as complacency, convenience, and confidence» (WHO 2014, 7). In addition to the three ‘Cs’ (complacency, convenience, confidence), two more factors were added (calculation and collective responsibility), leading to the ‘5 Cs’ model—the five drivers of vaccine acceptance or hesitancy (Betsch et al. 2015; 2018). However, this model has several limitations: firstly, it relies on studies conducted in high-income countries; secondly, it focuses mainly on individual and psychological determinants (Dubé et al. 2013; Shapiro et al. 2018); finally, it underestimates the social aspects that underpin vaccines choices and structural mechanisms.

These criticisms have informed reformulations of the models by other authors, such as Bedford et al. (2018), who included some structural and social dimensions in their analysis. Their proposal is helpful because it conceptualises hesitancy as a decision-making process influenced by structural and societal factors. Interpreting acceptance, refusal, and hesitancy in processual terms shows the coexistence of different factors (cultural, social, emotional, economic, political, spiritual, and cognitive) and reveals its flexibility and potential malleability (Kumar et al. 2016). A valuable perspective from which to analyse the interaction between different pathways through which social factors influence the choice to receive the vaccine is that of ‘social

exclusion' (Wiysonge et al. 2022). Therefore, focusing on the socioeconomic barriers to accessing vaccination services and the relationship between people and government institutions regarding healthcare is helpful.

Despite being only an individual choice, vaccination is influenced by social and health inequalities that arise from socioeconomic strains. Therefore, analysing vaccination through a social exclusion perspective makes it possible to focus on the barriers to accessing vaccination and on the approaches to addressing them rather than ranking reasons that influence vaccination choices. Furthermore, this perspective permits us to consider two additional elements: firstly, the structural inequalities of marginalised social groups and how these influence vaccine decision-making processes; secondly, how the governance of Covid-19 also plays a central role in people's choices and perceptions (Storer et al. 2022).

In addition to the vast literature on the determinants of vaccination hesitancy towards Covid-19 vaccination, several studies have focused on how PHC principles can feature prominently in strategies for implementing vaccination campaigns and increasing vaccination uptake, especially among high-risk or marginalised populations often designated as "hard to reach" (Chiolero et al. 2021; Pinaka et al. 2021). Far from addressing only immunisation, the PHC approach is an effective and key strategy by which to tackle health inequalities in terms of the quality of services and equity in healthcare systems (Starfield et al. 2005; WHO 2008; Iqbal and Chambers 2009; Norbury et al. 2011; Rasanathan et al. 2011).

2.1 Primary health care and vaccination campaigns

PHC denotes a heterogeneous set of practices, concepts and services. The definition of PHC dates back to the 1978 Alma-Ata International Conference on Primary Health Care (WHO 1978). The approach to PHC proposed at Alma-Ata is 'comprehensive' (Magnussen et al. 2004; Javanparast et al. 2022); it refers to a conceptualisation of care that is not limited to medical intervention, and it has a multidimensional conception of health that is not restricted to physical and individual states. Considering the various factors that influence health, the idea of healthcare underlined in this approach is proximity, based on community participation and the establishment of an interconnected system of services. The comprehensive approach differs from the selective one (Walsh and Warren 1979), which became hegemonic in the 1980s, using techno-centric and market criteria, such as cost-effectiveness evaluation, for planning and assessing healthcare interventions. Selective PHC involves vertically implemented programmes dedicated to specific pathologies; references to community participation and the social and multidimensional nature of health and illness are absent (Gish 1982; Rifkin and Walt 1986; Cueto 2004).

In this paper, by PHC we mean *comprehensive* PHC. There was renewed interest in comprehensive PHC principles during the pandemic, especially when it became clear that the crisis was not only health-related but also social and economic. This focus brought back the concept of syndemic (Singer and Clair 2003; Horton 2020). Alongside studies on the exacerbation of pre-existing inequalities for those already living in uncertain conditions and who suffered most from the pandemic's consequences (Burström and Tao 2020; Bambra et al. 2020; Wang and Tang 2020), some researchers have emphasised the need to reorganise healthcare systems by enhancing primary care service into the framework of health promotion. Spatial proximity is prominent among these principles, intended as distance/closeness to healthcare service (Daskin and Dean 2004). In addition, building a healthcare organisation capable of welcoming, valuing and involving individuals and communities is another essential factor. The principles of PHC are often incompatible with the effects of corporatisation and privatisation of health systems that occurred since the 1980s (André et al. 2016; Farris and Marchetti 2017). Moreover, hospital-centred systems are less attentive to healthcare's community dimensions.

