Global Health Promotion

Official Publication of the International Union for Health Promotion and Education

Publication officielle de l'Union internationale de Promotion de la Santé et d'Education pour la Santé

Publicación oficial de la Unión Internacional de Promoción de la Salud y Educación para la Salud

Volume 31 Number 2 June 2024

https://journals.sagepub.com/home/ped

ISSN 1757-9759

Realising the promise of health promotion through decolonization

Mihi Ratima

Fulfilling the potential of health promotion

The Ottawa Charter defines health promotion as 'the process of enabling people to increase control over, and to improve, their health' (1). The purpose of health promotion is well-aligned with Indigenous peoples' aspirations for self-determination, but there is a gap between intent and practice in health promotion. For health promotion to achieve its potential, it necessitates an understanding of the broader context of Western colonialism that became global from the fifteenth century onwards.

Colonization is an injustice, a deeply entrenched process of dispossession and control that continues to oppress Indigenous peoples (2). While it is now well-understood that the historical and ongoing impacts of colonization are devastating for Indigenous communities across the globe, the dark legacy of colonization extends its shadow to all humanity and the ecosystems that we are part of, which we rely on to sustain us. This is most obvious in regard to human-caused climate change that is driven by Western neoliberal imperatives and widely recognised as the fundamental threat to human health and survival, with inequitable impacts (3).

In 2022, delegates of the 24th International Union of Health Promotion and Education (IUHPE) World Conference on Health Promotion endorsed the Tiohtià:ke Statement, which calls for decolonizing health promotion (4). There are two key strands of decolonizing work required to realise the promise of health promotion. The first is to support self-determined Indigenous health promotion and the second is the work of decolonizing Ottawa Charter-based health promotion.

Self-determined Indigenous health promotion – a response to colonialism

Foremost Māori scholar Distinguished Professor Linda Tuhiwai Smith brought the term 'decolonization' into the global consciousness of Indigenous peoples in her book "Decolonizing Methodologies: Research and Indigenous Peoples", first published in 1999 and most recently updated in 2021 (5). The concept of decolonization to which she gave prominence differed from the earlier focus of decolonization on Indigenous peoples in Africa, Asia, Latin America, and other places emerging from European colonial rule and regaining independence and self-determination within their own lands. Distinguished Professor Tuhiwai Smith's reframing of decolonization, while still centred on self-determination, extended the concept to include those Indigenous peoples whose colonisers never left (such as Māori, Aboriginal Australians, Native Americans, and other groups) (5). The concept of decolonization challenges dominant Western worldviews, research methodologies and health promotion practices, and the myriad of other forms within which colonialism lurks in plain sight. It is about creating space for Indigenous peoples and Indigenous knowledges (5), freeing ourselves and taking back our power (6).

Indigenous health promotion is both an expression of Indigenous worldviews and a response to colonialism. It is an Indigenous-led decolonizing process that is about Indigenous peoples creating their own transformational change and achieving wellbeing. It is the process of increasing Indigenous peoples' control over the determinants of health and strengthening our identities as Indigenous peoples (7).

Te Pou Tiringa Incorporated and Taumata Associates, Taranaki, Aotearoa New Zealand.

Correspondence to: Mihi Ratima, Te Pou Tiringa Incorporated and Taumata Associates, 534 Manawapou Road RD12 Hawera 4672, Aotearoa New Zealand. Email: mihiratima@gmail.com

Global Health Promotion 1757-9759; Vol 31(2): 3–6; 1252382 DOI: 10.1177/17579759241252382 journals.sagepub.com/home/ghp

Indigenous health promotion takes many forms. For example, in Aotearoa New Zealand, *papakāinga* development (Māori co-housing often on ancestral lands) is a health promotion initiative. It is a place-based strategy for raising critical awareness, providing a safe harbour against the prevailing tides of cultural domination and an anchor for collective identity. Papakāinga offer a pathway for recovery from the disruption of colonization.

Our non-Indigenous colleagues have a critical role to play in supporting Indigenous health promotion. These non-Indigenous colleagues are allies when they recognise the essential value of Indigenous knowledges in generating solutions to the challenges Indigenous peoples and others face; make space for Indigenous leadership by acting with humility, integrity, and genuine respect; and use their privilege, platforms and skills in support of self-determined Indigenous health promotion.

Decolonizing 'generic' health promotion

The Ottawa Charter-based health promotion is primarily derived from a Western worldview and is also referred to as 'generic' health promotion in the sense that it is positioned as a universal process intended to be adapted to the needs, preferences and priorities of different population groups locally and globally. Three central elements of decolonizing work for all health promoters, that may happen in any order or simultaneously (8), are: 1) conscientisation (8,9) 2) resistance and 3) transformative outcomes (8,10).

Conscientisation

Increasingly health promoters are being challenged to engage in their own personal decolonization journey. It starts with critical self-reflection, which is a process of reflecting on ones' own identity, power, privilege and biases and the extent to which they are a product of colonialism (10,11). Conscientisation, the ongoing cycle of self-reflection, includes taking action to address the injustices of colonialism (8,9).

'Drawing on moral courage, health promotion researchers, policy-makers and practitioners must confront their discomfort, and unlearn and disrupt past assumptions and biases, in order to be the vehicles of systemic change towards more equitable healthful societies' (4).

Distinguished Professors Graham Hingangaroa Smith and Linda Tuhiwai Smith stress the importance of foundational knowledge and critical awareness in the process of self-reflection (10). That is, having '...a good understanding of the historical, social, cultural, economic and political relations of inequalities, privilege, and colonialism and an understanding of how these relations are produced and reproduced. A fundamental understanding here relates to how power is exercised and manipulated by dominant interest groups to maintain power and control over … colonized populations' (10, p. 22).

Engaging in decolonization training and education is critical for all health promoters. In Aotearoa New Zealand, decolonization workshops and programmes are part of the landscape, such as the Te Pumaomao Nation-Building Seminars, which have been delivered more than 1000 times in recent decades by Takawai Murphy and Chris Murphy (https://takawai.com/).

Resistance

As colonialism is pervasive within many societies, our acts of resistance must be wide-ranging to ensure we do not remain locked in the status quo. According to Penehira and colleagues (12) resistance is a collective approach to fighting back against the forces of colonialism, exposing unjust and inequitable distribution of power and standing in active opposition to social, political and economic forces that impact negatively on Indigenous peoples.

