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Rewriting global health

Reescrever saúde global[1]

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Abstract

The concept of global health has become popular even though its origins have come under critical scrutiny: namely, its origins in colonial medicine, its links to the protection of international trade and capitalist exploitation and its Orientalist assumptions. To what extent is the concept still adequate or useful? Is it possible to rewrite global health while recognizing and tackling its multiple forms of violence? I reflect on the potentiality of the concept of global health based on an ethics of writing that intends to be analytical (concerning its ability to reflect social tensions, the multiplicity of experiences, the social actors' justifications and claims, the oppression, and the unrealized potential); critical (concerning its ability to identify the contradiction between what social arrangements ostensibly proclaim and what they actually produce); and political (concerning its potential for emancipation and for the reparation of historical injustices). Five important aspects are identified toward rewriting the concept of global health: the global as planetary; the global as collective; the global as public; the global as peripheral; and the global as everyday.

Keywords: Global Health; Planetary Health; Emancipation; Critical Theory.

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Resumo

O conceito de saúde global popularizou-se mesmo com suas origens sendo alvo de um escrutínio crítico: nomeadamente, suas origens na medicina colonial, suas ligações com a proteção do comércio internacional e da exploração capitalista, seus pressupostos orientalistas. Até que ponto o conceito é, ainda, adequado ou proveitoso? Será possível reescrever a saúde global de forma a reconhecer e contrariar as suas múltiplas violências? Reflito sobre a potencialidade do conceito de saúde global a partir de uma ética da escrita que pretende ser analítica (respeitante à sua capacidade para refletir as tensões sociais, a multiplicidade de experiências, as justificações e reivindicações dos atores, a opressão e o potencial não realizado); crítica (respeitante à sua capacidade de identificar a contradição entre aquilo que os arranjos sociais ostensivamente proclamam e o que produzem de facto); e política (respeitante ao seu potencial emancipatório e de reparação das injustiças históricas). Identifico cinco vertentes importantes para um esforço de reescrever o conceito de saúde global: o global como planetário; o global como coletivo; o global como público; o global como periférico; e o global como cotidiano.

Palavras-chave: Saúde Global; Saúde Planetária; Emancipação; Teoria Crítica.

A matter of origin

Although the concept of "global health" has become popular in recent decades, it has also come under intense scrutiny. Its origins have been problematized as certain connections between global health and colonialism have been recognized. The beginnings of what we now know as global health can be found in colonial or tropical medicine, one of the earliest examples of "internationalism" in medicine and public health (Roemer, 1994). Colonial medicine emerged as an important part of a project of domination and expropriation (Anderson, 2006). Medicine was an instrument of violence in the context of the colony, especially through the colonization of bodies (Arnold, 1993). At the heart of colonial medicine, there is an anxiety related to the preservation of colonizers' bodies in the face of an unknown and inhospitable environment, and of a direct encounter with the bodies of the colonized. In light of an ideology of racial superiority, the latter are seen as inherently threatening, but also as something that must be preserved to have its economic usefulness maximized. The "international" dimension of medicine thus acquired a dual purpose: that of segregation, by which contact was carefully managed to maintain a separation between the "European city" and the native dwellings; and containment, by which the movements of people and goods were screened to prevent diseases in the spaces reserved for the colonizers and in the metropolis.

As part of the empire, therefore, international health sought to support economic goals such as the fluid exchange of goods (and of people-as-commodities) and resource extraction. In other words, internationalism in health is, since its origins, linked to the maintenance of a certain status quo. According to Nicholas King (2002), trade and the security of the mechanisms that support this commerce are central to the formation of international health. According to the author, the post-colonial period has not changed this. The International Sanitary Conferences, which began in the 19th century, showed, by emphasizing the standardization of containment measures to protect international flows, how the objective of protecting public health was part of a broader purpose toward

protecting a hierarchical global economy. The current International Health Regulations (IHR) also reveal this concern, safeguarding economic circulation in the event of epidemics. By focusing on notification systems and border surveillance capacity, these regulations emphasize the circumscription and containment of outbreaks in the periphery of the world economy.