Often, proposals in the field of PHC are accompanied by debates over the right to health and access to care (McDonald and Ruiters 2012; Musolino et al. 2020). The principles of equity, proximity, and community participation are crucial in associative and activist experiences in the health field. Several grassroots initiatives in Europe take a political interpretation of health. Mutualist initiatives have been established to oppose healthcare privatisation, the non-recognition of the universal right to health, and the exclusion of specific sections of the population from such services (Brenner and Lock 2022; Cabot 2016; Ghiglione 2018; Kokkinidis and Checchi 2021).

PHC principles are also applicable in vaccination, a medical activity with a social dimension. It is possible to study vaccination in a broader socio-cultural context, consider the factors influencing the decision-making process, and apply the multidimensional approach that PHC advise. For example, some studies have focused on the functioning of primary care services in vaccination and on the strategies for implementing it (Ratzan 2021; Chiolero et al. 2021). In particular, some scholars have examined barriers to accessing health and vaccination services, questioning the notion of vaccination hesitancy, which places responsibility on individuals without adequately considering its social determinants (Bedford et al. 2018; Bertoncello et al. 2020, Khan et al. 2022).

Moreover, other studies have focused on specific aspects of the principles of PHC. Among these, some investigations explore the relevance of the local context, which is understood in two ways: the first is the quality of vaccination services in terms of geographical and economic accessibility, availability and affordability, according to the WHO (2014); the second is the presence of 'local vaccination cultures' pertaining to people's experiences of health and vaccination services (Streefland et al. 1999). The latter has the local context and accompanying social and economic dynamics at its centre (Kumar et al. 2016). The focus on the local dimension is connected to the central factor of trust. The success of vaccine promotion corresponds with the public's trust in the vaccine, which is achieved through interventions built according to the characteristics of specific contexts (Rhodes and Strain 2000). However, mistrust has a historical memory, as Warren et al. (2020) indicated. Therefore, a necessary prerequisite for fostering trust is the trustworthiness of institutions because it is within institutions that the dynamics of race, class, gender and territorial exclusion have historically been reproduced (Willis et al. 2021).

Furthermore, the pandemic has affected the global population unequally, demonstrating the structural violence inherent in society (McClure et al. 2020) and highlighting a paradoxical aspect of the vaccination campaign. Burgess et al. (2021, 8) said, «now these communities are being asked to trust the same structures that have contributed to their experiences of discrimination, abuse, trauma, and marginalisation to access vaccines and to benefit the wider population». Therefore, policymakers should build dialogue and support local community initiatives in order to reach more people and enable broader participation in vaccination schemes, thus making their knowledge and experience the starting point in policymaking (Burgess et al. 2021). From this perspective, developing a vaccination campaign for the entire population, including groups in socioeconomically fragile conditions disproportionately affected by Covid-19, is a matter of social justice and equity (Khan et al. 2022).

3. Context, methodology and case study

This study focuses on the proximity vaccination centre in Palermo, Italy. It aims to analyse the critical experiences of institutions that guarantee vaccine access. The study was conducted in the social clinic in the

community centre[2] 'Anomalia', in Borgovecchio, a working-class district in Palermo. Following criticism of the official vaccination campaign, activists took the initiative to set up a grassroots and proximity vaccination centre.

3.1 The context: the vaccination campaign in Italy

The Italian vaccination campaign began in December 2020, initially targeting social categories which the national strategic plan classified as a priority: people with health vulnerabilities (including old age), health and social care workers, school and university staff, armed forces, police, prison services and employees of Residential Care Facility (Rsa). The vaccination campaign followed age, occupational category and comorbidity criteria to define priorities.

As Neri (2020) notes, two divergent trends have coexisted in the health governance in Italy during the pandemic: on the one hand, the (re) centralisation of administration by the state; on the other, the regional autonomy - a distinctive trait of the Italian health system. The organisation of the vaccination campaign has similar characteristics. On the one hand, there is a centralisation of decisions regarding the definition of the priority categories and the distribution of the vaccine doses; on the other, the delivery of the doses and the booking procedures are managed by Regional Health Departments and, in some respects, by Local health authorities. A common feature of the different Italian regions in the first months of the vaccination campaign was the organisation of large vaccination hubs with a high capacity for daily administration. However, this vaccination strategy did not adopt inclusive and local approaches involving local communities. Furthermore, the definition of priority categories did not take into consideration specific dimensions highlighted in the literature as determinants in the spread of the virus, in the possibility of complying with prevention measures, and in the choice to get the vaccine (overcrowded accommodation, distance from services, lack of documents, job insecurity, undeclared work).