Colonialism is characterised not only by the theft and unrelenting exploitation of Indigenous peoples' ancestral lands and other natural resources but also by the subjugation of Indigenous knowledges and the intellectual traditions from which they emanated. These factors underpin the global capitalist economic system that relies on endless overconsumption and consumerism and disregards the limits of our planet. It is a system that normalises and justifies individualism and greed, for example, enabling the powerful and elite richest 1% to be responsible for 16% of global carbon emissions, which is equal to that of the poorest 66% of humankind (5 billion people) (13). Closing the door on Indigenous knowledges and their potential to contribute to the best possible solutions to the challenges faced by communities, nations and globally has come at a huge cost.

The Legacy Statement from Indigenous delegates to the 2019 23rd IUHPE World Conference on

Health Promotion (Rotorua, Aotearoa New Zealand), Waiora – Indigenous Peoples' Statement for Planetary Health and Sustainable Development, was endorsed by all delegates (14). The Statement calls for privileging Indigenous peoples' voices and Indigenous knowledges as an act of resistance to Western intellectual imperialism. The Statement urges the health promotion community and wider global community to make space for Indigenous peoples' voices and Indigenous knowledges to unlock the potential to create a much wider range of solutions and actions on planetary health.

The later Tiohtià:ke Statement called on the health promotion community 'to actively decolonize our practices' (4). This is an act of resistance that involves analysing health promotion's own organisations, systems and practices to ensure that they do not inadvertently exacerbate colonialism and that they support Indigenous peoples' self-determination.

Acts of resistance don't need to be grand, but they do need to contribute to the decolonizing work of challenging and breaking down oppressive colonial structures and systems. It can be as simple as ensuring a seat at the table for Indigenous colleagues and community members, speaking up when something is not right and showing through actions that you genuinely recognise the value of Indigenous knowledges.

Transformative outcomes

In order to achieve decolonization, health promotion needs to make practical and tangible differences to address structural determinants of inequities and contribute to transformational change that aligns with the aspirations and priorities of Indigenous peoples themselves (8,10). Some Indigenous peoples may seek constitutional change to regain some of their political power lost through colonization (2), others are faced with active settler colonization and land grabs in real time (https://www.iwgia.org/en/). But whatever level health promoters work at, Indigenous peoples will expect accountability and measurable transformational outcomes (8,10).

Around 20 years ago I well remember hearing an early morning interview on Radio New Zealand, our national public broadcaster, with Māori health luminary Professor Emeritus Sir Mason Durie. The interviewer asked him if addressing the wide health inequities experienced by Māori was urgent. His reply was 'Yes, it's urgent, and it has been for the last 100 years.' It felt like not much had changed when just last month the new National-led coalition government repealed our world-first smokefree legislation, a health promotion intervention that would have ushered in our first Māori smokefree generation since colonization (all those born after 1 January 2009 who would never be able to buy tobacco in Aotearoa New Zealand). Despite many areas of progress, all Indigenous peoples continue to face major challenges to their health and wellbeing.

Conclusion

Decolonizing health promotion is a source of hope. It is a process that can free the minds of all health promoters from the shackles of colonialism. It is a process that through acts of resistance to the prevailing forces of colonialism can achieve transformational outcomes for communities. It is an opportunity for non-Indigenous health promoters, our allies, to also take up the mantle and join their Indigenous colleagues who have been engaged in decolonizing work for many years. It is time to realise the promise of health promotion through decolonization.

Declaration of conflicting interests

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The authors work and publications are supported by the Building Better Homes, Towns and Cities National Science Challenge (BRAX1901), the Health Research Council of New Zealand (21/508) and the Ministry of Business, Innovation and Employment (Endeavour Grant 62506 ENDRP).

References

1. World Health Organization. The Ottawa Charter for Health Promotion. World Health Organization [Internet]. 1986. [cited 2024 March 15]. Available from: https://www.who.int/
2. Jackson M. Decolonising education. In: Hutchings J, Lee-Morgan J (eds). Decolonisation in Aotearoa:

Education, Research and Practice. Wellington, New Zealand: New Zealand Council for Educational Research; 2016, pp.39–47.
3. Murphy T. Reflections from the trenches: decolonising hearts and minds in Aotearoa. In: Hutchings J, Lee-Morgan J (eds). Decolonisation in Aotearoa: Education, Research and Practice. Wellington, New Zealand: New Zealand Council for Educational Research; 2016, pp.78–85.
4. International Union of Health Promotion and Education. Tiohtià:ke statement: catalysing policies for health, well-being and equity. Glob Health Promot. 2022; 29: 3–7.
5. Smith LT. Decolonizing Methodologies: Research and Indigenous Peoples. 3rd ed. London: Zed Books; 2021.
6. Palmater P. Decolonization is taking back our power. In: McFarlane P, Schabus N (eds). Whose Land Is It Anyway? A Manual for Decolonization. Vancouver, BC: Federation of Post-Secondary Educators of BC; 2017, pp.73–78.
7. Ratima MM, Durie M, Hond R. Māori health promotion. In: Signal L, Ratima MM (eds). Promoting Health in Aotearoa New Zealand. Dunedin, New Zealand: Otago University Press; 2015, pp.42–63.
8. Smith GH. Kaupapa Māori theory: Indigenous transforming of education. In: Hoskins TK, Jones A (eds). Critical Conversations in kaupapa Māori. Wellington, New Zealand: Huia; 2017, pp.79–94.
9. Freire P. Pedagogy of the Oppressed. Harmondsworth: Penguin; 1972.
10. Smith GH, Smith LT. Doing Indigenous work: decolonizing and transforming the academy. In: McKinley E, Smith L (eds). Handbook of Indigenous Education. Singapore: Springer; 2018, pp.1–27.
11. Ratima M. Leadership for planetary health and sustainable development: health promotion community capacities for working with Indigenous peoples in the application of Indigenous knowledge. Glob Health Promot. 2019; 26: 3–5.
12. Penehira M, Green A, Tuhiwai Smith L, Aspin C. Māori and Indigenous views on R & R: resistance and resilience. MAI Journal. 2014; 3: 96–110 [Internet]. 2014 [cited 2024 March 5]. Available from: https://www.journal.mai.ac.nz/content/m%C4%81ori-and-indigenous-views-r-r-resistance-and-resilience
13. Khalfan A, Lewis AN, Aguilar C, Persson J, Lawson M, Dabi N, et al. Climate Equality: A Planet for the 99%. Oxford: Oxfam GB; 2023.
14. IUHPE. Waiora – Indigenous peoples' statement for planetary health and sustainable development. Rotorua [Internet]. 2019 [cited 2024 March 19]. Available from: https://hpfnz.org.nz/assets/Uploads/Indigenous_People_statement.pdf

Concrétiser la promesse de la promotion de la santé par la décolonisation

Mihi Ratima

Réaliser le potentiel de la promotion de la santé

La Charte d'Ottawa définit la promotion de la santé comme étant « le processus qui confère aux populations les moyens d'assurer un plus grand contrôle sur leur propre santé, et d'améliorer celle-ci » (1).