Global health has also been questioned because of its association with the emergence and consolidation of neoliberalism as the structure that dominates world economy (Keshavjee, 2014). Neoliberalism has led to the decline of a vision of health as a global public good, underpinned by a horizontal approach towards addressing the determinants of disease, and to the association of healthcare with interventions aimed at containing and controlling specific diseases. By supporting this project, global health would be, at best, an impoverished version of the overarching ideal of health present at the origin of the World Health Organization (WHO). This ideal was highlighted by the proposals to broaden the scope of international health mechanisms, basing it on the goals of primary health care, health promotion and "Health For All," presented by the 1978 Alma Ata Conference on Primary Health Care. Soon, however, these goals faced backlash. Accused of having become too politicized, the WHO curbed its ambitions in the face of the growing power of other international organizations (such as the International Monetary Fund and the World Bank) and non-state funders. At worst, therefore, global health would be complicit in the undermining of cooperation, solidarity and universality in health.

This questioning of the origins of global health points to a dilemma. Today, "globality" itself is being questioned. In certain left-wing sectors, the "global" is no longer seen as a synonym of convergence and harmony: the conflicts and hierarchies that underlie it are becoming increasingly clear. Some right-wing sectors also criticize a supposed "globalism," describing it as a political project aimed at the subversion of traditional values. Finally, in the current climate emergency context, some see the global as too centered on the human experience and not sufficiently attuned to the challenges posed by the Anthropocene. The very notion of global health is beginning to be threatened by the emergence of other concepts, such as planetary health and One Health. Given these multiple forms of violence present throughout this trajectory and considering these new challenges: has the time come to abandon global health?

The worlds we write

I propose that we focus on the concept of global health by exploring its potential rather than replacing it with something else. Each concept is an attempt to represent the world, which, in turn, advances through the concepts we create. I like to use the term "worldvision" to characterize this process of seeing the world, which is also a way to make it visible. Unlike a static view (present in the term "worldview," for example), the word worldvision evokes the movement of a dynamic and conscious outlook. Something that turns the concept into something unfinished, an unfinishable action: an incomplete relationship with the world. We often develop concepts in order to describe the world, capture its meaning and encapsulate it. But concepts only allow us to see the world and act in it through our human gazes and gestures, which are necessarily limited and transitory. We use concepts for this purpose until they themselves become the world—which often causes us to confuse our ideas with a supposed reality.

The adoption of a constructivist approach has caused the literature on global health to advance in the recognition of this transformation process. According to this approach, the world is composed of social constructs, that is, social facts which are results (more or less precarious) of disputes and negotiations. In this context, Colin McInnes and Kelley Lee (2012, p. 18) developed the concept of frame, which, according to their definition, is "based on a set of norms, privileges certain ideas, interests and institutions [...] each has particular answers to the questions of who and what is important in global health, and why." The authors refer to the frames that have been used to describe the elusive reality of global health: those of development, human rights, economics, evidence-based medicine, and security. These different frames often interact and have

been present throughout the trajectory of global health. Simon Rushton and Owain Williams (2012) complemented this idea by showing how the frames, composed of ideational structures, are also linked to a material dimension and, specifically, to a political economy. For Rushton and Williams, certain frames gain relevance through their resonance with the prevailing neoliberal paradigm.

All frames are processes through which global health is built, delimiting its space and establishing a set of assumptions for its interpretation and possible interventions. They do so by establishing what exists and what should exist, that is, the aspects of reality that are evident or a priority and the directions reality should be taking. Frames are not only analytical instruments, since they allow us to interpret a complex reality, but also normative ones because they enable us to think about interventions in the world according to our own interpretations.

Security, which has become an important frame in academic and political discussions on global health, is a relevant example. The security frame establishes a global health worldvision that presents certain health issues, such as infectious, "emerging" or "re-emerging" diseases (Garrett, 1996), as priority problems, since as they have the potential to cause disorder and conflict. This worldvision also advocates that diseases should, in some cases, be the object of an intervention that uses the methods and rationalities of militarism, since they have a potentially military impact. This conception led to an increasing implementation of military means to manage and contain health crises—this approach was used, for instance, in 2014-2016 during the Ebola outbreak in West Africa. It also led to the interconnection between the languages of health and security, evidenced by the use of war metaphors to describe diseases and our response to them (Sontag, 2002).

