



opencare

## Deliverable 4.5: Community driven care. A draft social contract

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## Drafting a social contract

*"The role of a clown and a physician are the same - it's to elevate the possible and to relieve suffering."*

- Attributed to Hunter Doherty  
"Patch" Adams (American physician, comedian, social activist, clown, and author)

Care is defined as "the provision of what is necessary for health, welfare, maintenance, and protection of someone". As such, everyone contributes to the care of someone else, many, whether directly or not, willfully or not. Quite remarkably everyone contributes, most of the times unknowingly, to hindering some declinations of care.

Furthermore, care, it turns out, is sort of fractal: its complexity doesn't diminish when we zoom to more specialized domains and so, for example, the medical definition of health, offered by the WHO back in 1948 and still actual, recites it is "a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity", forcing medical care to deal with the entire complexity of any other kind of care. In facts, this vision has deep roots, and already back in XIX century Prof Dr Rudolf Virchow (one of the most notable fathers of modern medicine) vehemently stated: "Medicine is a social science, and politics is nothing else but medicine on a large scale. Medicine, as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution: the politician, the practical anthropologist, must find the means for their actual solution. The physicians are the natural attorneys of the poor, and social problems fall to a large extent within their jurisdiction." <sup>1</sup>

However, do we ever reflect about whom to, and how, are the benefits of the acts of care distributed? And about what obligations descend from them?

Even if we don't explicitly, as individuals, philosophers in their quest to discover the ethical boundaries of

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<sup>1</sup> Wittern-Sterzel, R. Rudolf Virchow and his role in the development of social medicine. Verhandlungen der Deutschen Gesellschaft für Pathologie. 2003 ;87:150-157. PMID 16888907

social living have long proposed the concept of *social contract*. A social contract can be defined as the encultured set of principles ruling how a community lives together. Over time, this concept has been declined to emphasize the foundations of the contemporary political philosophy, from Hammurabi's code *skin in the game*, to Rousseau's *general will*, and Gauthier *prisoner's dilemma*, and a variety of mechanism nurturing and sustaining it have been proposed (religion, rational thinking, ...). In facts, the *fil rouge* binding every reflection on the nature of the social contract is not only of pragmatic nature, rather it is a moral investigation about the underlying mechanisms that bring to trading off individual freedoms in exchange for common (or others') good, from the second book of Plato's Republic, where the issue is treated by Glaucon's words, or the Buddhist text Mahāvastu, to today's neuroscientific research in empathy and altruism, and their evolution in competitive ecosystems.

It is beyond the scopes of this humble document to seek clarity concerning the foundations of social living. However, what we call the *social contract of community driven care*, turned out to be at the heart of most of the novelties and questions encountered in OpenCare. Hence, making explicit the above-mentioned contract is expected to be an important contribution to the maturation of the field.

Lest us first lay the boundaries of our quest: herein, we reflect on the social contract of those community driven care instances that respond to some unique, otherwise unmet need. We will think of uniqueness in the widest sense possible, where the need could be spiritual rather than physical for example. However, despite not having met any such case, or explicitly for that reason, we are not going to reflect on the social contract of initiatives that have merely redundant or competitive goals, as under such circumstances the existence of safety nets and, in facts, competitors nuances the ethical reflection and calls for a case by case analysis. We would like to emphasize herein that also in the case of "*products*" the social contract appears to emphasize the dimension of *services*. In facts, assistance, continuing development, "postmarketing" monitoring and users updates/information, trump the design and functionality of the product per se in the relationship with users. Furthermore, most (and all of those we encountered) community driven care products are not ultimately distributed as products, in order to work around the otherwise burdensome industrial and institutional certifications. They are rather distributed

as instructions and kits, threading at the border with educational and makers' projects. As such they shape themselves as services to begin with.

A social contract for community driven care would have to embrace the burden of responsibilities that emerges with care delivery, but also appropriately frame the expectations of reciprocity that are commonly born among participants.