Le but de la promotion de la santé correspond bien aux aspirations des peuples autochtones à l'autodétermination, mais il existe un écart entre les intentions et la pratique en promotion de la santé. Pour que la promotion de la santé puisse atteindre son potentiel, il faut comprendre le contexte plus large du colonialisme occidental qui s'est étendu à l'ensemble du monde à partir du XVe siècle.

La colonisation est une injustice, un processus profondément enraciné de dépossession et de contrôle qui continue d'opprimer les peuples autochtones (2). Même si l'on a maintenant bien compris que les répercussions historiques et permanentes de la colonisation sont dévastatrices pour les communautés autochtones du monde entier, le sombre héritage de la colonisation étend son ombre à toute l'humanité et aux écosystèmes dont nous faisons partie et dont nous dépendons pour notre survie. C'est une évidence en ce qui concerne le changement climatique d'origine humaine, alimenté par des impératifs néolibéraux occidentaux et largement reconnu comme la menace fondamentale pour la santé et la survie humaines, avec des effets inéquitables (3).

En 2022, les délégués de la 24ème Conférence mondiale sur la promotion de la santé de l'Union internationale de promotion de la santé et d'éducation pour la santé (UIPES) ont approuvé la déclaration de Tiohtià:ke, qui appelle à décoloniser la promotion de la santé (4). Deux grands volets de ce travail de décolonisation sont nécessaires pour concrétiser la promesse de la promotion de la santé. Le premier consiste à appuyer la promotion de la santé autodéterminée des populations autochtones et le deuxième, à décoloniser la promotion de la santé fondée sur la Charte d'Ottawa.

Promotion de la santé autochtone autodéterminée – une réponse au colonialisme

Tout d'abord, Linda Tuhiwai Smith, Professeure distinguée et chercheuse émérite maorie, a introduit le terme « décolonisation » dans la conscience mondiale des peuples autochtones dans son livre "Decolonizing Methodologies: Research and Indigenous Peoples", publié pour la première fois en 1999 et mis à jour récemment en 2021 (5). Le concept de décolonisation auquel elle confère une place éminente diffère de l'intérêt que l'on a pu porter précédemment à la décolonisation des peuples autochtones en Afrique, en Asie, en Amérique latine et en d'autres endroits qui se sont affranchis de la domination coloniale européenne et ont recouvré leur indépendance et leur autodétermination sur leurs propres terres. La nouvelle orientation stratégique de la décolonisation portée par la Professeure distinguée Tuhiwai Smith, tout en restant centrée sur l'autodétermination, a étendu le concept aux peuples autochtones dont les colonisateurs ne sont jamais partis (comme les Maoris, les Aborigènes d'Australie, les peuples autochtones de l'Amérique et d'autres groupes) (5). Le concept de décolonisation défie les visions du monde occidentales dominantes, les méthodologies de recherche et les pratiques de promotion de la santé, et la myriade d'autres formes dans lesquelles

Te Pou Tiringa Incorporated et Taumata Associates, Taranaki, Aotearoa, Nouvelle-Zélande.

Correspondance à : Mihi Ratima, Te Pou Tiringa Incorporated et Taumata Associates, 534 Manawapou Road RD12 Hawera 4672, New Zealand. Email : mihiratima@gmail.com

Global Health Promotion 1757-9759; Vol 31(2): 7–10; 1259601 DOI: 10.1177/17579759241259601 journals.sagepub.com/home/ghp

le colonialisme se cache à la vue de tous. Il s'agit de créer un espace pour les peuples autochtones et les savoirs autochtones (5), de nous libérer et de reprendre notre pouvoir (6).

La promotion de la santé autochtone est à la fois une expression de la vision du monde autochtone et une réponse au colonialisme. Il s'agit d'un processus de décolonisation conduit par les peuples autochtones qui consiste à créer leur propre changement transformationnel et à atteindre le bienêtre. Il s'agit d'accroître le contrôle des peuples autochtones sur les déterminants de la santé et de renforcer notre identité en tant que peuples autochtones (7). La promotion de la santé autochtone peut prendre de nombreuses formes. Par exemple, en Aotearoa Nouvelle-Zélande, le développement de *papakāingas* (co-habitation maorie souvent sur des terres ancestrales) est une initiative de promotion de la santé. Il s'agit d'une stratégie fondée sur le territoire pour sensibiliser la population, offrant un refuge contre les courants dominants de la domination culturelle et un ancrage de l'identité collective. Papakāinga offre un chemin vers le rétablissement après les bouleversements de la colonisation.

Nos collègues non autochtones ont un rôle essentiel à jouer pour soutenir la promotion de la santé des peuples autochtones. Ces collègues non autochtones sont des alliés lorsqu'ils reconnaissent la valeur essentielle des savoirs autochtones pour apporter des solutions aux défis auxquels font face les peuples autochtones et d'autres populations ; lorsqu'ils font de la place pour que le leadership autochtone puisse s'exercer, en agissant avec humilité, intégrité et un véritable respect ; et lorsqu'ils utilisent leurs privilèges, leurs plateformes et leurs compétences à l'appui de la promotion de la santé autochtone autodéterminée.

Décolonisation de la promotion de la santé « générique »

La promotion de la santé fondée sur la Charte d'Ottawa découle principalement d'une vision du monde occidentale et est également appelée promotion de la santé « générique », en ce sens qu'elle se positionne comme un processus universel destiné à être adapté aux besoins, aux préférences et aux priorités des différents groupes de population à l'échelle locale et mondiale. Les éléments centraux de ce travail de décolonisation pour tous les promoteurs de la santé, qui peuvent se produire dans n'importe quel ordre ou simultanément (8), sont au nombre de trois : 1) la conscientisation (8,9), 2) la résistance et 3) les résultats transformateurs (8,10).