The use of language is one of the interesting ways in which the framework of global health, based on security, represents the human relationship with the world and the attempt to construct it. The best example is the securitization theory (Buzan; Wæver; Wilde, 1998), which has become an important element of discussions about the health-security nexus (Ventura, 2016). According to this theory, threats are not objective and evident components of reality, but results of intersubjective meaning-making processes. An issue becomes part of the domain of security after one or more securitizing agents present it as a threat to the existence of a particular referent (a state or a community, for example). Through the securitization process, the existential character of a threat is seen to require the implementation of exceptional measures, which go beyond normal political procedures.

The implementation of security changes the character of problems and the political landscape in which they arise. As an intersubjective relationship between a securitizing agent and an audience, securitization is in itself a way to reconstruct the world that, eventually, allows certain political forces to enter various fields. Something that proves the power of security is the difficulty in undoing securitization processes once they are successful. How does security acquire this strength? A possible explanation is that the security sector is related to existential issues, that is, to the relationship of humans with death and finitude (Huysmans, 1998), and mobilizes fear, a human emotion that can be easily manipulated for political purposes.

A large part of the securitization literature focuses on the identification of discursive acts, that is, words that are said or written in this field. However, some authors have argued that the securitization process is a continuous process rather than an act: issues do not necessarily need to be explicitly presented as a threat (Bigo, 2008). Immigration, for instance (Huysmans, 2006), is often surreptitiously or implicitly associated with other threats, such as transnational crime or terrorism. In this example, the world is constructed not exactly by the spoken or written word, but rather by the unspoken, by suggestions or insinuations—or by the invocation or reactivation of shared and pre-existing meanings. Another relevant example of the limits of the securitization theory was established by the literature that analyzes the power of images, indicating that a visual approach is necessary for the proper construction of "threats" and "enemies" (Hansen, 2011).

I mention this discussion on the limits of securitization on the reflection over global health because it also points to a limit of my own argument. The discussion I present focuses on global health as a process and product of the world's construction. I favor the written word, and the act of writing, as central elements of this construction. But global health isn't built only through writing: it also includes images. I had the opportunity to study this in an analysis of the visual representation of community health workers by the World Health Organization (Medcalf; Nunes, 2018). I am also aware that the focus on the written word favors a pre-determined worldvision, a predisposition to the world that is based on an attempt to control and fix its meaning. The obsession with the attribution of meaning is a violence done to the world's complexity, ineffability, and beauty. The compulsion to control, which is rampant in our societies, threatens to drive us to extinction—as demonstrated by the current climate emergency. The act of writing is part of this ambiguous situation: it is one of the foundations of the civilization that has brought us to this watershed moment. But it is also endowed with emancipatory potential: writing is one of the paths to salvation we have left. I will return to this last point at the end of this essay.

For now, I would like to say that I still have much to learn from world-creating worldvisions that escape the purpose of control inherent in writing. As far as I know, the Aborigines of the territory we now call Australia believe in the world's creation through music. This tradition was mentioned by Steve Smith (2004) who, in turn, found it in the book *The Songlines* by Bruce Chatwin. According to Chatwin, the Aborigines believe that language began as music. The world and all its properties were created through the songs of the ancestors. Although I think that the idea of music as the world's creator is beautiful, I am inserted in the civilization of writing, which is very different from those that have traditions based on orality. I belong to the People of the Book. I am a person, a man, a white man, educated in Christianity, who writes. I have not learned how to sing yet.

How far the light goes

We write in order to build the world but also to make sense of it. We order and simplify the world so that it becomes perceptible and intelligible to us. By delimiting boundaries between what stays inside and outside, the framing process also limits what comes to us in the first place. This means that writing is also a form of erasure—not only of what remains unsaid, but also of what is actually removed from pages, or prevented from appearing on them.

In the health care field, invisible illnesses, such as those that affect mental health, and diseases in invisible populations, such as migrants, are frequently mentioned. Some prefer to refer to these issues as results of "invisibilization processes," recognizing that invisibility is not a permanent characteristic of a particular disease or group, but rather a process in which that disease or group is removed from the sphere of attention and consideration. Similarly, terminologies related to listening, to silence, or silencing are also used during discussions on health problems.