The most pressing issues of the first kind seem to derive from the challenges of sustainability of care. In community driven care, it would seem, there is commonly the belief that doing something is better than nothing, and that problem solving can happen on the go. However, to put it in words we often heard from our stakeholders: "it's dispiriting the amount of energies consumed in organisational survival".

Why does this especially count for the social contract? The reason lies in the overall design of accountability in care. Albeit care is a right, and access to it is already regulated in most or all Countries by dedicated legislation and by the steering of Executive powers, in practice care receivers quickly come to rely on specific forms of care and caregivers, and whilst this has a positive impact on their perception of health, or their outlook for the future, at least when the interaction is well designed, it introduces an important liability for the care receivers. They can feel abandoned when a certain initiative is discontinued. This abandonment can go beyond the stage of feeling, as people who used to cope with a certain condition may seriously struggle to readapt to a solitary effort, after experiencing some forms of partnership, and support. It is not uncommon to hear the words "empowerment" and "participation" when talking of community driven care, but one should not neglect that many stakeholders will be mostly beneficiaries, their participation coming in forms of access to services, utilization, rather than in outright production. Furthermore, it is worth highlighting that the totality of projects we explored, despite stressing their own participative nature, all boasted narratives identifying target populations with some needs, alas identifying potential care-receivers. Such individuals will often have to break trust barriers and to build significant connections in order to fully onboard on initiatives, whose sudden tear down can constitute a true shell-shock, heavily under investigated, and thus underestimated overall.

The first point of a social contract for community driven care initiatives, hence, should concern their

dependability over time, or outright transparency concerning a lack thereof:

1) This form of care is designed to outlive the individual initiators, and has a clear strategy towards sustainability, or the necessary situational awareness to navigate through changes preserving the right to care of its beneficiaries.

*1<sub>bis</sub>*) This form of care is designed to work as a catalyzer, it may remain available an arbitrarily short period of time, and it is explicitly meant at raising awareness and/or teaching coping or problem solving strategies and/or passing the responsibility of care onto well identified existing organizations, rather than offering outright care in the traditional, entrusting sense.

The reader should keep in mind that even emergency care forms could subscribe to #1, and should explicitly subscribe to #1<sub>bis</sub> when designed not to remain available over long terms. In facts, also for emergency forms of care citizens and community members build maps of trust, and should be aware of services that are not planning to stay.

From the first issue a much larger, albeit also more nuanced responsibility descends: that of being accountable for securing the conditions necessary to effective care, and to the achievement of health by care receivers, or eventual failure to do so.

In facts, at the roots of care it is fundamental to have as a transparent information as possible shared with the public, and agreed upon with the care receiver at the act of onboarding, concerning the expected benefits and their likelihood, and the associated risks and pitfalls. Such information, has to be pursued, organized, and should be of such nature to be falsifiable by the public in future investigation. Individuals in most modern Countries have limitations to their ability of waving rights, and adhering to shaky programs of care, may expose all parties to serious legal consequences, further to betraying the "primum non nocere" (first, do no harm) principle of care, already established in ancient times. When uncertainty concerning the effectiveness is high, independently of the believes of the organizers and participants, the program should be clearly classified as research, or be accompanied by clear disclaimers concerning is (proven) security, and its voluptuary nature.

The second point of a social contract for community driven care initiatives, hence, should concern their commitment to effective and safe care:

2) Care offered by our team/s is designed with you based on information that has been, and will be tested for validity concerning both its effectiveness and safety. Our partners and we commit to publicly discussing our practices, to be transparent and to have the opportunity of discovering what could be done better/differently.