Faced with the difficulty of reaching the entire population, a few months after the beginning of the vaccination campaign, health, regional and local institutions started to involve non-state actors working at a local level. Even before the pandemic, Third Sector associations and NGOs provided many services for people considered "hard to reach". This assortment of non-state actors was also involved in the vaccination campaign in different ways in each region and with different timeframes. However, while this enabled the development of more localised and targeted initiatives, it also reproduced regional organisational differences (Bertin and Cipolla 2013) and the dynamics of inequity in the National Health System (NHS). Namely, some population groups, although having similar needs as the rest of the population, when not more urgent, receive care and services that are differentiated and often not managed by the public governmental actor (Braveman and Gruskin 2003; Ambrosini 2015).

3.2 Methodology and case study

The study took place between April and May 2021 and adopted a case study approach (Yin 2003). The research was conducted primarily during online preparatory organizational meetings of the social clinic, which took place virtually as Sicily and Palermo were in lockdown at the time. The second phase consisted of observations during the first vaccination days. The sampling strategy adopted was that of quotas since the aim was to have a representative sample of those who carried out the vaccination initiative, i.e. social clinic

[2] 'Community centres' refers to grassroots and self-managed experiences within squatted spaces and often without legal recognition by institutions.

activists, doctors and nurses. As a result, data collection was conducted through non-participant observation and 12 semi-structured interviews with health workers (5 interviews, three physicians and two nurses) and social clinic activists (7 interviews) who took part in the initiative and who performed different tasks (reception, triage, post-vaccination waiting area, accompanying people during the 'vaccine pathway').
The interviews outline contained the following thematic axes: a) origin and development of the social clinic and the Anomalia community centre; b) health and social initiatives in the neighbourhood and the city of Palermo; c) involvement of the respondent within the social clinic and the vaccination hub; d) origin and development of the proximity vaccination hub; e) relationship with public institutions concerning the vaccination initiative. The observations carried out before the opening of the vaccination centre took place online during the preparatory meetings I attended. In this context, I declared my role as a researcher and sought consent for my activities. These preliminary meetings helped to reconstruct the initiative-building process and the negotiations with institutional stakeholders. In addition, in-person observations were conducted during the first three vaccination days. I observed how activists, doctors and nurses interacted with the inhabitants at different stages of the vaccination pathway: triage, waiting, vaccination and post-vaccination stages. Both online and in person, it was a non-participant observation, thus characterized by the non-direct intervention of the researcher during various interactions and meetings with informants. The number of activists present on vaccination days ranged between 20 and 25. The empirical material collected (interviews, field notes, and photographs) was analyzed by focusing on: the motivations behind the initiative; the principles underlying the social clinic's idea of health; the implementation of PHC concepts; the critique of the official vaccination campaign; thematization of the issue of hesitancy; spaces of action and discretion; and the distinguishing elements between the self-managed hub and the public hubs.

The Borgo Vecchio clinic was the only clinic in Italy conducting a vaccination project among the non-institutional and self-managed health initiatives. Therefore, it made for a suitable case study for a research project aimed at studying forms of solidarity and protest around the issue of vaccination from the perspective of vaccine promotion. Palermo is the principal city in Sicily, whose regional health system has been subject to the 'Recovery Plans' since 2007. These plans are instruments through which regions with structural health deficits and the national government establish objectives and strategic actions to restore financial balance (Azzolina and Pavolini 2012). Borgo Vecchio's clinic started its activities in 2016 in the community centre of Anomalia. In addition to healthcare-related activities in the clinic, the community centre includes a "self-managed gym" and hosts after-school activities and social and cultural initiatives for the citizens.
Moreover, public assemblies and initiatives dedicated to the neighbourhood, such as concerts, debates, and social events, are held here. The clinic aims to address the neighbourhood's scarcity of public health services and proposes new healthcare mechanisms to the inhabitants. The leading service offered is general medicine, accompanied by specialist services such as gynaecological services. The clinic is self-financed through crowdfunding initiatives and donations from private individuals. For instance, the echograph at the clinic was donated by a retired doctor shortly after the social clinic opened in 2016. During the pandemic, activities at the social centre and clinic ceased. After that, however, they resumed the launch of the vaccination centre. The vaccination campaign in Borgo Vecchio commenced on 5 May 2021 after two months of pressure from local and health institutions. According to activists, they administered approximately 500 vaccines from May 2021 to January 2022. The beneficiaries included residents (often older adults), people with doubts about vaccines, and those who had difficulty reaching the vaccination hubs.