This terminology makes it difficult to identify situations in which the problem is not exactly "invisibility" nor "silencing." A topic may be highly visible or audible in the public sphere and still not be the subject of attempts at resolution or effective resolution. Public health emergencies, for example, are a paradigmatic case. They receive a high level of political and media attention, but still have dimensions that go somewhat unnoticed. The relative inattention that was given to mental health issues during the COVID-19 pandemic demonstrates this. The use of the invisibility category (and of similar ones) is, therefore, reductive. The problem of the discussions on certain issues is not necessarily that they are silenced or invisible, but rather related to the way in which these issues are perceived and comprehended by social actors and inserted (or not) in a public policy agenda. That is, when we talk about the "attention" given to a problem, it is important to consider its quality before evaluating its quantity. An issue can trend in the media or be on the priority list of policymakers and yet be approached in a superficial, fruitless or counterproductive way.

I prefer to speak of neglect rather than invisibility (Nunes, 2016). Health neglect can be defined as a political process through which an issue is separated from the mechanisms that could effectively solve it. These mechanisms include the recognition of the importance of the issue by the social actors who could decisively influence its resolution, the existence of sufficient scientific knowledge, and the creation of effective public policies and social control over them. Neglect may include diseases, but it goes far beyond them. It is possible for a disease to be prioritized (with policies focused on its eradication or the control of its vectors, for example) while its socioeconomic determinants or the experiences of certain groups suffering from it are still neglected (Hotez, 2013; Oliveira, 2018).

The focus on populations is important because the way in which a disease is experienced in specific socioeconomic, cultural or historical contexts can be neglected—for example, when certain groups are more exposed to an illness than others, due to lack of public policies directed to the needs and specificities of these groups, or when the historical dynamics that caused these inequities are not recognized. The focus on neglected populations is also important since it points to the relational dimension of the problem. Neglect results from certain relationships within the political and social spheres. This becomes evident when certain groups are placed in a situation of vulnerability in the face of an illness or prevented from having access to the best health care. Underlying neglect is, therefore, power—a power that establishes a social hierarchy and leads to disadvantage, inequality, and harm (Nunes, 2014). Neglect is a manifestation of domination, tied to the destructive dynamics of capitalism, racism, misogyny, ableism, LGBTQ-phobia, and other forms of prejudice.

Reflecting on the neglect of certain populations is important, but not enough to solve the problem, given the challenges of thinking about illness in a planetary context. On the one hand, an important aspect of neglect is the syndemic nature of disease patterns, that is, the interactions that are established between diseases and conditions, with chains of causality that can potentiate negative effects, cause mutations, and alter transmissibility patterns. It is also necessary to consider the interactions between diseases and human behavior, which, once again, can produce important changes, such as antimicrobial resistance, for instance, which is partly related to the excessive use of antibiotics in our society. Interspecies transmissibility also poses challenges to the discussion on neglect. To what extent, for example, can the maintenance of the dominant standards in the food industry be considered a situation of neglect, considering that they promote the use of automation, greed, and cruelty in order to meet the needs of the growing human population, leading animals to be raised, transported, and traded under often dubious phytosanitary conditions? The Earth's devastation, with the loss of biodiversity, destruction of biomes and ecosystems, desertification, pollution of the oceans, among other effects, highlights the current scenario of tension in the relations between humans and more-than-human beings—a scenario that ultimately puts human survival at risk. All things considered, neglect is related not only to the way in which certain groups experience disease, but rather to scenarios of unhealthiness or illness in which the determination of diseases, considering a planetary context, is exponentiated by dynamics of domination that affect certain groups with special intensity, impacting their lives in a devastating way and hindering their possibilities of reaction.

Invisibility may be a layer of neglect or a path to it, but it is not the only one. An issue may be visible but considered unimportant. In this case, the situation would not be of invisibility, but of apathy—the denial of the importance of a particular problem, or of the groups that are exposed to it. It is also possible for an issue to be considered important but not included in the list of political objectives, which would result in an agenda or policy denial. Finally, it is possible for an issue to be targeted by policies that prove ineffective to solve it in a sustained way, because of their design, implementation or monitoring, which would result in a denial of care.