Furthermore, it descends from both of the above that any community driven care organization should ensure the resources to maintain the quality and throughput of its delivery constant and predictable over time, and should do so in ways that don't conflict with the need they satisfy, the service uniqueness, nor the interests and trust of their beneficiaries. This should be treated as an explicit challenge in every strategy, and communicated transparently all along the existence of the initiative, including the calls for support. But would the beneficiaries be able to hold the initiative accountable for the eventual failure of procuring sufficient resources? Would they be able to hold the organization accountable for sapping resources from questionable sources? Not many such instances have happened, mostly because of the nature of communication within and around community driven forms of care. In fact, as it is known by studies about medical liabilities, people tend to avoid legal means when they can have their objections heard by more direct ways. However, it would not be impossible, as community driven care becomes more common, and more important in the satisfaction of the needs of our populations, to envision a legal action against such an initiative for abrupt interruptions of service, sudden organizational changes with abandonment of committed paths by beneficiaries, or other similar instances. In fact, incorporated organization usually stipulate insurance contracts, or other financial strategies of risk mitigation that are never discussed in community driven care, either because of the unawareness of the issue, or because of the general lack of ready resources that pushes such thinking beyond the horizon. This should change, if we are serious about thinking of community driven care as a viable alternative path for the future of our societies.

The third point of a social contract for community driven care initiatives, hence, should concern their procurement of resources and their relative ethical standing:

3) We commit to transparency about our funding streams, and we commit to procuring and managing resources

adhering to the ethical standards we apply in all our activities, and in measure to sustain the continuity of our action, designing adequate fallback strategies should causes of force majeure cut us short of planned funding.

But let's take one step back. Community driven care should also ensure to reflect about local priorities when structuring its offer. This may sound counterintuitive, as most bottom up initiatives are born from the intuition of a group of founders, of pacemakers, sensitized to some issues enough to be stakeholders, and that is the fuel giving them impulse. As such, motivation, focus, and modalities, would seem to be already defined at the beginning. However, if the aforementioned fuel is the all important impulse of all, anyone should reflect on the abilities of care to shape and transform our societies before venturing in offering some form of care. Could there be an intersection between the wider needs of the local communities, and the needs the initiators would like to target? Is it possible to design the initiative as a platform, exploiting the initial focus as a first case to hone the governance and understand the value chains of care within the host community? Most of the times, these are questions to which community driven care gets by contrarian motion, as it struggles to survive and become sustainable, but which are often ignored by those initiatives that would have subscribed to #1<sub>bis</sub>, with potentially important social and ethical implications. The fourth point of a social contract for community driven care initiatives, hence, should concern their accountability for the social implications of their strategic choices:

4) We have designed this initiative with our community in mind, we struggle to maintain space and opportunities for everyone of you to join us and use, or ethically misuse what we maintain, so that the forms and offers of care existing here could evolve with the community itself. We are aware we cannot do everything alone, but we can facilitate you doing your part.

So far we have identified some fundamental pillars of the social contract for community driven care, focusing on the liabilities and duties of the care-givers, but what are the responsibilities, if any, that descends from the community's commitment to them, for the care receivers? Has the community driven care a right to be cared for by the groups of beneficiaries? Or can the community hold individuals accountable for their irresponsible behaviors?

Within the communities, it is not uncommon to capture signals of this kind of thinking. Why would somebody who

has never participated in the common life of the community expect to receive support when in need? Or Why would the community embark in caring for individuals whose behaviours expose them to repeated risks, or even worse exposes to risk the community itself?

This reasoning can be legitimated by arguments of mutualism and accountability to the community, and often permeates community driven care at several scales, and both explicitly and intuitively.

It is important here to lay a clear border to discriminate between different forms of care. In facts, during OpenCare the definition of what communities think of as being care has proven to be very wide, ranging from informal ER all the way to initiatives that care for common spaces or even just offer some insights about community activities to community individuals who need them to reflect on their activities and update them. However, not every form of care stands on equal ethical and legal grounds. Forms of care falling within the definitions of medical and social care, are to be considered human rights, and as such the circumstances under which access to them can be regulated and restricted are very limited and refer to special cases. No matter the irresponsible behavior behind a condition, ideological and moral barriers should not hinder accessibility of care. As instance, people abusing alcohol are excluded from the lists of liver transplant only on the ground that their substance abuse would nullify the benefit of the operation, but can be reintegrated in the list if they are demonstrably rescued from the dependence. Just as people involved in violent crimes, or people in jail for ominous crimes still receive care, and so do people that object against specific procedures on faith or ideological grounds.

