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EDITORIAL

Global Social Medicine for an Equitable and Just Future

CARLOS PIÑONES-RIVERA, ÁNGEL MARTÍNEZ-HERNÁEZ, MICHELLE E. MORSE, KAVYA NAMBIAR, JOEL FERRALL, AND SETH M. HOLMES

The papers in this special section work together to move toward a global social medicine for the 22nd century. They envision a global social medicine that confronts and moves beyond the traditionally colonial, xenophobic, heteronormative, patriarchal, gender-binary-bound, capitalist, and racist histories of the fields of global health and human rights. They seek to instantiate a global social medicine that centers knowledge and experiences from the Global South and works toward social justice and health equity at scale. In this special section, the authors are particularly interested in understanding, challenging, and expanding our perspectives and enactments of the right to health. Unlike neoliberal perspectives on health that often limit their explanatory capacity to how individuals behave in the world, the papers here move beyond the focus on lifestyles and on the phantasmagoria of a sovereign subject with supposedly free agency. Instead, authors work toward critical consciousness that accounts for structural processes—with their inequities and disruptions, as well as their effects on individuals—and how this consciousness can open new horizons for collective transformation and social emancipation in health.

These papers build on a long history of theorizing and critiquing coloniality and racism. The seminal works of Frantz Fanon (in the Antilles and beyond), W. E. B. Du Bois (in the United States), and Aníbal Quijano (in Latin America), to name only a few in the Antilles and beyond, theorize systemic racism and its intersections with colonialism.[1] These and other thinkers lay the groundwork for critical applications to diverse fields. In particular, these contributions are the foundation of key critiques of racism, colonialism, and neocolonialism in science and biomedicine, elucidating how these structural processes impact individual and collective health.[2] Such forces condemn some human groups not only to exclusion but to pure and hard "extinction."[3] This critical work on colonialism and racism has also shaped the framework of critical interculturality in health, which recognizes the weight of the coloniality of knowledge from Global North and Eurocentric perspectives and stresses the need for epistemology from the Global South and from social movements around the world.[4] Critical interculturality imagines a science that is critical and emancipatory

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and that serves people and collectives instead of those in power, such as nation-states and corporations. It also envisions the potential of a "critical consciousness of oppression" as a starting ground for individuals and social groups to transform the world.[5] Latin American thinkers have been developing this framework in relation to Latin American social medicine and collective health.

These critiques at the intersection of racism, colonialism, and medicine remain relevant today in the wake of so many recent tragedies, such as the deaths of Joane Florvil, Jina Mahsa Amini, George Floyd, and many others at the hands of the police and other violent institutions. Simultaneously, the continued rise of violent anti-immigrant xenophobia alongside new expressions of white supremacy and anti-Black and anti-Indigenous racism all continue to impact collective health. In response, 21st-century reflections and actions against coloniality and racism are changing, deepening, and broadening.[6] Within academic discussions, authors argue for the importance of decolonizing global health and advocate for an intercultural turn in health.[7] Scholarship on capitalism's relationship to modern-day medical institutions outlines structural determinants of health; and the framework of collective health broadens this analysis by stating that the movement of capital accumulation subsumes particular modes of living and embodies the phenotypic, genotypic, and psychological processes expressed in epidemiological profiles. In addition, major medical journals related to medicine focus on the importance of racism on multiple levels.[8] These analyses clarify how various historical and contemporary social and economic structural forces continue to impact the right to health.

In approaching this special section, we acknowledge that certain groups in power, especially in the Global North, have dominated the literature on the right to health. In order to counteract the forces of what Latin American theorists have termed "scientific ignorance," we attempt to bring into dialogue multiple frameworks that can help us understand the breadth and depth of the right to health from distinct social, disciplinary, and geographic locations around the world.[9] The papers in this special section reflect insights from the fields of social medicine, collective health, Latin American critical medical anthropology, the Indigenous research paradigm, health and human rights pedagogy, and structural competency. These contributions reflect ways to think and act from Africa, South Asia, Latin America, North America, Western Europe, and Eastern Europe, and are in conversation with one another as we work toward a better—perhaps deeper and broader—understanding of the right to health, global health equity, and social justice.