Therefore, it is possible to conclude that neglect does not only mean omission: it is produced. It happens as a result of political choices that promote invisibility, diminish importance, deny public policies, or restrict political

accountability in such a way that health care is never provided. However, it would be too hasty and simplistic to assume that the motivation behind neglect is necessarily a conscious, organized project. Sometimes neglect does have this intention, whether due to economic or strategic interests, or because of racism, selfishness, bad faith or other motivations. In these cases, neglect can happen through a set of actions, omissions, and obstructions—the Brazilian federal government's response to the COVID-19 pandemic is an example (Nunes, 2022). In other cases, neglect does not depend on a specific human agent, even if it is not detached from human action in the broad sense. Neglect may result from the way society is organized, that is, from the structures (laws, institutions, forms of organization of work and production) that have been consolidated in it, or from the relationships and parameters of action that these structures induce or allow. Neglect can thus be structural, systematic, or even institutional—that is, the production of neglect can be inscribed in institutions, including those that aim to alleviate it. In this context, neglect becomes impersonal. It does not necessarily require a willingness to neglect; It may even occur as a side effect or unintended consequence of the functioning of institutions or the implementation of policies.

Another misunderstanding about neglect relates to its eventual overcoming. Will there ever be a situation of non-neglect , that is, a future in which all the mechanisms that produce neglect are eliminated? In a world of limited resources, setting political agendas involves making choices and prioritizing certain issues. Something or someone will always be relegated to the background. Politics exists precisely because of the impossibility of doing everything to solve everything at all times. The opposite of neglect is, therefore, politics. Not the politics of competition, self-interest, and advantage over others or the denial of them, not the short-term, parochial politics, which only faces itself, a single privileged group or a certain species. On the contrary, a political path starting from neglect begins by recognizing that human interaction will always result in a certain degree of neglect. Recognizing this is a necessary first step to learn how to mitigate the most perverse effects of neglect.

The path from neglect encompasses a politics with an emancipatory purpose. Inspired by Ken Booth (2007), I understand emancipation as composed of the concrete political choices that make room for more people to have the ability to make decisions and act on issues concerning their own lives, and that allow human life to be guided by a relationship of respect with more-than-human lives and with the planet as a whole. Emancipation is not a grandiose and utopian narrative of the absolute freedom of the Man who conquers Nature. It is about alleviating (and, if possible, eliminating) the obstacles that prevent people from putting their own lives, their relationship with others and with what surrounds them in perspective, or alleviating what hinders them from influencing their own life trajectories. Booth argues that at every political juncture there is one choice that is more emancipatory than others. For all issues, from local to planetary, there are paths that allow more people to ascend from the struggle for survival and pursue their own versions of a good life. There are also paths that allow the good human life to be compatible with the rights of more-than-human species and with the Earth's preservation.

A political path against neglect must also promote the reparation of historical injustices, which is linked to emancipation. It is necessary to go beyond conjunctures and discrete choices, to work to dismantle or reconstruct the structures that, over time, have propitiated and legitimized systematic neglect. The need for reparative actions, especially equity-oriented affirmative action policies, helps justify "benign" forms of neglect, even if they are temporary. Considering the violence committed throughout history (during colonialism and slavery, for example), of instances when some individuals acquired wealth, advantages, and comfort at the expense of others who were plundered, curtailed, and destroyed, it becomes evident that those who still benefit from the effects of this injustice are now privileged. It is also fair to expect those who still enjoy these unjustly acquired advantages to assume their historical responsibilities during reparative processes.

In short, rethinking the directions of global health implies dealing with the effects of the construction of the world on the production of

neglect—an insoluble dilemma that points to the need for permanent political, emancipatory, and reparative work.

The writer in me

In the same way that the stories we tell about the world never do justice to its complexity and beauty, the words I write always seem inadequate to me. My relationship with the act of writing is ambiguous. I know I can only scratch the surface of what I want to say and what is possible to write. At the same time, I follow Joan Didion's (2006) maxim that, after all, "we tell ourselves stories in order to live."