However, as the activity that the community defines care gets farther away from that territory, it becomes possible to impose almost arbitrary access conditions. As instance a mutual fund, may decide to restrict access on the basis of faith, or professional belonging. Such criteria are usually valid, as long as they are explicitly advertised, and allowed by the form of incorporation chosen by the founders. Albeit often practically tolerated, arbitrary criteria, even if publicly stated, can be considered vexating and discriminatory if associated to the wrong legal framing, or in absolute, and can constitute a grave liability for the community behind.

It is worth highlighting that beyond the legitimacy of access regulation, the subsistence of arbitrary rules and restrictions can be considered as a distancing factor from universal recognition as care, which should be

universal and humanitarian, and not being restricted against any group.

The fifth point of a social contract for community driven care initiatives, hence, should concern their vision about people accountability:

5) We put in place every measure within our means to support your conscious participation to the production of the desired outcomes, and to support you in behavior changing and maintenance. However, we will never deny your access to care from us, as long as fall within the community we care for, as it is transparently stated and advertised in our statute.

5<sub>bis</sub>) We may enforce temporary restrictions to your access to care, under those circumstances in which your behavior represents an acute risk for the care providers (e.g.: violent or otherwise threatening behaviors), or whenever your behavior poses an absolute barrier to the achievement of the goal of said care, until modified (e.g.: requirement of discontinuation of alcohol abuse before accessing organs availability lists).

For this social contract to remain generic enough, yet effective, one last point has to be made, and it concerns the discipline of the interactions between the initiative of care and the receivers. This last pillar would have the role of preventing frauds and mitigating the risk of damages, willful or accidental ones, from both sides. In facts, especially when dealing with voluntary or blended forms of contribution of work, it is difficult to ensure a priori that over time nobody will try to renegotiate the rules of engagement, albeit with good intentions, for example aiming to satisfy a new need, or to optimize the efficiency of certain actions (e.g.: the recent polemics about rescuers at sea of migrants/refugee seekers, accused of getting too close to the coastal lines, and even of interacting with the syndicates exploiting human desperation in arranging dangerous and outrageously expensive trips, thus creating facilitating conditions for a crime under the intentions of saving more lives). In facts, since a certain degree of positive disobedience is in the DNA of most community driven care instances, ensuring without an explicit design that over time no breaches will happen is wishful thinking. Community driven care should be designed to be under the scopes of a trusted but independent auditing body, committed to cooperate with the advisory and executive boards towards the goal of maintaining a spotless ethical profile, while identifying situational changes as early as possible in order to adapt the practices and their governance to smoothly embrace new solutions that would not conflict

with the principles of care, and justice subscribed at the act of initiating any community driven care instance. The sixth and last point of a social contract for community driven care initiatives, hence, should concern their readiness to be independently reviewed and to turn criticisms into situational awareness:

6) We devote ourselves to care, and we are aware that the very objective and meaning of care evolve with the vision of the world of individuals and community. Thus, we commit to continuing independent evaluation of our activities, and to turning any breach or near miss consequently identified into the awareness of a changing landscape that would guide an evolution of our operations and governance. We invite all our members and users to raise a flag and report those instances in which needs required work-arounds, not because we aim to police the ethical dimension of your behavior, but because we want to rethink with you our rules and principles in order to find ways to accommodate the unmet needs you spotted in the most transparent and widely acceptable form possible.

Further articles could for sure be edited, but we are convinced that they would be informed by some specific declination of community driven care, and not general enough for this draft meant to serve as the starting point of a reflection within each project that lives and works with OpenCare.