La conscientisation

De plus en plus, les promoteurs de la santé sont mis au défi de s'engager dans leur propre voyage de décolonisation personnelle. Cela commence par une réflexion critique sur soi-même, c'est à dire un processus de réflexion sur sa propre identité, son pouvoir, ses privilèges et ses préjugés, et dans quelle mesure ils sont le produit du colonialisme (10,11). La conscientisation, le cycle continu de l'auto-réflexion, suppose d'agir pour remédier aux injustices du colonialisme (8,9).

« En faisant preuve de courage moral, les chercheurs, les décideurs et les praticiens de la promotion de la santé doivent faire face à leur inconfort, désapprendre et bousculer les idées reçues et les préjugés du passé pour être les véhicules d'un changement systémique vers des sociétés plus équitables et en meilleure santé » (4).

Les éminents professeurs Graham Hingangaroa Smith et Linda Tuhiwai Smith soulignent l'importance des connaissances fondamentales et de la conscience critique dans le processus d'autoréflexion (10). C'est-à-dire avoir « ... une bonne compréhension des liens historiques, sociaux, culturels, économiques et politiques des inégalités, des privilèges et du colonialisme et une compréhension de la manière dont ces relations sont produites et reproduites. Une compréhension fondamentale fait référence ici à la manière dont le pouvoir est exercé et manipulé par des groupes d'intérêt dominants pour maintenir leur pouvoir et leur contrôle sur [...] des populations colonisées » (10, p. 22).

La formation et l'éducation à la décolonisation sont essentielles pour tous les promoteurs de la santé. En Aotearoa Nouvelle-Zélande, des ateliers et des programmes de décolonisation font partie du paysage, comme les séminaires « Te Pumaomao Nation-Building », qui ont été animés plus de 1 000 fois au cours des dernières décennies par Takawai Murphy et Chris Murphy (https://takawai.co).

Résistance

Comme le colonialisme est omniprésent dans de nombreuses sociétés, nos actes de résistance doivent être de grande envergure pour veiller à ne pas rester enfermés dans le statu quo. Selon Penehira et ses collègues (12), la résistance est une approche collective pour lutter contre les forces du colonialisme, en dénonçant la répartition injuste et inéquitable du pouvoir et en s'opposant vigoureusement aux forces sociales, politiques et économiques qui ont une incidence négative sur les peuples autochtones.

Le colonialisme se caractérise non seulement par le vol et l'exploitation incessante des terres ancestrales des peuples autochtones et d'autres ressources naturelles, mais aussi par l'assujettissement des savoirs autochtones et des traditions intellectuelles dont ils sont issus. Ces facteurs sous-tendent le système économique capitaliste mondial qui repose sur une surconsommation et un consumérisme sans fin, et qui ignore les limites de notre planète. C'est un système qui normalise et justifie l'individualisme et la cupidité, par exemple, en permettant au 1 % des plus riches et des plus puissants d'être responsable de 16 % des émissions mondiales de carbone, ce qui est égal à celles des 66 % des plus pauvres de l'humanité (5 milliards de personnes) (13). Fermer la porte aux savoirs autochtones et à leur capacité de contribuer aux meilleures solutions possibles face aux défis auxquels les communautés, les nations et le monde entier sont confrontés a coûté très cher.

La déclaration des délégués autochtones à la 23ème Conférence mondiale de l'UIPES sur la promotion de la santé en 2019 (Rotorua, Aotearoa, Nouvelle-Zélande), *Waiora* – Déclaration des peuples autochtones pour la santé planétaire et le développement durable, a été approuvée par tous les délégués (14). La déclaration appelle à privilégier les voix et les savoirs des peuples autochtones comme un acte de résistance à l'impérialisme intellectuel occidental. La déclaration exhorte la communauté de la promotion de la santé et l'ensemble de la population du monde à faire de la place aux voix et aux savoirs des peuples autochtones pour libérer le potentiel de créer un éventail beaucoup plus large de solutions et d'actions en faveur de la santé planétaire.

La déclaration ultérieure de Tiohtià:ke, en 2022, appelle la communauté de la promotion de la santé à « décoloniser activement nos pratiques » (4). Il s'agit d'un acte de résistance qui consiste à analyser les propres organisations, systèmes et pratiques de la promotion de la santé pour s'assurer qu'ils n'exacerbent pas, sans s'en rendre compte, le colonialisme et qu'ils soutiennent bien l'autodétermination des peuples autochtones.

Les actes de résistance n'ont pas besoin d'être grandioses, mais ils doivent contribuer au travail de décolonisation qui consiste à remettre en question et à briser les structures et les systèmes coloniaux oppressifs. Cela peut être aussi simple que d'assurer une place pour des collègues autochtones et des membres de la communauté autour de la table, de parler haut et fort quand quelque chose n'est pas correct et de montrer par des actions que vous reconnaissez vraiment la valeur des savoirs autochtones.

Résultats transformateurs

Afin de parvenir à la décolonisation, la promotion de la santé doit faire des différences concrètes et tangibles pour remédier aux causes structurelles des inégalités et contribuer au changement transformationnel aligné sur les aspirations et les priorités des peuples autochtones eux-mêmes (8,10). Certains peuples autochtones peuvent demander un changement constitutionnel pour regagner une partie de leur pouvoir politique perdu par la colonisation (2), d'autres font face à une colonisation active et à des accaparements de terres en temps réel (https://www.iwgia.org/fr/). Mais quel que soit le niveau auquel les promoteurs de la santé travaillent, les peuples autochtones attendent que des comptes leur soient rendus et des résultats transformationnels mesurables obtenus (8,10).

Il y a environ 20 ans, je me souviens bien d'avoir entendu une interview matinale sur Radio Nouvelle-Zélande, notre radiodiffuseur public national, avec Sir Mason Durie, professeur émérite en santé maorie. L'intervieweur lui a demandé s'il était urgent de remédier aux grandes inégalités en matière de santé dont souffrent les Maoris. Il a répondu : « Oui, c'est urgent, et cela fait 100 ans que cela dure ». On a eu l'impression que peu de choses avaient changé lorsque le mois dernier, le nouveau gouvernement de coalition nationale a abrogé notre première législation antitabac, une intervention de promotion de la santé qui aurait inauguré notre première

génération maorie sans tabac depuis la colonisation (tous ceux qui, nés après le 1er janvier 2009, n'auraient jamais pu acheter du tabac en Aotearoa Nouvelle-Zélande). Malgré de nombreux progrès perceptibles, tous les peuples autochtones continuent de faire face à des défis majeurs pour leur santé et leur bien-être.