4 Results

4.1 Between motivation, rules, guidelines, and discretion: Organizational aspects of vaccination

The study's findings cover three aspects: first, the motivations underlying the initiative; second, the organisational structure of the vaccination centre; and third, the establishment of discretionary spaces for managing vaccination against Covid-19 when vaccination would usually be under the control of health authorities.

The vaccine centre's primary motivation was to protect the inhabitants' health in response to the onset of the pandemic (Siino 2021).

> For us, this policy of large vaccination hubs that process thousands of vaccines daily has the contours of a so-called 'big operation'. We do not deny its usefulness in absolute terms, but it is a choice that does not convince people to vaccinate. These old centralised models work in series and are depersonalising. Our neighbourhood has been hit hard by the pandemic, with several cases of house overcrowding, and following social distancing rules is difficult for many. Therefore, we decided to promote a proximity health initiative for vaccines. They [the inhabitants] know us and trust us. In addition, we take time to answer questions and doubts about vaccines. (Social clinic activist)

Strong criticism of the vaccination campaign and accusations of ignoring the needs of vulnerable people, who distrusted health institutions, prompted the setting up of the vaccination hub. In the first few months, vaccinations were conducted in large hubs such as the main one in Palermo, the 'Fiera del Mediterraneo' centre. This hub is located far from the city centre and is difficult to reach, particularly for the older adults in the Borgo Vecchio district. However, the hub's limited accessibility is not the only critical issue expressed. In preparatory meetings, the proposal for a vaccine centre in the neighbourhood was accompanied by broad discussions:

> Vaccines are one of the areas in which proximity interventions can be established. For us, it also means offering proper political criticism of the subordinate role of public institutions vis-à-vis pharmaceutical companies and the logic of pharmaceutical licences that nobody wants to question. This initiative [the self-managed vaccine centre] is part of an overall critique of the pandemic management and is not an isolated discourse. (Social clinic activist)

> This year, we realised that the pandemic affected people of distinct social classes differently and that the virus is not democratic. For example, many people have precarious jobs and overcrowded housing conditions. Lockdowns and quarantines cannot be implemented in these conditions. (Anomalia activist)

The discussion emphasises the political dimension of the self-managed vaccine centre in terms of the neighbourhood's needs. The prioritisation of the district, motivated by the discourse on social, economic and geographic determinants, is an element that differentiates the activists' goals from the nationally defined vaccination campaign guidelines regarding the priority categories. At that time (March and April 2021), more than 60 people were certified to receive the vaccine in the social clinic. As shown, discrepancies between the

national guidelines and the functional needs of the social clinic facilitated allowances for the organisation and running of the self-managed vaccine centre.

The first phase of construction of the proximity vaccine centre took place in March and April 2021 through a series of public meetings attended by the activists of the community centre, doctors from the social clinic, institutional representatives, and other associations in Palermo. Although the proposal specifically concerned the Borgo Vecchio neighbourhood, the desire to replicate the initiative in other areas was made explicit during the meetings:

> Borgo Vecchio is one of many vulnerable neighbourhoods, and it would be interesting to build an experiment that could be replicated in different neighbourhoods. (Social clinic doctor)

Initially, meetings focused on the feasibility of the proximity hub project and the best strategies to adopt. In several Italian regions, the vaccine considered most suitable for the groups "hard to reach" was the Janssen Covid-19 single-dose vaccine. The opening of the vaccine centre on 5 May marked the effective start of the project. The decision to start and continue opening once a week was motivated by the need to allocate time to set up the space and manage bookings.

The activists managed bookings; people could book directly by calling a dedicated phone number or visiting the site before vaccination. The number of bookings informed the vaccines needed to be delivered before opening the centre. Although the booking criterion had to follow national guidelines, the activists introduced criteria related to proximity and neighbourhood. For example, the activists' first question during the booking process was: 'Hello, do you live in the neighbourhood?'. If the person lived in the neighbourhood and matched the national criteria for access to vaccination, the reservation was immediately accepted. Differently, if the person resided within the neighbourhood but did not meet the other criteria, he/she was not registered immediately but was marked in a separate list in case there were leftover doses. The use of leftover doses is noteworthy here. As early as March 2021, the extraordinary national commissioner for the Covid-19 emergency declared, 'No more wasted doses". In this regard, Borgo Vecchio prioritised the neighbourhood's inhabitants over others. In the event of phone calls from inhabitants of other city areas, the activists exercised their discretion, regardless of the individual's age. After explaining the project's objectives, they prioritised the neighbourhood's inhabitants and encouraged individuals from other areas to use other vaccine centres.