Undersigning the present document is a declaration of adhering to a reflection about the ways to mature community driven care towards a realistic alternative to the contemporary centralized model of welfare that seems to have entered a crisis of trust and sustainability.

We invite the readers to post comments, and criticize for further development of this draft on the [opencare.cc](https://opencare.cc) platform.

## A social contract (Milestone 11)

### Community driven care. A social contract

1) This form of care is designed to outlive the individual initiators, and has a clear strategy towards sustainability, or the necessary situational awareness to navigate through changes preserving the right to care of its beneficiaries.

*1<sub>bis</sub>*) This form of care is designed to work as a catalyzer, it may remain available an arbitrarily short period of time, and it is explicitly meant at raising awareness and/or teaching coping or problem solving strategies and/or passing the responsibility of care onto well identified existing organizations, rather than offering outright care in the traditional, entrusting sense.

2) Care offered by our team/s is designed with you based on information that has been, and will be tested for validity concerning both its effectiveness and safety. Our partners and we commit to publicly discussing our practices, to be transparent and to have the opportunity of discovering what could be done better/differently.

3) We commit to transparency about our funding streams, and we commit to procuring and managing resources adhering to the ethical standards we apply in all our activities, and in measure to sustain the continuity of our action, designing adequate fallback strategies should causes of force majeure cut us short of planned funding.

4) We have designed this initiative with our community in mind, we struggle to maintain space and opportunities for everyone of you to join us and use, or ethically misuse what we maintain, so that the forms and offers of care existing here could evolve with the community itself. We are aware we cannot do everything alone, but we can facilitate you doing your part.

5) We put in place every measure within our means to support your conscious participation to the production of the desired outcomes, and to support you in behavior changing and maintenance. However, we will never deny your access to care from us, as long as fall within the

community we care for, as it is transparently stated and advertised in our statute.

6) We may enforce temporary restrictions to your access to care, under those circumstances in which your behavior represents an acute risk for the care providers (e.g.: violent or otherwise threatening behaviors), or whenever your behavior poses an absolute barrier to the achievement of the goal of said care, until modified (e.g.: requirement of discontinuation of alcohol abuse before accessing organs availability lists).

7) We devote ourselves to care, and we are aware that the very objective and meaning of care evolve with the vision of the world of individuals and community. Thus, we commit to continuing independent evaluation of our activities, and to turning any breach or near miss consequently identified into the awareness of a changing landscape that would guide an evolution of our operations and governance. We invite all our members and users to raise a flag and report those instances in which needs required work-arounds, not because we aim to police the ethical dimension of your behavior, but because we want to rethink with you our rules and principles in order to find ways to accommodate the unmet needs you spotted in the most transparent and widely acceptable form possible.

8) This care initiative may produce value that we do not map at a given time, as instance data or intellectual property. Our priority is the satisfaction of some fundamental, infrastructural needs for the wellbeing of our community, and we need to be sustainable, and we want to exert a multiplicative effect of our activities and yours. Hence, we invite all of you to participate to our periodic strategic exercises sharing your personal insights about our value chain. Third parties, exploiting our lack of awareness, and ultimately you and us, can scavenge value that gets ignored. We want to channel all the values and transactions generated within our initiative like ancient civilization would do with water, to ensure prosperity and sustainability for the entire community today and in the future. Sometimes this will mean that aspects of what we do will chose moderated form of openness, over the radical form some of us would favour. We will always be ready to engage with you in explaining and rethinking the reasons behind this, and the tradeoffs between benefits and pitfalls. Nothing is written in stone, but our will to do good.

## Part II

# A social contract for online design of care

Following public conversations (<https://edgeryders.eu/t/social-contract-draft/6977>) on the subject of the present deliverable, it has been decided in agreement with the consortium leaders that an extension, "Part2", would be produced focusing on the aspect of online design of care, and the relevant ongoing experience accumulated in OpenCare.