Conclusion

La décolonisation de la promotion de la santé est une source d'espoir, un processus qui peut libérer l'esprit de tous les promoteurs de la santé des chaînes du colonialisme. C'est un processus qui, par des actes de résistance aux forces dominantes du colonialisme, peut transformer les communautés. C'est une opportunité pour les promoteurs de la santé non autochtones, nos alliés, de prendre le flambeau et de s'unir à leurs collègues autochtones qui sont engagés dans ce travail de décolonisation depuis de nombreuses années. Il est temps de réaliser la promesse de la promotion de la santé par la décolonisation.

Conflit d'intérêts

Aucun conflit d'intérêt déclaré.

Financement

Le travail et les publications des auteurs bénéficient du soutien du Challenge scientifique national néo-zélandais pour l'amélioration de la construction des logements et des villes (Building Better Homes, Towns and Cities National Science Challenge, BRAX1901), du Conseil néo-zélandais pour la recherche en santé (Health Research Council of New-Zealand, 21/508), et du Ministère néo-zélandais des entreprises, de l'innovation et de l'emploi (Ministry of Business, Innovation and Employment, subvention Endeavour 62506 ENDRP).

Références

1. World Health Organization. The Ottawa Charter for Health Promotion [Internet]. Geneva: World Health Organization; 1986 [consulté le 15 mars 2024]. Accessible à : https://www.who.int/
2. Jackson M. Decolonising education. In: Hutchings J, Lee-Morgan J (eds). Decolonisation in Aotearoa: Education, Research and Practice. Wellington, New Zealand: New Zealand Council for Educational Research; 2016, pp.39–47.
3. Murphy T. Reflections from the trenches: de-colonising hearts and minds in Aotearoa. In: Hutchings J, Lee-Morgan J (eds). Decolonisation in Aotearoa: Education, Research and Practice. Wellington, New Zealand: New Zealand Council for Educational Research; 2016, pp.78–85.
4. International Union for Health Promotion and Education. Tiohtià:ke statement: catalysing policies for health, well-being and equity. Glob Health Promot. 2022; 29: 3–7.
5. Smith LT. Decolonizing Methodologies: Research and Indigenous Peoples. 3rd ed. London: Zed Books; 2021.
6. Palmater P. Decolonization is taking back our power. In: McFarlane P, Schabus N (eds). Whose Land is it Anyway? A Manual for Decolonization. BC, Canada: Federation of Post-Secondary Educators of BC; 2017, pp.73–78.
7. Ratima MM, Durie M, Hond R. Māori health promotion. In: Signal L, Ratima MM (eds). Promoting Health in Aotearoa New Zealand. Dunedin, New Zealand: Otago University Press; 2015, pp.42–63.
8. Smith GH. Kaupapa Māori theory: Indigenous transforming of education. In: Hoskins TK, Jones A (eds). Critical Conversations in Kaupapa Māori. Wellington, New Zealand: Huia; 2017.
9. Freire P. Pedagogy of the Oppressed. Harmondsworth: Penguin; 1972.
10. Smith GH, Smith LT. Doing Indigenous work: decolonizing and transforming the academy. In: McKinley E, Smith L (eds). Handbook of Indigenous Education. Singapore: Springer; 2018, pp.1–27.
11. Ratima M. Leadership for planetary health and sustainable development: health promotion community capacities for working with Indigenous peoples in the application of Indigenous knowledge. Glob Health Promot. 2019; 26: 3–5.
12. Penehira M, Green A, Tuhiwai Smith L, Aspin C. Māori and Indigenous views on R & R: resistance and resilience. MAI Journal. 2014; 3: 96–110.
13. Khalfan A, Lewis AN, Aguilar C, Persson J, Lawson M, Dabi N, et al. Climate Equality: A Planet for the 99%. Oxford: Oxfam GB; 2023.
14. IUHPE. Waiora – Indigenous peoples' Statement for Planetary Health and Sustainable Development. Rotorua; [Internet]. 2019. [consulté le 19 mars 2024]. Accessible à : https://www.iuhpe.org/images/CONFERENCES/world/2019/Indigenous_People_statement_final.pdf

Cumplir la promesa de la promoción de la salud mediante la descolonización

Mihi Ratima

Alcanzar el potencial de la promoción de la salud

La Carta de Ottawa define la promoción de la salud como "el proceso de empoderar a las personas para mejorar su salud y ejercer un mayor control sobre la misma" (1). El propósito de la promoción de la salud está en concordancia con las ambiciones de los pueblos indígenas para su autodeterminación, pero hay una brecha entre la intención y la práctica. Para que la promoción de la salud logre todo su potencial, se requiere comprender el contexto más amplio del colonialismo occidental que se hizo global a partir del siglo XV.

La colonización es una injustica, un proceso profundamente arraigado de desposesión y control que continúa oprimiendo a los pueblos indígenas (2). Bien se sabe que los impactos históricos y actuales de la colonización son devastadores para las comunidades indígenas alrededor del planeta, pero aún el oscuro legado de la colonización extiende su sombra a toda la humanidad y a los ecosistemas de los que hacemos parte, de los que dependemos para sostenernos. Esto se hace más evidente con los cambios climáticos causados por el hombre que han sido incitados por los imperativos neoliberales occidentales y ampliamente reconocidos como la amenaza fundamental a la salud humana y a la supervivencia, con impactos no equitativos (3).

A finales del 2022, los delegados de la 24ª Conferencia Mundial de Promoción de la Salud, organizada por la Unión Internacional de Promoción de la Salud y Educación para la Salud (UIPES), respaldaron la Declaración Tiohtià:ke que hace un llamado para descolonizar la promoción de la salud (4). Se requieren dos facetas clave para desarrollar ese trabajo descolonizador y hacer realidad la promesa de la promoción de la salud. La primera es apoyar la promoción de la salud indígena autodeterminada, y la segunda, trabajar para descolonizar la promoción de la salud basada en la Carta de Ottawa.

