EDITORIAL

Towards a Health from the South: A decolonial and sanitary sovereignty epistemology

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The asymmetric contemporary world-system, reproducing a Center-Periphery order with dehumanizing speed resulting from globalization, is the result of a process of folds that in the Latin American Caribbean region has to do with the historical constitution of America itself, and of capitalism in its transitions between colonial, modern/eurocentered, developmentalist, liquid and neoliberalized models (Mignolo and Walsh, 2002) as patterns of power that leave less and less space for health and good living.

In this context, the epistemological bases of health have tended to move in a pendulum motion between the reproduction of a constant coloniality of power and health knowledge (Quijano, 1999), making the historical cycles move in accumulations of imported theories, policies and methodologies, in a permanent dynamic of imitation or, in the best of cases, in the adaptation of theses to the global North. Each episteme produced sedimentations, geo-cultural accumulations and institutional condensations in the health field, in academia, in the States, and in the societies as a whole throughout the 20th century.

Latin American critical thinking on health in the 21st century is not enough to look only to and from Latin America and the Caribbean. A first exercise of deconstruction is essential, which implies outlining a primary methodological objective based on the need for decolonization of health, aimed towards a geopolitics of the global South. That is to say, there is a need to transcend the Eurocentric bases of the thinking, theories and policies of the Pan-American health doctrine, because in this categorical framework is hidden and concealed that which justifies the reasons for the dependence, the inferiorization and the hierarchical order of knowledge (superior-inferior, North/South) based on a copy-paste dynamic through the epistemic lens of the global North.

To carry out a systematic review of the dimensions of health as an international issue, of how geopolitics determines the political-health agenda, and of how health in the global South is conditioned by the relations of the current world-system (Wallerstein, 2005), we must first trace the the genealogy of two referential frameworks that prominently and repeatedly appear as disciplining and vertebrating axes of reflections, theories, methodologies, agendas and political actions in this field. In this essay, we call this the international health of pan-Americanism (IHP) and liberal global health (LGH).

A hypothesis of this article is that, as we enter into the genealogy and historical becoming of international public health (Cueto, 2015) -expressed today as health pan-Americanism- and its postmodern continuum of current global health (Birn, 2011), we immerse ourselves in the heart of colonial reason and relationships, and its old-new languages as communicating vessels of reproduction and power relations in the field of

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health. These denominations are not simply devices of two models of historical, conceptual and methodological approaches and understandings of international health, or of the geopolitics of power and health knowledge.

Neither the international health of Pan-Americanism (IHP) nor liberal global health (LGH) is a strictly geographical metaphor, or of the forms that health acquires outside borders and in the relationship between nation-states; rather, both are instruments of geopolitics that crystallize, represent and reproduce relations of global power blocs and the perennialization of their epistemologies. They have been transformed into apparatuses of power reproduction within the world system. Although it can be considered that the epistemic foundations of health as an international issue come from the accumulation linked to the past of the colonial powers from the XV to the XIX century - when they began to generate mechanisms to address health in their colonies pressed by the concerns of the colonizers themselves in the metropolis-colony relationship that later will have readjustments of the Center-Periphery -, and from there the concerns of colonialism/diseases/trade as bases of later tropical medicine and the Pan-American doctrine.

These IHP and LGH devices were able to produce and mold Latin American and Caribbean health diplomacies, transform the professional profiles of universities and study centers as health training institutions, and mold public health government managers into permanent reproducers and administrators of theories, policies, logics, agendas and canned goods that express their geopolitical health interests.

The agenda, geopolitics and actions of liberal global health, of the regional Pan-American doctrine, and their national and local impacts have implications for this intrinsic character of dependence that generated a homogenization of possible paths and a limited understanding of the specificity and international determinations of health located in the globally peripheral capitalism (Basile, 2018).

Now, the reproduction of health dependency processes is not only an external phenomenon, but also builds foundations and traces that are also manifested in internal forms and structures, especially in academia, in the public health management of the State or in the cultural hegemony of societies.

Latin America and the Caribbean are traversed by a geopolitics of dependence on health "isms": developmentalism, neoliberalism and Pan-Americanism.

The field of health has been present in the epistemic and operative body of development theory since the second half of the 20th century. Specifically, in Latin America and the Caribbean, taking as a milestone the Alliance for Progress in the 1960s under the creation of ECLAC (CEPAL, in its Spanish acronym), the concept of health has also reproduced the ideology of development. Both the traditional public health current and a large part of social medicine were trapped in the development thesis (Basile, 2020a).