As argued in that conversation, a full deliverable on the social contract behind the dynamics of online design of care would not be feasible because, unlike our original expectations when writing the proposal, most of the online conversations could be classified as p2p education or consultancy, or even auditing, rather than outright design of new or renewed care delivery, which usually got ignited, or shared, on the platform, but happened largely off-line.

The edgeryders platform has however become the most prominent medium to a handful of instances of design by the OpenCare community, and this part2 will reflect on them, and try to extrapolate what a social contract at scale would look like. The most notable design efforts, for the readers' convenience, are:

- a) OpenAndChange  
<https://legacy.edgeryders.eu/en/openandchange-coordination>
- b) OpenRampette  
<https://legacy.edgeryders.eu/en/openrampette-the-procedure-the-prototype>
- c) OpenVillage <http://openvillage.edgeryders.eu/>

Interactions on web platforms are dominated by the following parameters:

- 1) declared values and principles
- 2) composition of the community
- 3) interactivity of the exchanges
- 4) governance/content-moderation strategies
- 5) perceived risks associated with the exchange
- 6) perceived chances of gain/satisfaction arising from exchange
- 7) subjective validation of promises' fulfilment

The platform adopted by OpenCare is the result of a teamwork centred around the Edgeryders, which pre-dates the project itself. The accumulated experience, both at the community level, and at the individual level by a few key players, is especially evident in their gameplay on

the points #1, #2, and #4, on which we can share a clear view of the underlying social contract.

Concerning the declared values and principles, the OpenCare experience is strongly suggestive of the worth of maintaining a lean approach, strongly defining just the *fundamentals*, and letting the community shape and negotiate iteratively the specific definitions, and implementations, of values and principles, as new meanings emerge and evolve over time.

In facts, at the entire platform level the IP policies are explicitly tuned towards radical openness, except for a few strategic threads that are ad-hoc embargoed to avoid steering and biasing the community during transition phases (cfr Deliverable 6.5). Hence, the platform is configured as a micropublishing environment (cfr Deliverable 6.1), and this is clarified to the community at onboarding through the funnel each individual member has to go through before becoming active on the platform. This is also reinforced through several key documents that a curious/dubious user could check at any time.

This radical openness approach could expose community members to the risk of competitive exploitation by better tooled up members, or external predators. Seldom resorting to stricter access policies, as mentioned above, blending of online and offline conversations, and the natural entry barrier to a conversation for a non engaged new comer work in unison to give community members a competitive head-start while maintaining a low-overhead right to circulate and exchange information wide and broadly across the boundaries of the platform.

Hence, a first item of the ideal social contract we are set to describe, would be the following:

- 1) We make available to the public, and clear, the values to which this ecosystem is devoted, and we ensure that every member has agreed to those founding principles. Sensitive to the fact that specific community values and goals can emerge and evolve over time, we explicitly let them being negotiated by the community itself on the platform, and make it our task to periodically gather the sense of what is happening and give it back to the community itself in a condensate format to facilitate their reflection and criticism of their own evolving identity.

Given the above, many new online community efforts appear still today to fall for the fallacy that the founding principles will naturally give raise to the "right" community. In facts, we are so used to read about the

role of user experience design, and trajectories to forget that, paraphrasing JurassicPark, *life will always find a way*. If the declared values, and platform design certainly have a role in ensuring a good start to a community, it is but a matter of time for a platform to be hijacked by “parasitic” activities (e.g. commercial SPAM), some of which can radically change the implicit sense of belonging and ownership, ultimately transforming the community.

In facts, a significant effort in OpenCare, and in the overall edgeryders platform, has been invested in online community management, and offline activities to continuously reinforce the input of new lymph, and the external perception of identity of the community. This is a process that loosely scales, as it is often spontaneously carried out by community members themselves. However, it is mandatory to account for it when initiating and managing a new collective intelligence effort.