Taking a rights-based and decolonial approach is critically important to expand the literature on the right to health from multiple social and geographic angles and to gather analyses from communities and territories with a long history of struggle against colonialism, racism, and other systems of inequity, accumulation, and dispossession.[10] In different ways, the papers included in this section seek to redefine their relationship with the communities and collectives with whom they work and form part. These analyses seek to strengthen the recognition of other logics—logics that are not only different from the sources that have nourished social medicine but also distinct from those that have nourished scientific knowledge; logics that are markedly diverse and non-Eurocentric. This allows for the validation of subalternized, popular, and Indigenous knowledge, illuminating dimensions of reality made invisible by scientific ignorance while pushing toward a more just social medicine.[11]

Building from Paul Farmer's legacy

This special section was developed to honor and build upon the legacy of Paul Farmer, who died suddenly one year ago (on February 21, 2022). Farmer's work had profound impacts worldwide on those who knew him and those who, even without knowing him personally, were inspired by his work.

In his writing and actions, Farmer sought to broaden the horizons of human rights. This is reflected clearly in his paper "Challenging Orthodoxies," in which he introduced his plans for *Health and Human Rights Journal* as incoming edi-

tor-in-chief.[12] In this paper, he invites us to broaden the right to health toward the economic and social rights that allow us to work toward global health equity. Beyond his many publications pushing toward global health equity, his legacy is seen in his active "pragmatic solidarity" as the co-founder of Partners In Health, including his activism and advocacy.

In this special section, we honor the legacy of Paul Farmer by following his iconoclastic stance, working to expand the horizon of the right to health, changing whose voices are centered, and broadcasting the experiences and knowledge too often ignored by hegemonic perspectives. In these ways, we work to build a social medicine for the 22nd century that works against racism and colonialism on all levels, from intrapersonal to interpersonal, epistemic to material, and institutional to structural. In honoring Farmer's legacy, we learn from and acknowledge the myriad scholars and traditions that shaped his work, from Fanon to Galtung, liberation theology to decolonial praxis, Latin American social medicine to critical medical anthropology thinkers such as Paola Sesia and global health equity leaders such as Agnes Binagwaho (both of whom have commentaries in this special section). The lineages of thought and action that compelled Farmer are historically deep and geographically broad.

Broadening the right to health

This special section aims to provide a space for interaction and dialogue among diverse voices working for global social and health justice. Its papers result from practices that struggle to broaden the predominant meaning of both human rights and health itself.

The paper by Mireia Campanera, Mercè Gasull, and Mabel Gracia-Arnaiz utilizes the framework of the social determinants of health to interrogate the structural aspects of food insecurity. Through an ethnographic study carried out in Catalonia, Spain, with primary health care teams, this paper focuses on the lack of responsiveness of these professionals to the basic needs of the most oppressed social groups. Although health and social policies speak of the need to consider the social determinants of health—especially after the 2008 economic crisis—primary health care practices have achieved little concerning these determinants. The authors argue that scarce resources at the primary health care level and the lack of training for professionals to transcend the individualistic view of health and food insecurity result in the failure to respond to the social determinants of health. Considering food from a human rights perspective, this paper discusses the reduction of food to a matter of mere individual responsibility while concealing the political dimensions of a fundamental right on which health closely depends.

A number of papers carry out this broadening of the horizon of right to health using the tools provided by the relatively recent framework of structural competency. Each takes a clinical problem as a starting point and then shows the problem's structural determination. These papers broaden the right to health by underlining the critical importance of structural processes.

Margaret Mary Downey and Ariana Thompson-Lastad, for example, establish that "structural competency and the right to health are complementary frameworks that should inform each other." In the process, they make innovative and compelling connections between the social determinants of health approach and what C. Wright Mills conceptualized as the "sociological imagination."[13] Their work focuses on medical social workers in a maternal and child wellness center, as they conceptualize individual troubles as part of larger societal issues produced by imbricated institutional, structural, and historical forces beyond the control of any one person.