With the irruption of developmentalism, health did not escape the imprint of the dominant debates or its Eurocentric and Pan-American pattern of power and knowledge in the region. It is essential to understand how, in the case of Latin America and the Caribbean, the relationship between health and development had a great impact on: the epidemiology of disease classification; the transnationalization of medical and hospital care models; the design of health policies and systems; the importation of Eurocentric social protection models and dependence on health technologies; the purchase and consumption of medicines; the health sector economy; and the response to epidemics and public health emergencies, among others.

The theorization of development is not only enunciative, but, for decades, it will determine the global and regional agenda of Pan-American public health in the Latin American and Caribbean region. Therefore, it will have a multiplicity of expressions in health, as an international issue in the field of public policies and cooperation, as well as in international agreements and declarations on the subject.

From its inception, development has been assimilated through a biomedical analogy to the life cycle of the human being, with a linear vision of the economic evolution of societies through the natural stages that the West was responsible for exporting and promoting as a universal culture (Rist, 2002).

The effort to provide scientific premises to the theory of development implied a conceptualization based on the theory of stages

where all States were dedicated to living in development. For many, this would mean becoming nations, where societies and Nation-States develop in the same way, only that some did it better and at a faster speed. In this nomenclature also enter the field and health sector. Development planning includes health policies, services and systems, diseases to be eradicated, life expectancy to be managed, years of life gained or lost and DALYs and QALYs as units of health measurement. Thus, the adoption of behavioral norms, attitudes, measures and values identified with Western society and modern economic rationality has been installed as an ideal to be achieved and a sociopolitical goal to be conquered (Dos Santos, 2020). The concept of development that prevails in the field of health systematically avoids describing the power relations of the contemporary world system embodied in the unequal ways of living, getting ill and dying from the metabolism between society and nature (Breilh, 2013).

According to Theotonio Dos Santos (2020), the very characterization of underdevelopment is connected to the expansion of capitalism in the global North, currently known as "development". Dos Santos is one of the authors argues that underdevelopment is a process closely connected to the expansion of the central countries, considering that development and underdevelopment are two sides of the same process.

Secondly, analyzing the doctrine of Pan-Americanism is a substantial conceptual exercise, because this geopolitics has a direct impact on the birth and growth of developmentalist regionalism in health. The field of public health in the region cannot be understood without the Pan-American matrix (Basile, 2020a). From a decolonial point of view, it is important to describe Pan-Americanism as the current that has hegemonized international public health in Latin America and the Caribbean since the end of the 19th century and throughout the 20th century.

The doctrine of Pan-Americanism was always influenced by the foreign policy interests of the United States, and was reinforced in 1904 by the ideology of the Monroe Doctrine. This Pan-American perspective visualized the region as a territory of exploitation, domination and expansion of geostrategic, military, commercial and health interests. Therefore, in the eyes of the US, Pan-Americanism was always based on its interests of hegemony in the region (Basile, 2020a).

The matrix of health Pan-Americanism was defined from its birth under this ideology. Its thesis was to analyze the population’s health situation or the health of the region as a whole, in a way that was conceived and guided from Washington. In particular, as a unit of analysis, diseases that cross the borders of countries and the role of nation-states are dealt with in a preferential manner. Although on the surface we can see pan-Americanism and common objectives, in the epidermis the relationship of sanitary colonialism between coloniality, diseases, borders and trade continues to be very much alive.

Of course, these matrixes have undergone contemporary epistemic readjustments. The political complex between states of the global center, philanthropic foundations, pharmaceutical groups, and financial and trade organizations such as the World Bank (WB), OECD, WTO or the IMF, together with NGOs (Non-Governmental Organizations of the North) became central actors of a new global health agenda, where the extra-health organizations have a leading role in the modulation of reforms to health policies and systems (Ugalde & Homedes, 2007). In the light of this globalizing context, a new interpretation of health problems in geopolitics was consolidated, based on the primacy of the rules imposed by neoliberal globalization: the so-called global health (Birn, 2011).

For liberal global health, the unit of analysis becomes the liberalizing globalization centered on the individual with the idea of an "international community", public-private partnerships and the financialization of the health field, extra-health agents and corporations, global health security and, at the same time, a paradigm that speaks of gender equity, human rights and accountability.