The way I navigate between languages is an example of this ambiguity. I feel at home when writing in Portuguese, but I spend much of my time reading, speaking, and thinking in English. I move between these two languages in my everyday life, making thousands of small subconscious choices, following, for this, criteria of effectiveness or taste. As a Portuguese citizen who, at the time of writing this essay, was living and working in the UK, I spend much of my time writing in a place that could be called exile, distant from my mother tongue. This results in an increased distance between me and my academic essays. "Health" is, to me, colder and more distant than "*saúde*" (which means health in Portuguese). Writing this essay in its original Portuguese was a momentary homecoming.

The way in which I position myself as an European man who studies Brazil and writes about the Brazilian reality is also ambiguous, since it is a very different reality from mine. The reality about which I write is permeated with forms of inequality, violence, and injustice that I cannot, in my privileged and protected existence, even begin to understand. I know that my vision is that of a foreigner. I also know that, as a Portuguese man, coming from the land of Pedro Álvares Cabral and educated in a system that propagates a sanitized and beatific version of colonization, I run the risk of having a gaze and a writing impregnated with the emanations of the swamps of the empire. Within this risk and this ethical negotiation, writing is permanently questioning. I consider that there is a critical value in this distance, this process of distancing my own view and trying to empathize with a reality that is not mine, without intending to reduce it to what is familiar to me.

As a result of this tension in my positioning, I see writing as a matter of debt—literally. When I write, I pay a debt, but at the same time, I incur more debt—to all those who inspired me, taught me, showed me how to observe the world, let me into their homes and days, allowing me to see their worlds, those who shared their ideas with me, accompanied me on the journey. My words are not mine alone. I have never written anything by myself. And this debt I have incurred impels me to write more, to write again, to try to have my writing rewritten. Writing is a debt in the sense of commitment. I try to use my privilege to be an ally in politics of emancipation and reparation. I have access to resources and spaces that others do not have. But I am not a witness to anything, nor am I anyone's spokesperson, because I know that I should not claim to speak on behalf of others. By writing, by making it my life, I am above all a debtor.

It is relevant to discuss the supposed separation between the self who writes and the world we write about. Critical Theory reminds us of the impossibility of separating the subject from a supposed "object" of thought (Held, 1990). This becomes particularly relevant when we approach political and social realities in which we inevitably participate. We are not neutral observers and knowledge is not unbiased or objective. On the contrary: through the notion of constitutive interests of knowledge (Linklater, 2007), Critical Theory tells us that knowledge derives from our position in society and from the agendas, assumptions, interests, desires, and prejudices that we bring to the act of knowing. This underlines the importance of assuming an interest on emancipation and historical reparation during the act of building knowledge. The "writing of the world," as a way of constructing knowledge, is also an intervention in the world that goes beyond the act of writing.

This issue intersects with the idea of a critical approach to global health (Biehl; Petryna, 2013). This type of approach begins with a reflective moment, in which we recognize ourselves as actors in the world we study and write about—and through this reflection, we assume responsibility. Unlike some

followers of Critical Theory, I will not go so far as to say that if knowledge does not question the status quo it ends up being complicit in its maintenance. One of the purposes of Critical Theory is immanent critique, that is, the critique made from within structures of domination, identifying contradictions and flaws in existing arrangements to expose their hypocrisy, insufficiency, and contingency–and opening up the possibility for transformation (Antonio, 1981). This is the kind of approach I propose: an immanent critique of global health, one that points at the multiple forms of violence in society and exposes them as hypocrisy, while helping to leverage the existing potential.

A matter of place

This chapter began with an origin story: health internationalism that hides a colonial legacy. Reflecting on this internationalism, Didier Fassin (2012) discussed the scope of global health beyond a supposed dissolution of borders. For him, global health is also a "powerful analyzer of contemporary societies" (Fassin, 2012, p. 103): its meaning reflects society's parameters and allows us to make critical comments on them. We gain a lot by considering this when we discuss the meaning of global health, and more specifically, what "global" means in relation to health. The global is more than "borderlessness," the idea that health and illness happen in a world without borders. This idea is highly dubious, given the persistence of inequalities and divisions, not only in terms of geography but also in relation to gender, race, socioeconomic status, age, disability, and other characteristics. Our world is still filled with multiple, interconnected borders.