Public authorities were responsible for transporting, managing and storing the vaccine vials. Activists managed triage, the vaccination itself, and the entire 'vaccination pathway'. The triage phase involved a questionnaire similar to that used in official hubs. In addition to the standardised questions, topics related to work, state of mind, housing conditions and any difficulties encountered in the recent period were also included. The triage became a form of pre-interview and a moment of exchange, so much so that it emerged as the preliminary space for expressing doubts, fears and narrations about the vaccine. Doctors and nurses administered the vaccine and were all activists and volunteers. As health professionals, they were already known in the neighbourhood for the health services they had provided since 2016. After consulting the triage form, health professionals answered questions before and after vaccination. Activists also supervised the post-vaccination waiting room, which became a crucial space for building relationships and dialogues.

In the vaccination pathways, there is a coexistence – although not always peaceful or explicit – between the formal procedures of vaccination and the spaces of discretion of activists. This discretionality highlights the character of the activists' initiative.

Furthermore, the organisation of the spaces during the days of vaccine administration contributed to the visibility of the political aspects of the initiative. The following photographs, taken during a vaccination day, show the unusual juxtaposition and coexistence of symbols and slogans of a marked political character, such as Champagne Molotov and Anti-Fascist Resistance, with elements belonging to the field of healthcare:

Figure 1 - Setting of vaccination days in the community centre

Source: *Photographs taken by the author*

The focus on the setting is valuable for understanding the context in which people vaccinate and for a more general comprehension of the relationships established in that space.

4.2 PHC Principles in action

The second and third research questions examine the defining characteristics of this self-managed centre and the implications of applying certain PHC principles in vaccination. The systematisation of the empirical data follows four dimensions that characterise comprehensive PHC: the concept of health as (1) multidimensional, (2) relationship orientated, (3) requiring proximity, and (4) based on trust. We shall discuss each of these dimensions below.

Multidimensionality of health. The vision of health that emerges is multidimensional and intended as a set of processes in which health is seen not only as a 'state' but also as a resource, whether for an individual or a group. This concept has been the basis of the social clinic's activities since its opening in 2016.

> Running a health clinic in Borgo Vecchio considers many different interacting factors. There are no public services in the neighbourhood. People do not have many reference points, and I am not just talking about health services. [...] Let us say that the basis of our activity is the discourse of the social determinants of health, so for us, it is all connected: home, work, family, transport, neighbourhood conditions, etc. Neighbourhoods like this one are contexts with deep inequalities, so we need to be able to recognise the social causes of illness and fight for a dignified right to health. (Doctor, social clinic)

This interview reveals some of the concepts that arose from the Final Report of the Commission on Social Determinants of Health (2009), in which the relationship between illness, cure and health, and the intersection between structural factors (socioeconomic, political, and historical) and internal processes (behavioural, physiological, psychological, and communicative) becomes evident.

Relationship. The interviews repeatedly emphasise the relationship between patients and doctors and between the community centre and neighbourhood inhabitants. As outlined in the previous section, activists and doctors managed the entire 'vaccination pathway'. In light of this, the doctor-patient dyad, which is often the focus of studies on the relationship in healthcare settings (Freidson 2002), should be examined by widening the view to encompass the relationship between health activists and health professionals.

> We do not want to apply a vertical relationship; we do not want this for vaccines now, but this is the basis of the social clinic, which has been open for years. We want to confront and facilitate awareness processes. To be able to do this on vaccination, which is a complex topic, we decided to start with small numbers. If we can proceed in a relational manner that characterises us, we will increase the number. (Social clinic doctor)

The initiative aims to provide the information for patients to make a well-informed decision, thus clarifying doubts and concerns. Although the proximity centre aimed to increase vaccination in the neighbourhood, the activists said they did not want to downplay people's confusion, concern and anxiety.

The medium of time emerges as an essential element in constructing trusting relationships in two ways. Firstly, the social clinic has been active in the neighbourhood for a long time (approximately five years) and has become a point of reference over time. Secondly, time is indispensable for building trust, enabling people to get to know one another, expressing doubts and conducting collective discussions. Based on observations during the vaccination days, the issue of time emerged among activists and those who came to be vaccinated. In addition, time is a vehicle for redefining the therapeutic relationship; in its absence, a change in the doctor-patient relationship is considered impossible.