Thus, it is worth highlighting five central processes that were consolidated with the birth and apogee of this liberal global health model that are defined, not from its laudable statements but from the agendas, policies and global actions that it operationalizes (Basile, 2018):

1. Social reforms to the State and sectoral reforms to the neoliberal health systems.
2. The functionalization of public health (pan-Americanism at the international level) to the mandates of the market, i.e., to the commodification of health and life and the residual role of the State. This was called Essential Public Health Functions (EPHF) with the confluences of a complementary agenda between WHO (PAHO), the World Bank and corporations.
3. The consolidation as hegemonic actors of the financial pharmaceutical industrial medical complex and transnational corporations (including a nascent health philanthrocapitalism) with a structuring role in the global health agenda (Birn & Richter, 2018).
4. Birth of new global health diplomacies and technocracies that, when acting and intervening in this international geopolitics of Development, including Latin American and Caribbean ones, are implementers, operationalizers and executors of the agendas of supposed "consensuses" of global health and international Center-Periphery cooperation.
5. The growing nexus between health and national security from the imposition of global health security as a way of understanding, preparing and responding to global epidemiological crises.

The matrix of development and pan-Americanism has modulated and permeated social medical thought in Latin America and the Caribbean, and the matrix of global health, together with the structured pluralism and social risk management that functionalized the public health of biopolitics and governmentality.

How can we transcend the reproduction of coloniality and of theoretical, public policy, and governmental dependency in the geopolitical field of health in the 21st century?

From within Latin America and the Caribbean, a new regional process is being built in the Regional Group on International Health and Health Sovereignty of the Latin American Council of Social Sciences (CLACSO), which is born from new networks among hundreds of researchers, study and research centers, universities and new articulations with social movements and governmental administrations in the region. This process was born from the need to develop a new platform for training, study, Latin American critical thinking and geopolitical action in the field of construction of an epistemology of Health from the South. All of this, with the aim of producing new connections between decolonization, emancipation, autonomy and sovereignty in the field of health, towards a new conception of the South South International Health and Sanitary Sovereignty (SSIHSS).

This platform was not born as a quest or statement to "decolonize" Liberal Global Health (LGHS) or Pan-American International Health (IHP), or to democratize the Western medical authority of the WHO. Rather, the objective has been to build an epistemological alternative for global South Health. Currently, flows and decolonization attempts occurring in the academia of the North - for example in global health - seek to open decolonization without the correspond epistemological transformations, to decolonize without changing the reproduction of the asymmetrical geopolitics of power and knowledge.

Our efforts cannot be focused solely on decolonizing the global center. They must focus on building an alternative, complex, decolonial, intercultural and democratic epistemology of health from the South.

Starting from this relational epistemic-political problem, the significance of thinking and practicing a Health from the global South implies a first flow of emancipation: the decolonial and epistemic turn. It is perhaps the path that Latin America and the Caribbean must still deepen in the study, in the shaping and the construction of a political thought-action of regional health sovereignty.

Opening a decolonial turn and decolonial turns (Maldonado-Torres, 2008) in the field of Health from the South accounts for a change of coordinates based on Latin American critical thinking in health. Giving meaning to the forms of thought that are simultaneously inspired by the crisis of thought and of the civilization project of the Global Center (Eurocentrism/Pan-Americanism) "from which modernity and globalization are conceived as intimately, if not constitutively linked to the production of multiple relations of colonial character, and to decolonization as a possible project or horizon of change. The foundation of decolonizing thought and of the decolonial turn itself lies in the emergence of a new type of subject" as the Puerto Rican Maldonado Torres puts it.

Now, to a large extent, in the face of a global system that reproduces the epistemologies

and health policies of the global North, national theses of confrontation are often enunciated.

The second flow of emancipation, it is then necessary to modify the unit of analysis in the spatial scale and temporal scale of observation, going on to problematize the processes of the modern world system in its four divisions: racial hierarchical superior-inferior order, the new international division of labor, the international division of nature and the international division between Center and Periphery as key epidemiological and global health markers. This implies assuming a change of categories and scales.

This general dimension of an observation scale based on the category of international health determination implies making visible the evident conditioning factors and adversities towards a healthy life in the Periphery (Dos Santos, 2020). The international determination of health is expressed in different dimensions and levels. This framework of categories evidences the reductionism inherent in the assumption that the production of responses to health-disease processes rests on what happens only between and within each Nation-State, without fundamental linkage or recognition of the geopolitical determinations of health and life in the South, or in the Periphery (Dos Santos, 2020).

Now, the irradiation and reproduction of international determination starts from understanding the complexity of conditioning factors and adversities in the multiple levels of the contemporary world system, for the specificity of Latin America and the Caribbean as a space of globally peripheral capitalism (empirical quarantines, neohygienism, militarization, punitive vigilantism), the reconfiguration of health systems based on theories of development and financial insurance pluralism coverage markets, the geopolitics of global health security and increasing militarization in the face of epidemiological threats to the global North, the formation of health diplomacies and technocracies for the administration of North-South health theories and policies, among others (Basile, 2020b).

