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COMMENTARY

Global Voices for Global (Epistemic) Justice: Bringing to the Forefront Latin American Theoretical and Activist Contributions to the Pursuit of the Right to Health

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The invitation by the *Health and Human Rights Journal* guest editors to provide a commentary for this special section comes just as we approach the first anniversary of Paul Farmer's untimely passing. As the date nears, I am inevitably reminded of, and deeply inspired by, Farmer's contributions and uncompromising commitment to global health equity, social justice, economic and social rights, and a rights-based approach in his clinical practice, intellectual work, and health activism.[1] In Farmer, such a commitment became particularly resolute in relation to the poor, the dispossessed, and the outcasts, wherever they may live: Siberian prisons; urban slums of Lima, Boston, or Port-au Prince; or poverty-stricken rural villages in Haiti, Peru, Malawi, Rwanda, Lesotho, Guatemala, or Mexico. Just as important among Farmer's legacies—and one that strikes a particularly sensitive chord with me, as a critical medical anthropologist myself—is the pursuit by this exceptional scholar of an activist, politically engaged, and nonetheless rigorous and reflexive medical anthropology.

The papers that make up this special section of *Health and Human Rights Journal* draw on some of these legacies and on other like-minded theoretical, practice-oriented, and activist frameworks, namely social medicine, collective health, and structural competency in medical, community, and public health training and service provision. The guest editors have envisioned the possibility of an enriching, cross-fertilizing dialogue between these three approaches and have encouraged a debate around their potentialities, without ever losing sight of the final goal: the fulfillment of the right to health for all. I surmise that the contributing editors clearly saw the potential of all three frameworks to expose and to dissect the impact of structural social inequalities on health and well-being, while also concretely promoting the right to health in actual practice.

The papers in this section take up the challenge to use one or more of these frames of reference to consider the right to health; they do so in different ways and to varying degrees, approaching them from different epistemic angles and applying them to diverse health problems in a wide range of socio-geograph-

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ical settings, including the United States, Chile, India, Uganda, Haiti, Spain, Mexico, Ghana, and Roma communities in Bulgaria, North Macedonia, and Romania. Most of the papers refer to the right to health or, more commonly, the difficulties or failure to fulfill it; some have engaged explicitly with the structural competency framework in service provision or in medical training, and others make explicit reference to the social medicine paradigm in their community and advocacy work involving the training of health professionals or the delivery of medical services. Two of the papers link to and draw from collective health and make contributions based on this framework in relation to the health, knowledge, and priorities of Indigenous people.

In my view, it is important to stress that two of these frameworks—social medicine and collective health—stand out as strong theoretical contributions from Latin America, a continent that has offered a particularly fertile ground for the development of original and innovative critical thinking in health and social sciences, as well as the promotion of the right to health as a basic human right in international law. I venture that the contribution from Latin America to the formulation and adoption of the right to health is probably unknown to most, for which reason I will dedicate a few lines in this commentary to that story as well.

It is with Farmer that I begin this commentary. My words are centered on the contributions of Latin American praxis-oriented critical thought in pursuit of health equity, social justice, and the fulfillment of the right to health as a basic human right—contributions that Farmer recognized in his own particular ways but that, by and large, tend to be ignored in hegemonic Anglophone global health production. This last point I find crucial, and I will pick it up again later.

As we all know, Farmer was stationed as a professor in the heart of privileged academia: the distinguished Harvard University, where much knowledge—including in social sciences, public health, clinical medicine, political economy, and critical theory at large—is created and from where much radiates to the rest of the world with the unmistakable imprint, distinction, and oftentimes nonchalant obliviousness of its entitled origins. Far from being a pompous, convoluted, and conceited intellectual from the top of the top of hegemonic academia, Farmer was quite the opposite: people who knew him personally remark on his unpretentiousness, human and intellectual generosity, and deep-felt empathy with his fellow human beings and with the ever-expanding plights of deprived humanity.