La promoción de la salud indígena autodeterminada como respuesta al colonialismo

La eminente profesora distinguida maorí Linda Tuhiwai Smith trajo el término 'descolonización' a la conciencia mundial de los pueblos indígenas en su libro *Decolonizing methodologies: research and Indigenous Peoples* (traducido al español como *A descolonizar las metodologías. Investigación y pueblos indígenas*), publicado en 1999 y actualizado en el 2021 (5). El concepto de descolonización al que la autora dio relevancia difería del enfoque anterior de descolonización sobre los pueblos indígenas de África, Asia, Latinoamérica y otras regiones que emergen del dominio colonial europeo y recuperan su independencia y autodeterminación en sus propios territorios. El replanteamiento de la descolonización que hizo la profesora distinguida Tuhiwai Smith, todavía centrado en la autodeterminación, extiende el concepto para incluir aquellos pueblos indígenas cuyos colonizadores nunca se fueron de sus tierras (como los maorís, los aborígenes australianos, los nativos americanos y otros grupos) (5). El concepto de descolonización desafía las cosmovisiones dominantes occidentales, las metodologías de investigación y las prácticas de la promoción de la salud, así como un sinnúmero de otras formas en las cuales el colonialismo acecha de manera evidente. Hace referencia a la idea de crear un espacio para los pueblos indígenas y los conocimientos indígenas (5), liberándonos nosotros mismos y recuperando nuestro poder (6).

Te Pou Tiringa Incorporated, Taumata Associates, Taranaki, Aotearoa Nueva Zelanda

Correspondencia a: Mihi Ratima, Te Pou Tiringa Incorporated and Taumata Associates, 534 Manawapou Road RD12 Hawera 4672, Aotearoa, New Zealand. Email: mihiratima@gmail.com

Global Health Promotion 1757-9759; Vol 31(2): 11–14; 1252383 DOI: 10.1177/17579759241252383 journals.sagepub.com/home/ghp

La promoción de la salud indígena es tanto una expresión de las cosmovisiones indígenas como una respuesta al colonialismo. Es un proceso de descolonización liderado por los indígenas, que consiste en que los mismos pueblos indígenas crean su propio cambio transformacional y obtienen su bienestar. Es el proceso de incrementar el control de los pueblos indígenas sobre los determinantes de la salud y de fortalecer nuestras identidades como pueblos indígenas (7). La promoción de la salud indígena toma muchas formas. Por ejemplo, en Aotearoa Nueva Zelanda, el desarrollo *papakāinga* (vivienda maorí compartida a menudo en tierras ancestrales) es una iniciativa de promoción de la salud. Es una estrategia basada en el lugar, con el objetivo de aumentar la conciencia crítica, proporcionar un puerto seguro contra las mareas prevalecientes de dominación cultural y un ancla para aferrar la identidad colectiva. Papakāinga ofrece un camino para recuperarse de la disrupción de la colonización.

Nuestros colegas no indígenas desempeñan un papel fundamental en el apoyo de la promoción de la salud indígena. Ellos son aliados cuando reconocen el valor esencial de los conocimientos indígenas para generar soluciones a los desafíos que enfrentan los pueblos indígenas y otras comunidades; abren espacios para el liderazgo indígena al actuar con humildad, integridad y auténtico respeto, y ponen su privilegio, sus plataformas y sus habilidades al servicio de la promoción de la salud indígena autodeterminada.

Descolonizar la promoción de la salud 'genérica'

La promoción de la salud basada en la Carta de Ottawa se deriva principalmente de una cosmovisión occidental y se dice también que es una promoción de la salud 'genérica', en el sentido en que está posicionada como un proceso universal pensado para adaptarse a las necesidades, preferencias y prioridades de los diferentes grupos de población en los ámbitos local y mundial. Hay tres elementos centrales del trabajo de descolonización para todos los promotores de la salud, que pueden ocurrir en cualquier orden o de manera simultánea (8), a saber: 1) concientización (8,9), 2) resistencia y 3) resultados transformadores (8,10).

Concientización

Cada vez más, los promotores de la salud son retados a emprender su propio camino personal de descolonización. Este comienza con una autorreflexión crítica, es decir, un proceso para pensar en su propia identidad, en sus propios poder, privilegios y prejuicios, y en qué medida estos son producto del colonialismo (10,11). La concientización, el ciclo continuo de autorreflexión, incluye la adopción de medidas para enfrentar las injusticias del colonialismo (8,9).

> "Con base en el valor moral, los investigadores de la promoción de la salud, los legisladores y los profesionales deben hacer frente a su incomodidad y desaprender e interrumpir los supuestos y los prejuicios del pasado, con el fin de convertirse en vehículos del cambio sistémico hacia sociedades más equitativas y saludables" (4).

Los profesores distinguidos Graham Hingangaroa Smith y Linda Tuhiwai Smith enfatizan en la importancia del conocimiento fundacional y de la conciencia crítica en el proceso de la autorreflexión (10).

> Es decir, "...entender correctamente las relaciones históricas, sociales, culturales, económicas y políticas de las desigualdades, del privilegio y del colonialismo, así como comprender cómo estas relaciones se producen y reproducen. Una comprensión fundamental aquí se refiere a cómo los grupos de interés dominantes ejercen y manipulan el poder con el fin de mantener el poder y el control sobre (...) poblaciones colonizadas" (10, p. 22).

Participar en capacitaciones y educación sobre descolonización es de vital importancia para todos los promotores de la salud. En Aotearoa Nueva Zelanda, los talleres y programas de descolonización hacen parte del paisaje, como los seminarios Te Pumaomao Nation-Building que han sido dictados en más de mil ocasiones en las recientes décadas por Takawai Murphy y Chris Murphy (https://takawai.com/).

Resistencia

Como el colonialismo está presente en muchas sociedades, nuestros actos de resistencia deben tener una amplia cobertura para asegurarnos de no permanecer encerrados en el *statu quo*. De acuerdo con Penehira y sus colegas (12), la resistencia es un método colectivo de defensa contra las fuerzas del colonialismo, exponiendo la distribución injusta y desigual del poder y manteniendo una oposición activa a las fuerzas sociales, políticas y económicas que impactan de manera negativa a los pueblos indígenas.

El colonialismo se caracteriza no solo por el robo y la constante explotación de las tierras ancestrales y otros recursos naturales de los pueblos indígenas, sino también por la subyugación de los conocimientos indígenas y de las tradiciones intelectuales de las cuales estos emanan. Dichos factores sustentan el sistema económico capitalista mundial que depende de un ilimitado y excesivo consumo y consumismo y que es indiferente a los límites de nuestro planeta. Es un sistema que normaliza y justifica el individualismo y la codicia, por ejemplo, y permite que el 1 % representado por una élite rica y poderosa sea responsable del 16 % de las emisiones mundiales de carbono, que equivale a las del 66 % más pobre de la humanidad (5 mil millones de personas) (13). Cerrar la puerta a los conocimientos indígenas y su potencial para contribuir con las mejores soluciones posibles frente a los desafíos que enfrentan las comunidades, las naciones y el mundo en general, ha tenido un costo enorme.