Hence, a second item of the ideal social contract we are set to describe, would be the following:

- 2a) We commit to continuously investing in community management activities. Some of this are almost invisible, as assuring that relevant people are informed when a question goes unanswered for too long, some others may appear a bit more obtrusive, like questioning not immediately clear posts/behaviours to facilitate a public reflection and understanding among members.
- 2b) We commit to continuously investing in nurturing exchanges at the edges of the community, with groups and communities that identify as “other” from ours, to ensure a healthy circulation of ideas, expertise, and people across all, and avoid the formation of bubbles or echo-chambers.

It descends from the previous paragraphs that an online community is an ecological niche open for competition. As it happens in biological systems, one of the strongest weapons of defense against competitors is the cohesion of the community currently occupying said niche. Much like the advantage of guerrillas knowing how to exploit the geographical microscale properties of a territory, or maybe even more relevantly like the gut flora overwhelming with its intricate metabolic network of cooperation any potential competitor, a community is more resilient to external stressor as it is more connected, and more so in a time scale that thwarts high-jacking attempts. This is not a trivial challenge as, despite all the efforts put in by community management, it is difficult, if even desirable, to obtain a reliable

commitment to real-time interaction by community members. The OpenCare experience seems to suggest that design and UX may play a role in removing barriers to interactivity and engagement (cfr <http://legacy.edgeryders.eu/> Vs <https://edgeryders.eu/>). However, the editors of this document have no access at present to significant quantitative data to estimate the veracity of this hypothesis (the new website is active since too recently yet, and many confounding factors would complicate the interpretation of any finding at this point in time). Nevertheless, removing barriers does not equal to promoting a behaviour. In fact, as the recent polemics touching the larger general social media (e.g. Facebook, Twitter, ...) have brought to public attention, the trade-off between engagement and exploitability is a tough one to strike, the more appealing becoming the social experience, the easier its community vulnerability to exploitation or extremization.

The solutions adopted by OpenCare is imperfect, as it scales at the cost of human investment, and depends on a great deal of encultured expertise, rather than standardized practices that would easily be encoded and passed over. However, it is a good working solution to explore the space of possible solutions with an agile approach, taking advantage of the culture of the edgeryders community, in which users and maintainers blend and the identities fade into each other, offering a natural sandbox to test strategies to bring out the best of online community engagement and collective intelligence, and mitigate the risks they are exposed to. Furthermore, thanks to the funding in support of OpenCare, the consortium is developing analytics tools that conjugate ethnography and quantitative network analysis, and testing their use to evaluate hypothesis on the impact different strategies exert on community's behaviours (cfr <https://appliednetsci.springeropen.com/articles/10.1007/s41109-017-0049-9>), a unique *atout* of this experiment, which is made available opensource to anyone out there (<http://164.132.58.138:9000/index.html#/dashboard/about>). Hence, a third item of the ideal social contract we are set to describe, would be the following:

- 3) We put our best efforts into maintaining the platform and its community true to its original founding principles, and honest to themselves. To this end we invest in community management efforts, and we strive to measure the output of this activity to make it objectively assessable by any of you. The same tools and practices we adopt, are open to anyone on this platform, and we

proactively support you to engage in gardening activities: WE are the community, no one excluded.

A correlated yet independent issue is that of contents on the platform. This is not simple either, as community conversations could go astray responding to random provocations, and vulnerabilities can emerge from most dimensions of the design of the platform, and its services.

However, as most (if not all) vulnerabilities would fall under the umbrella of other components of this social contract, it is worth highlighting here what a response should not be. It is all too tempting (Facebook, we are looking at you) to enforce a reactive mechanism of censorship, simply trying to pluck undesired content from the platform, but the opencare experience suggests this is not something that really works at scale. Sensible decision-making concerning the purpose and meaning of content would require human judgement, and negative moderation is known to struggle against most advanced spam attacks (again, consider how facebook succumbed to Russian highjacking of its on services during the last US elections). Instead, as with nurturing a growing child, the best approach seems to keep negative reactions to a minimum, and rather invest in positive stimuli. Engaging the content of a post with questions, and maintaining interactions in each thread up to speed with small incentives and soft pushes, has the effect of strengthening the communication and shared sense making of the community itself, while putting most trolling and generic SPAM activities at bay. It is of course inevitable to be able to respond to outright SPAM attacks (think sales of Viagra, advertisement of Russian women meeting sites, and the famous Nigerian petrol dollars, for example) with suppression of the content, capability that is designed in the way itself posts and posters are tracked, but again resorting to this sort of measures should be restricted to the bare minimum of clearly black and white instances. In all other instances, governance efforts pay most back when they are positive, group reflection strategies.