We can also directly witness Farmer's writing, with his characteristic clarity of thought; his genuine expression of moral indignation at social injustices, human suffering, the unequal burden of preventable deaths, and "structural violence" experienced by the global poor; and his passionate defense of the underserved, marginalized, oppressed, exploited, excluded, and dispossessed individuals or social collectives from the Global South.[2] I would argue that his generosity, intellectual honesty, and humbleness also manifested themselves through an explicit recognition of the eclectic and pragmatic traditions of thought from which he drew inspiration, where some Latin American intellectual currents stood out. In many ways, inspired by these currents, Farmer proposed a broadening of our understanding of, and acting upon, health and human rights.[3]

Thus, Farmer openly declared how progressive Catholic liberation theology (especially with the figures of Archbishop Oscar Romero from El Salvador and Friar Gustavo Gutiérrez from Peru) and its focus on the poor, as well as Paulo Freire's pedagogy of the oppressed from Brazil, had a major impact on his ways of thinking and acting as a physician, medical anthropologist, and health activist, particularly his criticism of colonialism, capitalist exploitation, and neoliberal policies in global health and their adverse effects on the poor and dispossessed.[4]

To these, a third, perhaps less explicitly declared, vein came to make an impact on Farmer: a humanitarian strand of Latin American Marxist-influenced praxis where the development of critical thought has been inextricably accompanied and reinforced by a commitment to the transformation of unequal and unjust health conditions

and their underlying social causes. Undoubtedly, this progressive action-in-the-world-oriented praxis is present in both liberation theology and Freire's popular education.

Liberation theology and popular education also share a peculiar utopian drive in their uncompromising social engagement to transform unequal and oppressive conditions for the poor. I believe these features made both currents particularly attractive to someone like Farmer, who openly declared his aversion to detached, sterile, and speculative intellectual work that is too far removed from the daily struggle to make ends meet for most of the people of our living planet.[5] Farmer believed that knowledge is and should be produced first and foremost for social change in order to overcome injustice, inequality, and other prevailing social ills. It seems to me that his conviction was not solely the product of a rational mentalist intellectual exercise: it was *senti-pensante* (felt-thought), as Colombian sociologist Orlando Fals-Borda (the father of participatory action research) would say, and it was rooted in passion and moral outrage.[6]

Here, it is worth highlighting some parallels with these other Latin American critical currents of thought. In a similar way to Farmer's, Marxist-oriented praxis is a central tenet of Latin American critical epidemiology, social medicine, and collective health.[7] From the start, these three interrelated—at times, interchangeable—theoretical orientations have vehemently opposed what Farmer called "the public health orthodoxy" and have worked strongly for the right to health for all; and they have done so for decades, in many cases prior to Farmer.[8]

These theories have produced important studies on a wide variety of health and disease problems from a political economy perspective, revealing the complexities and entanglements of what Jaime Breilh calls the "social determination of health."[9] Influenced by Gramscian ideas around (1) the necessity to unite theory and action to mutually inform and reinforce each other, (2) the sociopolitical role of organic intellectuals, and (3) their direct engagement in conscious practice, proponents of these currents of thought have long posited that the "generation and transmission of knowledge" are powerful "tool[s] for change."[10] I find it important to highlight these parallels and reflect on these theoretical orientations whose exponents have concomitantly promoted progressive health policies, social justice, and the universal right to health and health care. In Latin America, critical epidemiology, social medicine, and collective health (the preferential term for social medicine used in Brazil) have multiple identities, and their orientations are far from being monolithic. What is clear is that, all together and at the same time, they are thriving schools of critical thought, distinctive research fields and methodologies, and transformative social and political movements.

It is worth remembering that paradigmatic theories, especially those linked to transformative action, do not emerge in a vacuum; they may well flourish in very adverse circumstances, against dominant paradigms, and as counter-hegemonic projects. These frameworks are, in fact, the historical products of particularly challenging contexts: as we know, Latin America and the Caribbean are two of the most unequal regions in the world; nor should we forget that Farmer himself forged his thinking and life activism in Haiti, the poorest country of our entire Western hemisphere.

These inequalities are the tangible inheritance of a harsh history of colonialism, unfettered capital accumulation and predatory capitalism, centuries of pillage and devastation of nature across entire regions, the dispossession of Indigenous territories, the genocide of millions of Native and Black people, the brutal implementation of forced labor and African slavery in the plantation economies, and, after independence, the yoke of British and US imperialism. More recently, these inequalities have developed from the establishment of authoritarian regimes or outright bloody military dictatorships; the exercise of political violence and the massive or selective annihilation of the opponents to political or, increasingly, economic megaprojects; the predominant patriarchal *machismo* with its own culture of death; the ruthless implementation of structural adjustment programs and neoliberal doctrines; and the extreme concentration of power

and wealth among national economic elites. And most recently, inequalities are being worsened by the ongoing "war" on drugs and organized crime, with hundreds of thousands of people killed or disappeared. It may be worth (re)reading Eduardo Galeano's *Open Veins of Latin America* for a powerful, clearly articulated, historically informed, and morally outraged account of what the region has experienced from the conquest to the late 20th century.[11]