La Declaración Legado de los participantes indígenas en la 23ª Conferencia Mundial de Promoción de la Salud de la UIPES en el 2019 (Rotorua, Aotearoa, Nueva Zelanda), *Waiora – Declaración de los pueblos indígenas para la salud del planeta y el desarrollo sostenible*, que fue adoptada por todos los delegados (14), hace un llamado para privilegiar las voces y los conocimientos de los pueblos indígenas como un acto de resistencia al imperialismo intelectual occidental. Esta Declaración insta a la comunidad de la promoción de la salud y a la comunidad mundial en general a abrirles espacio a las voces y conocimientos de los pueblos indígenas para desbloquear el potencial de crear un abanico mucho más amplio de soluciones y acciones para la salud planetaria.

La Declaración Tiohtià:ke, que le siguió, en el 2022, hizo un llamado a la comunidad de la promoción de la salud para "descolonizar activamente nuestras prácticas" (4). Este es un acto de resistencia que implica analizar las propias organizaciones, sistemas y prácticas de la promoción de la salud con el fin de garantizar que no exacerben de manera inadvertida el colonialismo y que, por el contrario, apoyen la autodeterminación de los pueblos indígenas.

Los actos de resistencia no necesitan ser grandes, pero se requiere que contribuyan al trabajo descolonizador de desafiar y derribar las estructuras y los sistemas coloniales opresivos. Esto puede ser tan simple como asegurar un lugar en la mesa para los colegas indígenas y los miembros de la comunidad, elevar la voz cuando algo no es correcto y mostrar, a través de acciones, que genuinamente se reconoce el valor de los conocimientos indígenas.

Resultados transformadores

Con el fin de lograr la descolonización, la promoción de la salud debe plantear diferencias prácticas y tangibles para abordar los determinantes estructurales de las desigualdades y contribuir con el cambio transformacional que se alinea con las aspiraciones y prioridades de los mismos pueblos indígenas (8,10). Algunos pueblos indígenas pueden buscar un cambio constitucional para recuperar parte del poder político que perdieron durante la colonización (2), otros se enfrentan a asentamientos coloniales activos y al acaparamiento de tierras en tiempo real (https://www.iwgia.org/es/). Sin embargo, cualquiera que sea el nivel en el que trabajen los promotores de la salud, los pueblos indígenas van a esperar una rendición de cuentas y unos resultados transformacionales mensurables (8,10).

Hace unos 20 años, recuerdo bien haber escuchado una entrevista muy temprano en la mañana en las ondas de Radio New Zealand, nuestra emisora pública nacional, con el experto maorí en salud, el profesor emérito Sir Mason Durie. Al preguntarle si era urgente abordar las amplias desigualdades en salud que experimentan los maorís, su respuesta fue: "Sí, es urgente, y lo ha sido durante los últimos 100 años". Parece que no mucho ha cambiado, pues apenas el mes pasado el nuevo gobierno de coalición revocó nuestra legislación, pionera en el mundo, contra el tabaco. Era una intervención de la promoción de la salud que habría marcado el comienzo de una primera generación maorí libre de tabaco desde la colonización (a las personas nacidas

después del 1 de enero del 2009 no se les permitiría comprar tabaco en Aotearoa Nueva Zelanda). A pesar de las numerosas áreas de progreso, todos los pueblos indígenas siguen enfrentando grandes desafíos para su salud y su bienestar.

Conclusión

Descolonizar la promoción de la salud es una fuente de esperanza. Es un proceso que puede liberar de los grilletes del colonialismo las mentes de todos los promotores de la salud. Es un proceso que, mediante actos de resistencia contra las fuerzas del colonialismo que aún prevalecen, puede lograr resultados transformacionales para las comunidades. Esta es una oportunidad para que los promotores de la salud no indígenas, nuestros aliados, tomen también el relevo y se unan a sus colegas indígenas, quienes han estado involucrados en el trabajo de descolonización desde hace mucho tiempo. Es el momento de hacer realidad la promesa de la promoción de la salud mediante la descolonización.

Declaración de conflicto de intereses

La autora declaró no tener potenciales conflictos de intereses con respecto a la investigación, autoría y/o publicación de este artículo.

Financiación

El trabajo y las publicaciones de la autora están financiados por Building Better Homes, Towns and Cities National Science Challenge (BRAX1901), el Health Research Council of New Zealand (21/508) y el Ministry of Business, Innovation and Employment (Endeavour Grant 62506 ENDRP).

Referencias

1. World Health Organization. The Ottawa Charter for Health Promotion. World Health Organization [Internet]. 1986. [Consultado el 15 de marzo del 2024]. Disponible en: https://www.who.int/
2. Jackson M. Decolonising education. En: Hutchings J, Lee-Morgan J (eds). Decolonisation in Aotearoa: Education, Research and Practice. Wellington, New Zealand: New Zealand Council for Educational Research; 2016, pp.39–47.
3. Murphy T. Reflections from the trenches: decolonising hearts and minds in Aotearoa. En: Hutchings J, Lee-Morgan J (eds). Decolonisation in Aotearoa: Education, Research and Practice. Wellington, New Zealand: New Zealand Council for Educational Research; 2016, pp.78–85.
4. International Union of Health Promotion and Education. Tiohtià:ke statement: catalysing policies for health, well-being and equity. Glob Health Promot. 2022; 29: 3–7.
5. Smith LT. Decolonizing Methodologies: Research and Indigenous Peoples. 3rd ed. London: Zed Books; 2021.
6. Palmater P. Decolonization is taking back our power. En: McFarlane P, Schabus N (eds). Whose Land Is It Anyway? A Manual for Decolonization. Vancouver, BC: Federation of Post-Secondary Educators of BC; 2017, pp.73–78.
7. Ratima MM, Durie M, Hond R. Māori health promotion. En: Signal L, Ratima MM (eds). Promoting Health in Aotearoa New Zealand. Dunedin, New Zealand: Otago University Press; 2015, pp.42–63.
8. Smith GH. Kaupapa Māori theory: Indigenous transforming of education. En: Hoskins TK, Jones A (eds). Critical Conversations in kaupapa Māori. Wellington, New Zealand: Huia; 2017, pp.79–94.
9. Freire P. Pedagogy of the Oppressed. Harmondsworth, UK: Penguin; 1972.
10. Smith GH, Smith LT. Doing Indigenous work: decolonizing and transforming the academy. En: McKinley E, Smith L (eds). Handbook of Indigenous Education. Singapore: Springer; 2018, pp.1–27.
11. Ratima M. Leadership for planetary health and sustainable development: health promotion community capacities for working with Indigenous peoples in the application of Indigenous knowledge. Glob Health Promot. 2019; 26: 3–5.
12. Penehira M, Green A, Tuhiwai Smith L, Aspin C. Māori and Indigenous views on R & R: resistance and resilience. MAI Journal. 2014; 3: 96–110 [Internet]. 2014. [Consultado el 5 de marzo del 2024]. Disponible en: https://www.journal.mai.ac.nz/content/m%C4%81ori-and-indigenous-views-r-r-resistance-and-resilience
13. Khalfan A, Lewis AN, Aguilar C, Persson J, Lawson M, Dabi N, et al. Climate Equality: A Planet for the 99%. Oxford: Oxfam GB; 2023.
14. IUHPE. Waiora – Indigenous peoples' statement for planetary health and sustainable development. Rotorua [Internet]. 2019. [Consultado el 19 de marzo del 2024]. Disponible en: https://hpfnz.org.nz/assets/Uploads/Indigenous_People_statement.pdf