Proximity. Proximity is understood in terms of spatial and physical distance to healthcare facilities (Daskin and Dean 2004). Unlike large vaccination hubs, the self-managed centre was easily accessible from the neighbourhood. In addition to opening on vaccination days, the community centre remained open daily and frequented by many inhabitants for various purposes (e.g. information meetings or cultural events). This accessibility enabled overcoming certain obstacles to vaccine access for the neighbourhood's inhabitants, especially older adults who had to make reservations online. Visiting the community centre directly or booking a vaccine by telephone facilitated access.

Trust. Another theme concerns the concept of trust. Trust is repeatedly mentioned in the interviews and is considered by activists as essential in political and health initiatives, particularly in the context of vulnerability.

The concept of trust is complex and does not have a clear definition. For the clinic activists, the trust that the people of the neighbourhood placed in the clinic resulted from the two dimensions mentioned above: relationship and proximity. These factors enabled the social clinic to be perceived as a viable 'alternative' to the public health system, which inhabitants considered remote and malfunctioning. The exploration of trust carried out by activists refers to the role that forms of trust, both interpersonal and institutional, play in society and healthcare systems (Meyer et al. 2008). Distrust and distancing from general practitioners emerged as a theme, accompanied by a more general distrust of the healthcare and social systems. This link between the local and systemic dimensions of distrust is referred to the study conducted by Ward and Coates (2006), which focuses on the relationships between local and global dimensions, as Giddens (1990) has also investigated. Social clinics have a particular position within these two dimensions of trust because they are situated outside the institutional framework. This distance from the institutional framework affords an element of legitimacy and signifies trustworthiness for people. In addition, the distance and differences from institutions are sources of recognition by the neighbourhood's inhabitants.

4.3 Swinging allegiances: Between criticism and institutional collaboration

Entering Borgo Vecchio and walking towards the social clinic, one immediately notices the banner posted outside the community centre to mark the first vaccination day: 'politics protects profits, we protect the community'. This statement exemplifies the difference between social clinics and government institutions. Despite the initial diffidence, the activists held several organisational meetings with local and health authorities to set up the vaccination centre cooperatively. Moreover, the management of vaccines presupposed substantial control by health authorities. It involved strict regulations in many aspects of their administration (number of doses, names of those vaccinated, storage and certification). Through the fourth research question regarding the relationship between institutions and the self-managed vaccine centre, different aspects of (in)formalisation and the coexistence of two contradictory aspects of the relationship –distance and collaboration –emerge.

The social clinic is in a community centre without formal recognition, and the institutions are often the object of criticism and claims. However, a relationship between the assembly of activists and the institutions exists and is based primarily on a form of political recognition. This recognition results from the power relations between civil society actors and public institutions.

The process of setting up the vaccine centre is essential to identify collaborative dimensions between the social clinic and the institutions and the interaction between formal and informal dimensions across organisational and political factors. For example, the relationship with the local commissioner for the Covid-19 emergency in Palermo, a doctor closely aligned with the clinic's work since before the pandemic, is noteworthy. During the meetings, the exchanges between the commissioner and the activists alternated between informal and friendly language and a technical and formal tone. For instance, during an online meeting, the commissioner stated:

> I finally see lovely people. Let us talk because I want to stay here and listen to you as long as possible. After all, you are essential to the city. [...] We have to wait for the necessary authorisations and understand the future of the Johnson [Janssen] vaccine. If that goes well, the proximity hub can be established in Borgo Vecchio, but if we need vaccines with more doses, we have to wait and see because the organisation is complex. (Local commissioner for the Covid-19 emergency for Palermo)

In this case, political recognition followed previous knowledge of the social clinic project and an acknowledgement of its importance. As discussed in Section 4.1, the collaboration with institutions also occurred on vaccination days concerning the handling of vaccines, bureaucratic procedures and contact with other vaccination hubs. Another aspect that highlights the cooperative nature of the initiative is the proposal's pioneering nature. Alongside the collaboration, the activists emphasise the characteristics that differentiate social clinics from public services. This emphasis consisted of explicitly stating that the former was not intended as a substitute of the official healthcare service; instead, they aimed to address the community's needs. For example, in an interview, one activist reported the following:

> How do we distinguish ourselves within a debate with solidaristic and charitable aspects as focal points? We always have to keep this question in mind. We tell everyone who calls when we do the triage and during the vaccination that we are doing something that we should not be doing because we are not a public service. We are firstly interested in people understanding this and that public institutions do. This initiative comes from collaboration with institutions, but this will not limit the criticism that we offer. (Social clinic activist)