As schools of thought and research fields, critical epidemiology, social medicine, and collective health emerged or re-emerged in the 1970s in opposition to prevailing functionalist and positivist paradigms in hegemonic public health and preventive medicine at the time.[12] The conventional paradigms were ill-equipped to, and not particularly inclined to, understand the complexities and dynamics of social inequalities and health. Eric Carter and Marcelo Sánchez Delgado, for their part, maintain that the history of social medicine as a movement of ideas is not linear, coherent, or unidirectional; it does not respond to just one theoretical paradigm; and it distinguishes itself for being ideologically pluralistic and diverse, where—beyond contrasting postures within structural, historicist, or culturalist Marxian traditions—poststructuralist social theory, including Foucauldian and other ideas, have found fertile ground.[13]

Accepting the richness of this diversity, social medicine and collective health have developed critical intellectual traditions, particularly in Argentina, Brazil, Chile, Colombia, Cuba, Ecuador, and Mexico, at least since the 1970s but in some cases as early as the 1930s.[14] They have done so by promoting lively debates and building and consolidating collective associations and continental networks for the exchange of ideas, scholars, publications, and students. They have dedicated their reflections to the complex, dialectical, processual, and historically construed relationships between two aspects: on the one hand, health, the unequal burden of disease and mortality, social suffering, poorly financed care systems, and the expansion of medicalization to different spheres of human life, and, on the other, class structure and inequalities, gender and ethnic subordination and discrimination, capitalism and colonialism, the extreme concentration of wealth and widespread poverty, racism, political violence, environmental destruction, dispossession, social deprivation, and the dissimilar formations and roles in health policies by nations-states and their state apparatuses, including the establishment of official medical institutions and public health care systems and the open or veiled support for the commodification and privatization of medical services.

One of the central theoretical propositions that critical epidemiology and Latin American social medicine have developed is the concept of "the social determination of health," an important analytical tool advanced by Breilh, a leading and prolific critical social thinker, physician, and epidemiologist from Ecuador.[15] Although not all agree with its epistemological premises, theoretical arguments, or possibilities of implementation, this conceptual approach has made an impact among many social medicine practitioners, academics, and schools in Spanish- and Portuguese-speaking circles of knowledge production and critical thought.[16] Breilh has been developing this concept since the late 1970s in order to stress the historical, material, ideological, dynamic, multicausal, and contextual nature of the "health, disease and care processes," a seminal concept coined by Eduardo Menéndez to which I return later.[17] Only very recently have some Anglophone practitioners, movements, and writers begun to explore, acknowledge, and utilize this concept.

The conceptualization of the "social determination of health" predates by several decades and presents important epistemic and ideological differences from the later and much more widely known formulation of "the social determinants of health" advanced by a commission appointed by the World Health Organization (WHO) in 2005.[18] WHO has been criticized for translating complex and dynamic social realities into discrete and isolated categories, organized in static hierarchies that do not allow full understanding of the underlying articulations and actual structural processes behind health and social inequalities.[19]

Some of the papers included in this collection refer precisely to this WHO notion, and Farmer himself referred to the social determinants of health as a welcome corrective to narrow biological theories of disease causation. As most other scholars from Anglophone academia or other non-Latin American latitudes, they are probably not familiar with the underlying debate, nor with the existence of this more precise, rigorous, processual, practice-oriented, and counter-hegemonic epistemic formulation. Only very recently is the social determination of health being brought to the English-speaking academy in a few major medical journals.[20]

One last major theoretical contribution to the contextual and dynamic understanding of health, health care, and medical pluralism in Latin America that deserves mention is the fruitful conceptualization of the "health/disease-illness/care process," "self-care," and "the hegemonic biomedical model" developed by Eduardo Menéndez, an influential medical anthropologist in the Spanish-speaking world who came from Argentina to Mexico to escape the military dictatorship.[21] Menéndez's contributions include a rigorous critique of public health policies, theoretical and methodological orientations, and limitations; his critique has been strongly inspired by Gramsci's historicist perspective and cultural hegemony theory.