Along a similar line, Michele Friedner brings disability justice explicitly into the nexus of the right to health and the framework of structural competency. Her paper analyzes the Indian program to promote biotechnical assistance to deaf children (including cochlear implants) living below the poverty line. She argues that by focusing solely on the "right to hear" and cochlear implants as a response to deafness (as opposed to other forms of

social and medical inclusion), health professionals ignore the complex work required to maintain cochlear implant infrastructures, as well as the advocacy work done by disability activists in India. She advocates for including disability justice as a core aspect for structural competency and the right to health. Her proposal is consistent with and broadens the United Nations Convention on the Rights of Persons with Disabilities, which promotes the right of persons with impairments to live a full and dignified life.

A similar line of intersection between structural competency and the rights-based perspective is proposed by Michelle Munyikwa, Charles Hammond, Leanne Langmaid, and Leah Ratner. They address the difficulties in the transition from pediatric to adult care for adolescents and young adults living with medically complex chronic diseases. The authors' argument is that a safe, structurally aware, and interpersonally supported transition to adult services is a key component of the right to health for all people, especially for youth dealing with medical complexity and structural vulnerability. Including concrete cases from the United States and Ghana, the paper offers vivid images of the transition from pediatric to adult care, illuminating the importance of structural aspects such as stratification between public and private health insurance systems. The authors aim to produce a structurally responsive and equitable transition medicine that includes empathic attitudes and material means. The text broadens the horizon for perspectives on structural competency while offering a useful model for this health care transition.

Although the work of Marek Szilvasi and Maja Saitovic-Jovanovic is not explicitly situated in relation to the structural competency framework, their perspective is perfectly compatible with the aspect referred to as "structural humility."[14] Their paper analyzes Roma community-led initiatives using social accountability and legal empowerment approaches to advocate for equitable fulfillment of the right to health. The argument is grounded in the pioneering work of Anuradha Joshi, who complements social accountability and legal empowerment approaches, following the legacy and broadening the important work on social accountability developed in South Africa, Latin America, Indonesia, and South Asia.[15]

Szilvasi and Saitovic-Jovanovic explicitly recognize that the quality, affordability, and inclusiveness of health care systems are determined by what they call, following the work of Jo Phelan and Bruce Link and of Scott Stonington et al., "fundamental determinants of health."[16] Szilvasi and Saitovic-Jovanovic's paper is instructive regarding the concrete difficulties that the development of structural competence can encounter not only in health teams but also in the very collectives and communities that fight for their rights, something that Carlos Piñones-Rivera and colleagues have called "collective structural competences."[17] The authors point out the need for further efforts toward collective, advocacy-focused, and community-driven actions that tackle structural factors determining the right to health. Following Farmer, they argue that we must go beyond a right to health care, integrating all of the aspects of social, economic, and political life that determine health.

When the points of view of Indigenous peoples are considered, the right to health is broadened in important ways. This special section includes two papers that reflect experiences of struggles for the right to health within Indigenous communities in South America in relation to understandings from collective health and critical interculturality in health. Both show the colonial condition within neoliberal capitalism, the impact it has on the individual and collective health of Indigenous peoples, and how communities theorize and organize to confront this oppression.

Adimelia Moscoso, Carlos Piñones-Rivera, Rodrigo Arancibia, and Bárbara Quenaya analyze their collaborative work as Indigenous (Aymara) people and allies in Chile to problematize the very matrix from which the right to health is defined and explore the advantages of situating work in an Indigenous research paradigm.[18] This epistemological shift arises from the need to decolonize research, which at times considers Indigenous peoples to be only objects of investigation and not producers of knowledge themselves, who may have their

own epistemological and even ontological logics.[19] Specifically, analyzing the death of an Aymara wise woman, and the sociolegal strategy used to confront the lack of cultural appropriateness in health care, this paper highlights how colonial logics are reproduced in the field of the right to health care, denying other ways of producing evidence to demonstrate the violation of health care rights. In doing so, the authors build from understandings of collective health to argue that research on the right to health must confront and counteract the hegemony of a limited biomedical gaze over the knowledge of Indigenous peoples.