Hence, a fourth item of the ideal social contract we are set to describe, would be the following:

4) We commit to granting our community and platform a clean and workable environment with the least interference from us. Even when this is requested, we will wear the robe of users, engaging as much as possible other members in a respectful and curious fashion, trying to turn any apparent disturbance into an opportunity of community growth. Only in the most extreme and clear cases

of trolling and SPAM will we resort to removal of contents.

The challenges that we numbered #5 and #6 have not been sufficiently characterized in OpenCare. Has stressed above, most members perceive the platform as an ecosystem rich of learning and p2p knowledge exchange and refining opportunities, rather than as we initially hypothesized a platform for co-design. Many exchanges point to external, third parties' content, and conversations switch on- and off-line frequently. This could be a sign of a still evolving set of services (design can be quite resource intensive, whilst the platform today is still handling exclusively micropublishing, and threaded reactions), or the optimum of such a collective intelligence effort, for which being an open system could be a feature.

As we stand, it is impossible to extrapolate what a sustainable social contract for community led online design would pursue concerning opportunity and risk communication, and sharing. Thus we will leave these as open questions.

The last point, subjective validation of promises' fulfilment, is especially sensitive though, and in OpenCare this has played an important role in pivotal moments. As mentioned above, there have been instances (OpenAndChange, OpenVillage, ...) when the community has been called to invest a significant amount of focus and time on pre-identified goals, within specified time windows, under the promise of an opportunity of collective gain.

To an inattentive eye OpenAndChange, despite the enormous moral achievement of succeeding in the assembly of a large scale federated proposal by a community of people whom have (at least in part) never met before, could look like a failure. In facts, soon after passing the administrative validation, the proposal was dropped out of the review and did not make it in the final shortlist, not to mention obtaining the grant it had aimed for. Nevertheless, a few (a majority?) of the actors involved in that effort, have again joined forces and are investing time and resources in the effort named OpenVillage. The reasons behind this are multiple, and a few encompass that impalpable domain of human relationship and trust that underlay the synchronicity of the first effort. However, the most interesting ones concern the dimension we are interested in here. In facts, thanks to the transparent and open approach adopted during the ramp up phase of OpenAndChange, each group and individual saw its work credited publicly, and gained a high confidence map of the skills of its partners. This capital, which was already discussed at

the time could be repurposed and reused in bootstrapping initiatives, has found a natural reinvestment in OpenVillage. The two, apparently distant initiatives, threaded a link between human investments that strengthened the perception of trustworthiness, the expectation of gain by community members.

This informal mechanism of crediting has been perceived so clearly that one of the community members kicked-off an experience of formalization and quantification (<https://pay.coupons/>), which is federated in the mechanism of the OpenVillage.

Hence, the seventh and last item of the ideal social contract we are set to describe, would be the following:

7) We commit to acknowledge the investments of any kind that you put in shared and community activities, and we are ourselves invested in ensuring a fair and just redistribution of gains among all that contributed to the initiative at any stage, knowing that a surgical room would not work properly, not matter how good the surgeon and anaesthetist, if the cleaning personnel or the secretary did not do their job properly. Tracking and accounting in large collectives, working on creative and innovative initiatives is not always straightforward, but we put our best efforts to evolve our strategies and to listen to your feedbacks to improve the system effect of the work we do together.