Without losing sight of methodological and theoretical rigor in their analytical production, Latin American proponents of social medicine and collective health have actively participated in transformative social movements and political struggles, and many suffered the adverse consequences of their progressive political affiliations and their opposition to the military dictatorships of the 1960–1980s in the Southern Cone. Since the late 1970s, they have contributed to many important areas, including the development of progressive health and social policies in their respective national arenas; the struggle against structural adjustment and defunding of public health care systems; active opposition to the privatization and commodification of the provision of health services; the support of unions, worker, and grassroots organizations in their demands for better work, living, and environmental conditions; gender implications in the health/disease/care process; and the denunciation of malnutrition, infectious diseases, preventable child and maternal mortality, toxic waste and environmental pollution, and their differential impact on health status among disadvantaged social collectives. They have also promoted social accountability and community participation in health policies; the defense of social security funds; the inclusion of social sciences and critical thinking in medical and public health curricula; the formation of social medicine networks, associations, publications, and support groups across Latin America; mental health support to victims of torture and political repression; and the establishment of universal and free health care for all.[22] In particular, the establishment of health reform and the Unified Health System in Brazil at the end of the 1980s was to a great extent the result of the active participation of the *sanitarista* movement in the strong democratization drive that followed the end of the dictatorship; the Unified Health System has become a tangible contribution to the fulfillment of the right to health in this South American nation.[23]

Because the right to health constitutes an important unifying thread across the papers included in this special issue, I also want to mention the contribution of Latin American nations to the development of the right to health. Outside the circles of legal experts and historians of human rights, this is probably an unknown story to most people. Paolo Carozza and others have argued convincingly that the formulation of the right to health in international law drew heavily from a distinctive Latin American philosophy of human dignity, social justice, and the protection of perceived disadvantaged social collectives (such as mothers, children, and the elderly) that was influenced by a mix of socialist emancipatory thought, Catholic social doctrines of the late 1800s and early 1900s, and a new trend of 20th-century social liberalism.[24] This philosophy permeates most constitutions of Latin America, beginning with the 1917 Constitution of Mexico that was drafted after the Revolution and was an inspiration for other constitutions in the continent.[25]

Likewise, the integration of the right to health in the United Nations Universal Declaration of Human Rights of 1948 (and its subsequent inclusion in the International Covenant on Economic, Social and Cultural Rights, approved by the United Nations in 1966 during the Cold War) was also made possible by a series of favorable circumstances at the end of World War II in which Latin American nations played a key role. In 1945, 50 nations convened in San Francisco for the founding of the United Nations: 21 were from Latin America, the most sizeable regional representation of all.[26] Historians and legal scholars recall that the delegations from Chile, Panama, Cuba, Mexico, and the Dominican Republic were particularly vocal and worked in unison to champion the inclusion of economic and social rights—including the right to health—in the Universal Declaration of Human Rights, sharing a special concern for ethnic discrimination after the horrors of the Holocaust. In the end, it seems that it was the widespread knowledge of the atrocities committed by Nazi Germany and the urgent need for global peace (with the Cold War already looming) that finally overcame the reluctance of the United States, Great Britain, and France, who initially wanted to restrict the declaration to civil and political rights, primarily because their own constitutions did not include social and economic rights, which sounded too socialist in nature.[27]

This commentary on the multiple theoretical and programmatic contributions of Latin American scholars, activists, practitioners, policy makers, and even diplomats in furthering the right to health amounts to a deliberate and small subversive act in that it works against epistemic injustice in knowledge production and circulation.[28] Like the guest editors of this special section, I am convinced that these frameworks that originated in Latin American critical theory show tremendous vitality, theoretical strengths, pertinent methodologies, and analytical and transformative potential. They have produced in the past and continue to produce today significant, valuable, relevant, innovative, and vigorous evidence-based knowledge that better frames and reflects upon processes in which domination and subordination, economic exploitation and capital accumulation, dispossession and deprivation, patriarchy, and social discrimination and even extermination are historically enacted and reproduced along class, ethnic, gender, racial, age, national, cultural, and environmental lines. They also highlight how these multiple processes produce differential adverse effects on the health and well-being of specific individuals and collectives. In other words, I argue that these frameworks offer powerful epistemic tools to dissect, understand, and then potentially transform the dynamics around the functioning and unfolding of what Farmer called "structural violence," always contextualized in specific locations and times.