The emphasis on the political nature of the vaccine centre underlines how it was not only an assistance initiative but also the result of ongoing struggles in the neighbourhood. Thus, two dimensions of the social clinic identified by Pecile (2017) emerge: the social one and the political one. At the social level, mutualistic practices and a comprehensive approach to healthcare counterbalance the absence of public services in a context particularly affected by the Covid-19 crisis. At the political level, there is a struggle to re-appropriate the right to health and criticise institutions. Criticism about the official vaccination campaign is directed primarily at local and regional administrations. For instance, the social clinic criticised the local administration in January 2022 after the flooding occurred because of railway-related work, resulting in puddles in several areas. A public statement by the social clinic states:

> Over and over again, the administration and affiliated agencies have been asked to do something about cleaning Via Archimede in Borgo Vecchio. Despite repeated promises, RAP [Resources Environment Palermo], Amap [Municipal Water Company of Palermo] and the councillors in charge have ignored this request. Even the local health authority recently produced a report that spoke of 'serious health and hygiene risks' for those living in the area. However, the health of its citizens is not a priority for those who administer this city. It is a city where not even the efforts of doctors and volunteers who offer a free service to their fellow citizens are valued or facilitated. [...] We will provide vaccines in sewage and rubbish. (Social clinic press statement)

In this statement, the clinic's involvement in the vaccination campaign reinforced criticism against the municipal administration. The relationships between clinics, health authorities and local institutions are fluid and variable. Collaborative aspects prevail among health authorities. In contrast, conflicting and oppositional characteristics dominate the relationship with regional and local administrations.

Busso and De Luigi (2019) proposed a practical conceptual framework to study this vaccination initiative and identified two analytical dimensions of collective social actors. The first one relates to the functions of collective social actors, namely the provision of services and some political pressure. The second dimension concerns the degree of integration with the public sector and collaboration with other social actors. Concerning function, the activists emphasised the political and claim-making nature of the initiative and did not aim only to provide a service. The public communication aspect of the initiative became openly conflictual at times, as evidenced by the direct interlocutions with representatives of the institutions.

Some criticism also arose concerning the limited number of vaccine doses administered, which was not comparable to the number of official vaccination centres. Owing to limited vaccine availability, social clinics cannot compete with government institutions, which thus leads activists to pursue more critical discourses. Finally, the degree of integration with the public sector is less ambiguous. The community centre has no formal recognition; therefore, this initiative does not exhibit a high degree of integration within the public sector. In addition, the entire organisation of the vaccination process—excluding the transport and storage of the vaccine doses—was managed by activists with informal organisational structures that were defined in the meetings held by the community centre. This framework makes it possible to consider how collective actors play different roles simultaneously and how areas of tension may affect these roles. Another function of this framework is to observe individuals' pathways and roles. For instance, in this case study, the role of the special commissioner for the emergency in Palermo was significant, as he found himself in that institutional role during the pandemic crisis. However, he also emphasised his affinity for the social clinic's initiative and his support for the proposals suggested by these collective social actors.

4 Concluding remarks

The results suggest that the primary goal of the proximity vaccine centre in Borgo Vecchio was to safeguard the inhabitants of this district of Palermo, who were severely affected by the pandemic. The interviews show that vaccine hesitancy, and its social determinants, cannot be understood as distinct factors. Regarding the organisation of the vaccination sessions, the elements of relation, spatial proximity and "trust" have emerged as essential factors in promoting social and health initiatives in working districts. Promoting "trust" and spatial proximity means using a space already known and attended by the inhabitants, such as the community centre Anomalia, and managing the vaccination process by people familiar with the neighbourhood.

The 'proximity' vaccination campaign is a concrete example of putting into practice the principles of comprehensive PHC in vaccination initiatives. This approach focuses on the local territory and its inhabitants, attempting to establish organisational arrangements to reach people who would not go to official vaccination hubs.

The social clinic aims to develop solutions adapted to vaccine hesitancy challenges through the 're-localisation' of the interventions. The accessibility of vaccination has to be considered alongside the issue that vaccine availability alone is insufficient to encourage people to get the vaccine. At the critical juncture represented by the pandemic, the social clinic of Borgo Vecchio occupies a dual space between proximity and reliability. This space creates an unprecedented "area of discretion and agency" in deploying a local vaccination campaign.

Furthermore, the involvement of the social clinic in the vaccination campaign represents an unprecedented collaboration between the official healthcare system and an informal organisation. The interest in this initiative is based not only on its uniqueness compared with other grassroots health organisations that have emerged from social movements but also on the fact that the self-managed vaccination centre constitutes a privileged observation point for analysing the relationship between a self-organised experience and governmental institutions. This paper has shown how radical criticism of the deficiencies and lack of inclusiveness of the NHS coexists alongside a vaccination project constructed with the official authorities in charge of the vaccination campaign in Palermo.