In this context, I propose thinking of the global in health not as an empirical fact that has already been achieved, but as a promise–a horizon that is in motion but serves as a reference point for criticizing concrete policies. This promise, which aims to recover a sense of the global in health after the multiple criticisms it has received in recent years, is based on the assumption that, rather than describing a world in which borders would have blurred, global health should be actively involved in the fight against the various borders that are reproduced on a daily basis. This struggle has five strands–five ways to rewrite the global in health. The first is the global-planetary one. In it, the global indicates the totality of the planet, its different species and ecosystems that sustain life and that have a dignity that is independent of their usefulness to humans. Understanding global health in this way implies recognizing the deep interconnection between the health of humans and the entire more-than-human planet, from which humans cannot be separated.

The second strand is the global-collective one. In it, the global means a commitment to a vision focused not on individuals abstracted from their context, but on collectivities inserted in a scenario of social and political relations, in which diseases emerge and acquire their meaning (Paim; Almeida Filho, 1998). The idea of collective health, which gained strength in the debates on public health and social medicine in Latin America, carries the concept of global health as a project for social transformation.

The third strand is the global-public one. Within this concept, I refer to the "public" in the sense of responsibility and management. Health must be seen as a universal right that should be guaranteed by public agencies motivated solely by the good of each and everyone, agencies that depend on citizens' participation and control over aspects such as design, implementation, and monitoring. The health councils, present in the Brazilian Unified Health System (SUS), are, despite their various inadequacies, a step in this direction (Pereira Neto, 2012), as well as the social participation mechanisms provided for in the Brazilian Constitution of 1988.

The fourth strand is the global-peripheral one. The global has to come from the margins, or rather from the knowledge and worldvisions that have been historically marginalized–from the periphery that has been contained and controlled through the legislative and security apparatus of colonialist-inspired global health for centuries. We need a decentralized global health, increasingly occupied by these different and rich knowledges, languages, and ways of thinking, since they are based on distinct experiences of power relations and structures. This occupation movement must have purposes related to emancipation and historical

reparation, constituting a process of subversive decolonization of the places that originated global health. It is important to note that the peripheral is not limited to the countries and regions of the so-called "Global South," even though approaches to global health from the South are part of what is needed (Ventura et al., 2020). At the same time, it is necessary to question the meaning of "Global South," recognizing the presence of peripheral knowledge and worldvisions in the power centers of the "North," and resisting the temptation to create watertight, immutable and geographically determined categories.

The fifth and final strand is that of the global-everyday. The concept of everyday life, present in Marxist and feminist critiques, allows us to think about the intersections between what is commonly referred to as global and local (Lefebvre, 1991; Smith, 1987). The authors who work with this concept refuse to dismiss everyday life as something trivial or inconsequential. They believe the opposite: everyday life reveals the atomization of relations, the commodification, bureaucratization, urbanization, and specialization of labor, which are intrinsic to the global organization of capitalism (Gardiner, 2000). The global reproduction of inequality, social vulnerability and neglect can be observed precisely in the concrete relations of daily life. The concept of everyday life also allows us to think about possibilities of resistance, because daily life is not only the terrain of alienation, but also the platform for the realization of human potential. Everyday life reveals various dimensions of human existence, including the "poetic, irrational, corporeal, ethical and affective" (Gardiner, 2000, p. 19) ones, which means it can become a privileged field for the transformation of reality.

It is also the place where an ethics of writing can be negotiated. I mean a writing that aims to be analytical (investigating and reflecting social tensions, the multiplicity of experiences, the justifications and claims of social actors, oppression, and unrealized potential); critical (identifying contradictions between what social arrangements ostensibly proclaim and what they actually produce); and political (oriented towards emancipation and the reparation of historical injustices). The everyday act of writing, as inconsequential as it may seem, is part of this repeated form of constructing the world that underlies all our efforts to make sense of global health. This is what I do, this is how I start.

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Authors' contributions

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