As a result, these frameworks deserve to be known to the large public health, critical social sciences, and human rights intellectual and activist communities around the globe. But the hard reality is that they are not. The generation of critical thought, policy achievements, or other transformative interventions in health from Latin America or from the Global South in general are immersed in an unwritten but very effective continuation of colonial relations in the political economy of knowledge production and distribution of our contemporary information era.

Latin American social medicine and collective health scholarship and its contributions to the generation of knowledge have been systematically obscured, largely ignored, and possibly even plainly erased in mainstream Anglophone global health literature and social health critical thought from the Global North. Examples abound. A first example is the widespread narrative among historians and public health specialists and practitioners in the Global North that centers almost exclusively on Rudolph Virchow from Prussia/Germany (and to a lesser extent Jules Guerin from France, or Edwin Chadwick from England) as the founding father of social medicine at a global scale, from which all subsequent developments in the discipline allegedly derived.

This is a historiographical metanarrative that arranges the spread of seminal socio-scientific ideas from Europe to the rest of the world in a neat, coherent, and linear continuity across continents and

times that cannot withstand an inquisitive gaze attentive to historical and contextual contingencies.[29] When all is said and done, it is profoundly Euro(ethno)centric and has become hegemonic in the literature; even Farmer, who traveled and came to know and appreciate intellectuals and activists from Latin America, usually referred only to Virchow as his motivating figure in his social medicine-inspired work trajectory.[30] Seemingly, this hegemonic metanarrative allows very little space for accounts that highlight vital and robust Latin American contributions to the field of social medicine. This special section of *Health and Human Rights Journal* is therefore an important—while of course initial, partial, and imperfect—attempt to counteract epistemic injustice based on colonial, ethno-nationalist, and racial capitalist relations.

A second example is provided by certain instantiations of the structural competency framework itself. In their seminal piece from 2014, Jonathan Metzl and Helena Hansen introduce this concept as if it were innovative and original to advocate for the need to teach structural competencies in clinical practice and to transform medical education in the United States. Succinctly, this proposal advocates for teaching critical thought to health personnel as a tool to change clinical interactions and the practice of medicine, to improve the understanding on the part of medical personnel of underlying social causes of ill health, and to envision possibilities of transformation of those social and health causes. I find that this proposal features striking similarities to previous recommendations made by Latin American social medicine scholars and activists since at least the 1960s–1970s with the implementation of some seminal teaching programs for health professionals in Mexico and Brazil. These teaching programs were actively and financially supported by individuals such as Argentine physician and sociologist Juan César García, who worked at the Pan American Health Organization from 1966 to 1984.[31] The Mexico teaching program continues today and has trained several generations of health professionals in the "structural competencies" that the social medicine framework provides. Metzl and Hansen's article makes no mention of this preceding experience; likely, the authors had never heard of it, although it was reported in several publications in Spanish and English.[32] The point I want to make is that while this social medicine experience from Latin America is mostly unknown and rarely cited in mainstream Anglophone academic journals, the structural competency framework proposed by Metzl and Hansen enjoys recognition, and their article is cited globally. This special section of *Health and Human Rights Journal* is a rare example of acknowledgment of the contributions from Latin American social medicine and collective health by scholars involved in structural competency and other frameworks in the Anglophone world.[33]

A third and final example is the erasure of Breilh's "social determination of health" concept from mainstream Anglophone public health, critical health and social sciences, and epidemiology journals. In an all-too-often repeated history in Anglo academic-scientific production and circulation, the alternative formulation of "the social determinants of health" was published much later in English and disseminated globally in highly rated and often-cited journals and in working documents from key multilateral agencies. It quickly became hegemonic in global health, with no mention of Breilh's concept, although Breilh himself argues that many of the experts in the WHO commission who came up with the "social determinants of health" idea were familiar with his work and knew of its relevance.[34] If this is true, this double process of expropriating concepts without acknowledging their intellectual origins and presenting reformulations of them as original ideas amounts to an act of intellectual extractivism, made possible by prevailing colonial relations in knowledge production and circulation between "core" and "peripheral" academia.[35] Breilh's recent book-length publication in English and his forthcoming article in *Global Public Health*, as well as commentaries on his work in English, may just begin to help counteract this trend.[36]