Along the same line, Marcela Castro and Ana María Alarcón's paper provides insights into how the Mapuche people strive to fulfill their Indigenous rights to land and health within a profoundly unequal racial capitalist, colonial, global market system. Based on interviews with Mapuche people from diverse sociocultural roles, the authors explore the knowledge that Mapuche people from the Araucanía (Chile) have about nature, well-being, and their relationships with the Chilean state. Through the voices of Mapuche interviewees, Castro and Alarcón guide us into critiques of the extractive policy implemented by the Chilean state; the colonial logic that guides the industrial occupation of their territories and violates Mapuche ancestral rights; and the enormous changes in their ecosystem and the subsequent impact on the well-being of their communities. The authors analyze the contradiction between Mapuche epistemologies and the capitalist and positivist logic consecrated in the current Chilean Constitution. While the latter conceives of ecosystems as unlimited resources that can be exploited, the former connects health to the natural ecosystem and promotes nature's protection through the recognition of the rights of nature itself. Changes affecting the ecosystem have generated uncertainty and a lack of well-being, violating the right to full health. Moreover, many interviewees describe this colonization and neo-colonization as a severe loss and important trauma in their people's history. Throughout, they express their struggle to recover and validate their constitutional rights as well as their collective health.

The last two papers broaden right to health pedagogy and propose important theoretical developments for doing so, based on extensive work in global health in Latin America and Africa.

Luis Ortega, Michael Westerhaus, Amy Finnegan, Aarti Bhatt, Alex Olirus Owilli, Brian Turigye, and Youri Louis are part of EqualHealth, a transnational group of social medicine educators and practitioners who work in Uganda, Haiti, and the United States. In this paper, they reflect on their collective development of an integrated framework in human rights education, grounded in transformative pedagogies to foster dialogue between Latin American social medicine, collective health, and the framework of structural vulnerability.[20] They argue that transformative pedagogy should guide collaborative curricular design and evaluation oriented toward learner outcomes linked with social change. They propose pedagogical tools grounded in the dialogue between those critical and transformative pedagogies to actualize the human right to health.

Likewise, Fátima Rodríguez-Cuevas, Jimena Maza-Colli, Mariana Montaño-Sosa, Martha De Lourdes Arrieta-Canales, Patricia Aristizabal-Hoyos, Zeus Aranda, and Hugo Flores-Navarro from Compañeros En Salud, a Mexican organization related to Partners In Health, criticize the fact that most of the curricula in global health are developed and delivered in the Global North for students from high-income countries who in most cases will not end up working in global health. Considering this, their organization has created a human rights-based global health and social medicine curriculum adapted to the local setting of their rural region in Mexico. Alongside Farmer's standpoint, this curriculum expands the right to health, advocating for an integrative human rights approach in which social and economic rights are given the core relevance they deserve while also emphasizing civil and political rights. The right to health cannot be seen as an independent human right; it is interdependent on other economic and social rights, such as the rights to work, water, food, housing, education, and nondiscrimination.

Based on 10 years of experience, Rodrí-

guez-Cuevas et al.'s work underlines the importance of developing and implementing interdisciplinary curricula and emphasizes the importance of integration with communities. In their words:

> *Compañeros En Salud aspires to establish more proximity with the communities in order to understand their perspectives and, in turn, improve the services and care they receive. Last but not least, we have learned that the joint construction of a knowledge paradigm, agreed-upon intervention criteria, and the promotion of shared values between the medical team and the community generates the possibility of communicating through a language that helps unify the members of each cohort.*

Conclusion: Implications for a new global social medicine

This collection of papers building from the legacy of Paul Farmer shows us the possibilities that global social medicine practice and scholarship hold for the right to health. This globally diverse social medicine confronts North-South asymmetries while thinking and working toward racial justice and against coloniality. This will be a social medicine critical of the nation-state's role in reproducing power asymmetries, hierarchies, and exclusions. It will also be critical of that same nation-state's inability to protect its citizens' health in the face of the power of large corporations and distortions from neoliberal regimes. It will be a social medicine that responds to the concrete needs of individuals and collectives and, therefore, intimately connects with social movements and community processes. It will address racial justice in all its dimensions (including epistemological, institutional, and structural ones). The social medicine of the future will not be Eurocentric or Anglocentric; it will build its proposals and actions on the basis of the different ontologies, epistemologies, methodologies, and ethics that are at the heart of social movements, in critical dialogue with the best anti-hegemonic proposals of knowledge from around the world—including and moving far beyond Europe and Anglophone North America. This social medicine invites us to think in renewed ways about the right to health, including, as Farmer teaches us, everything that allows and produces full health for all.

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