The differential distribution of resources of domination, exploitation, dependence and subjugation is configured as the general dimension of determination of international health in the modern world. This flow of determinations reveals the supposed process of superiority and centrality of the developed world expressed in geopolitical power and highlights the fact that this world system is not a "system" of the world, but a system that considers itself "the world".

Faced with this process, it reinforces the need to expand the frames of reference of a South-South international health (Basile, 2018) to put at the center the role played by the international determinations of the contemporary world system in the geopolitical production of the ways of living, getting sick and dying, i.e., the society-nature metabolism and this cognitive capitalism (Basile and Feo, 2022).

Conjugating and complementing the theory of dependence of Dos Santos (2020) with the challenges of the 21st century and the theory of autonomy of Helio Jaguaribe (1979; 1986), implies opening a search for the maximum capacity of autonomy in decision-making in the prevailing global context. Counteracting the hegemonic logics of Pan-American health and liberal global health is perhaps a founding premise that allows for a genuine formulation of emancipatory policies, goals and strategies based on the actors and voices of the South. This is conceptualized as an approach to Health Sovereignty (Basile, 2020a).

Producing territories and the territorialization of regional health sovereignty not only implies greater degrees of autonomy in nation-state units and national societies. National sovereignties are not enough.

Health sovereignty is not a theory-action based on the unit of analysis of the nation-state and its borders but, rather, on the permanent construction of spaces of regional health political autonomy. This concept is based on the recognition of interdependence in the contemporary world system (Empire and World Economy) and its international determinations in health that are expressed in adversities and conditioning factors for the South.

Health sovereignty is not a theorization thought from and with the unit of analysis of Nation-States, nor thinking of an update of the thesis of national development and simply import substitution or the construction of a productive industrial complex of health in a developmentalist key.

In his contributions, Jaguaribe (1986) does not consider autonomy as a movement from within and inward (Borders/Nation-States). Undertaking an autonomizing strategy with national discourses and practices can produce some degree of sporadic autonomy as long as there is some international permissibility of the world system, but there are always complications in terms of viability in the medium and long term. It usually ends in frequent isolations, blockages and disciplining of the global towards the local.

Maturana (1994) explains that the mechanism that makes us autonomous is autopoiesis. To understand the autonomy of a living being, we must understand its internal structure (Maturana and Varela, 1994). To understand the health sovereignty of Latin America and the Caribbean, we must understand the structure of the contemporary world system, especially the bases of the reproduction of dependency, subordination and coloniality in health.

Thus, four key learning flows and movements appear (Basile and Feo, 2022):

- *First, to problematize, study, understand and deconstruct the conditioning factors, adversities, and dependencies for health from the South in a decolonial theoretical-conceptual and technical-methodological key at the territorial, local, national and regional levels.*
- *Second, to make visible the consented and satellite health dependencies, their diplomatic forms, their governmental, technical and academic forms, their reproduction and perennialization mechanisms.*
- *Third, to deepen the theoretical and technical-political bases for the construction of spaces of regional autonomy (margins of maneuver) defined as regional sanitary sovereignty.*
- *Lastly, pooling regional health strategies from the South also means getting out of the domestication suffered by the "South South" because of the health agenda of the global North.*

The driving concept behind these flows is health sovereignty. Starting from a socio-cultural, political-health diversity of territories, territorialities, States and societies in the processes of regionalism in health.

Health autonomy and sovereignty is not a stable and permanent conquest. To go through this process is to face tensions, adverse reactions, attacks, advances and setbacks.

It seems necessary to review from the perspective of the Latin American critical theory in health the logic of living in a world of undisputed, totalizing, monocultural and universal scientific certainties. A reconfiguration of how we know international health and epidemiology in the 21st century. Perhaps it is time to invite us to suspend our habit of certainties, of sophisms, of dilemmas, of liquid slogans, and to refound a potentiality of producing alternatives from the South.

To resituate in the center of the Latin American-Caribbean region the construction of public fabrics of sanitary sovereignty and principles of international health from the South. This does not only concern and depend exclusively on intergovernmental relations in the moments of government of the "States". Regional health sovereignty is a strategic process that is nested in the interweaving of territories, territorialities, societies, communities and actors in the construction of an epistemology of Health from the South. This is where we are.

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