The systematic exclusion of contributions from Latin American as well as other non-English-speaking "peripheral" schools of critical thought from the hegemonic circles of knowledge production and

circulation in the Global North has been exposed by several scholars throughout the years.[37] In relation to this problem, I turn to my last comment. The exclusion cannot be explained entirely or solely based on the existence of language barriers, since there have been some concerted efforts to publish and make available to audiences of the English-speaking world literature from the social medicine, collective health, and critical epidemiology frameworks, originally published in Spanish or Portuguese, and to reconstruct in English publications the historical genealogy and contributions of this field of critical thought. To make my point, it suffices to scan some of the sources referenced in this essay, several of which have been published in English—and some even in leading public health journals.

Colleagues and I have made similar arguments with regard to critical medical anthropology produced in Latin America—arguments that can be easily applied to the field of social medicine and collective health. We reflected on some of the explanations forwarded by important critical thinkers who are sensitive to this issue, explanations that I recall here:

> *Waitzkin et al. (2001: 315) suggest that this lack of impact [of Latin American academic production on health and social sciences] "reflects an erroneous assumption" that the "intellectual and scientific productivity of the 'third world' manifest a less rigorous and relevant approach to the important questions of our age." Narotzky (2002) points out that hegemonic Anglo-American academia has systematically ignored anthropological production published in Spanish, including by those who work from similar political economy perspectives. Martínez Hernáez (2008) … argues that there are multiple ironies to this obliteration. This includes Anglo-American anthropologies' and Critical Medical Anthropology's claim to ownership of political economy and neo-Marxist theoretical approaches that originated in Latin American critical thought (such as dependency or under-development theories) or in southern Europe (Gramsci's theory of hegemony), while they ignore social science production that builds upon these traditions in Portuguese, Spanish or Italian. Other progressive theories such as collective health and social medicine have been marginalized and colonized, while the epistemic hierarchy of scientific knowledge production and the hegemony of the anglophone academic systems of ranking and qualification remain unchallenged (Santos 2014).*[38]

In reference to medical anthropology, Martínez-Hernáez conjectures that the invisibility in hegemonic Anglophone academia of critical thought generated in peripheral regions such as Latin America is the result of a peculiar form of ethnocentric intellectual domination (I would call it "intellectual colonialism") that posits that all knowledge produced and circulated in languages other than English or external to self-established Anglo intellectual frontiers is inconsequential and therefore does not deserve any attention.[39] He also ventures that Anglo and Anglo-influenced academic scholarship is immersed in an accelerating process of commodification that requires continuous theoretical innovations to increase what I would call its exchangeable value in the global market of knowledge production and consumption. Menéndez makes a similar point on the need to innovate theoretically when he discusses the constant inventions and obliterations of concepts in the history of social and medical anthropology, including in Latin America.[40] I clarify that commodification is not just an economic process; it also and primarily involves cultural capital attached to varying degrees of academic prestige. In the end, these two concomitant processes identified by Martínez-Hernáez go a long way in explaining why Latin American social medicine and collective health are largely unknown or ignored in hegemonic Anglo public health and social science literature (including literature produced from a critical emancipatory perspective), while the structural competency framework, generated much more recently in US academia, is beginning to enjoy wide global audiences.

I will not go further in this critique regarding the political economy of knowledge production, circulation, and consumption because it would go beyond the scope of this commentary. I want to clarify that I have no intention of marking a clear-cut categorical distinction between critical thought produced in the Global South versus critical thought produced in the hegemonic academy of the Global North. In the real world, these processes are much

more complex, confused, multidirectional, and contradictory. Nor am I interested in constructing a counter-hegemonic grand metanarrative apologetic of Latin American critical thought in health and social sciences. What I propose is the inclusion of a serious and transformative discussion on epistemic justice in our debates around the cross-fertilization of critical thought paradigms in global health and social sciences. And, in the best tradition of Marxist-inspired praxis and following the legacy of Paul Farmer, I am looking forward to actively and collectively subverting the hegemonic rules of a commodified and colonial science. In this endeavor, we should always keep in mind that the ultimate objective is to construe and use knowledge in order to make the world a better place, foster human solidarity, struggle for social justice, achieve well-being, and make the right to health true for all. Only collectively can we strive in that direction.

Acknowledgments

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