The results show how this vaccination initiative has also created the possibility of political recognition of the social clinic by the authorities in charge of the Covid-19 emergency in Palermo. This initiative has an

undisputed political basis, closely linked to the power relations between self-organised actors and institutions and the mutual recognition of those different actors' roles in the emergency phase. The social clinic does not aim to be a surrogate of the state but rather to provide a more functional alternative to the neighbourhood's needs. Nonetheless, the tension between political activity and the risk of functioning as a substitute for the state is undeniable. This case study highlights how the boundaries between the functions and positioning of collective social actors are ambivalent and sometimes uncertain. It is in this space of uncertainty that potential contradictions emerge. The self-managed vaccination centre is an initiative that presents itself as political, claiming and advocating action in opposition to governmental institutions. This attitude does not mean the absence of collaboration with institutional actors nor the absence of complementarity with public services and the provision of services, in this case, vaccination.

In a perspective that goes beyond the case study and considers the overall management of the vaccination campaign, it is possible to make a final observation concerning the differentiated treatment and management of the people targeted as "hard to reach". Throughout Italy, there have been numerous collaborations between institutions, civil society, and third sector organisations to vaccinate specific categories of people (namely undocumented individuals, people on the move, and the homeless) (Matteini 2021; SIMM 2021). These initiatives responded to the need to activate local networks to implement the vaccination campaign. However, in most cases, the challenging attitude toward the public health system that characterised the Borgo Vecchio initiative was absent or much weaker. One example is the Turin vaccination centre involving the Third Sector Association (Gruppo Abele) and a private hospital. The involvement of this multiplicity of actors was a response to the need to expand vaccination coverage in an emergency. However, the patchwork of various vaccination initiatives risks failing to define a long-term solution to make services accessible and trustworthy for the population.

Furthermore, differential management emerges from another distinctive feature of vaccinations for "hard to reach" groups, namely the administration of a one-shot vaccine, the *Johnson & Johnson's Janssen Covid-19 vaccine*. This vaccine was considered the most effective for a fragile population for whom the organisation of the second dose would have been complicated. However, this approach had two limitations. On the one hand, the second dose was also necessary with *Johnson & Johnson's Janssen Covid-19 vaccine*. On the other hand, this vaccine proved less effective (66%) than others (Vaxzevria, BioNTech, SpikeVax) (Centers for Disease Control and Prevention 2022). Highlighting these limitations is essential to reflect on the uncertain and blurred boundaries between elements of solidarity and claiming the right to health with dynamics that risk producing or reinforcing further social inequalities and differentiation.

The case study presents some peculiar characteristics (total informality, political nature of the action, conflict with the institutions). However, this study has some limitations. Firstly, it includes only one case study. Secondly, it is necessary to point out that the numerical extent of the vaccination doses distributed is not comparable to the extent of vaccinations in official centres. Another limitation is the duration of the research, as the observations and interviews took place during the construction and opening phase of the vaccination centre and not during the subsequent months of activity. The observation of the continuation of the activities of the self-managed vaccination hub would have allowed for greater data collection and a longer-term perspective. Hence, research over a more extended period would have made it possible to think about forms of participant observation and to bridge another gap, namely the perspective of the neighbourhood inhabitants.

Despite these limitations, initiatives such as the vaccine centre in Borgo Vecchio, if analysed from a multi-actor angle, signal the existence of spaces and attitudes beyond the pro and anti-vaccination dichotomy (Gobo and Sena 2019). Although operating outside the healthcare system has created opportunities to put into practice

the principles of PHC, it is still being determined whether the long-term result will bring citizens and public services closer together. On the contrary, persistent differentiation risks reproducing inequalities and difficulties in accessing health services. Furthermore, the research acknowledges and problematises the role and dynamics involved in grassroots initiatives in the healthcare field, emphasising the need for a critical analysis of the relationships between different actors (in this case, health institutions and civil society collective actors) in the provision of services.

This paper suggests that further studies should be carried out on the roll-out of the vaccination campaign in the different Italian regions, taking into account the mechanisms of delegation by health authorities to civil society and third sector actors. Furthermore, a follow-up study should establish who the beneficiaries are and what the outcomes are, and should also consider the forms of collaboration and conflicts among various social actors and whether or not there are instances of cooperation between the different actors in and beyond the emergency.

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