Original Article

Bridging the commercial determinants of Indigenous health and the legacies of colonization: A critical analysis

Daniel Eisenkraft Klein[1] and Amy Shawanda[2]

Abstract: To date, there has been scarce effort to consider the intertwining of colonization and the commercial determinants of Indigenous health. This is a vital omission, and one that this paper proposes to address. We propose how four losses of tradition borne out of colonialism are intertwined with four respective commercial determinants of Indigenous health: 1) loss of traditional diets and the ultra-processed food industry; 2) loss of traditional ceremony and the tobacco industry; 3) loss of traditional knowledge and the infant formula industry; and 4) loss of traditional support networks and the alcohol industry. Building on Indigenous efforts to decolonize spaces and assert control over their own lives, we argue that analyzing the mechanisms through which industry activities intersect with colonial legacies will improve broader understandings of Indigenous health disparities.

Keywords: tobacco, Indigenous health, determinants of health, equity/social justice, breastfeeding, food security, alcohol

Introduction

Scholars have increasingly identified how components of late-stage capitalism and poor health outcomes are fundamentally intertwined. A few industries, including tobacco, alcohol, and ultra-processed foods, are now major contributors of poor health and premature deaths in Canada and internationally (1). Though frequently selling very different products, these organizations often operate using similar strategies, including political lobbying, campaign donations, public relations committees, and greenwashing strategies, to diminish the focus on their broader harmful impacts (2). Bridging these industries and tactics are *the commercial determinants of health* (CDOH), a conceptual framework and academic field that refers to commercial determinants as drivers of health (3). The CDOH generally cover three main areas: first, unhealthy commodities that contribute to ill-health; second, the business, market, and political practices that harm health and are employed to sell these products and secure favorable regulatory environments; and third, the global drivers of ill-health, such as neoliberalism, that have facilitated the proliferation of these commodities and strategies (3).

Despite the growing focus on the CDOH, there has been a conspicuously absent consideration of their intersections with Indigenous health disparities. This is a crucial omission: a number of the most prevalent health issues within Indigenous communities, including high rates of commercial tobacco use, alcoholism, obesity, and diabetes (4–6), are significantly associated with private sector interests (7). Moreover, the CDOH have the potential of contributing to an investigation of upstream determinants of health, something that has been repeatedly called for when addressing Indigenous health inequities (see Carson *et al*., (8); Kolahdooz *et al*., (9)).

To date, there has been just one review of the commercial determinants of Indigenous health, by

1. Dalla Lana School of Public Health, University of Toronto, Canada.
2. Waakebiness Institute for Indigenous Health, Dalla Lana School of Public Health, University of Toronto, Canada.

Correspondence to: Daniel Eisenkraft Klein, Dalla Lana School of Public Health, 155 College St., Toronto, ON, M5T 3M7, Canada. Email: Daniel.eisenkraftklein@mail.utoronto.ca

(This manuscript was submitted on 31 March 2023. Following blind peer review, it was accepted for publication on 23 June 2023.)

Global Health Promotion 1757-9759; Vol 31(2): 15–22; 1187614 DOI: 10.1177/17577592311876l4 journals.sagepub.com/home/ghp

Crocetti *et al*. (10). Crocetti *et al*. conducted a systematic scoping review of available evidence on the commercial determinants of Indigenous health and well-being, identifying six industries: extractive (mining), tobacco, food and beverage, pharmaceutical, alcohol, and gambling. Our paper builds on the review by Crocetti *et al*. and existing knowledge of commercial determinants of Indigenous health by centering the intertwining of colonial loss and the commercial determinants of health.

Overall, the legacy of colonization, including the impacts of residential schools and broader assimilation practices, is recognized as the single most significant determinant of Indigenous peoples' health (11). In this vein, our paper proposes how four losses of tradition borne out of colonization are intertwined with four respective commercial determinants of Indigenous health: 1) loss of traditional knowledge and the infant formula industry; 2) loss of traditional diets and the ultra-processed food industry; 3) loss of traditional support networks and the alcohol industry; and 4) loss of traditional ceremony and the tobacco industry. We propose that progress in understanding the commercial determinants of Indigenous health – and Indigenous health inequities more generally – requires ongoing reflections on the intersections between colonial legacies and health-harming industries' activities that have largely gone unexplored to date.

Loss of traditional knowledge and the infant formula industry

Breastfeeding has clear and well-established health benefits, including reductions in childhood infectious diseases, mortality, and malnutrition for the child. Mothers who breastfeed see pronounced reductions in their risks of diabetes, breast and ovarian cancers, and cardiovascular disease (12). At present, the World Health Organization recommends children are breastfed exclusively from birth to six months, and that breastfeeding continues up to two years or more after the introduction of solid foods (13). Despite this, breastfeeding initiation rates for Indigenous women in Canada are 77.8%, compared with 88% for non-Indigenous women in Canada (14). This discrepancy, over entire Indigenous populations, has had enormous consequences for both Indigenous mothers' and children's health (14).

Prior to settlers' arrival, Indigenous women traditionally breastfed their babies (15). Historically, women in Indigenous communities commonly supported breastfeeding by assisting in the care of other children and/or breastfeeding when the biological mother was unable to (16). Fathers sought to provide the best cuts of meat to their partners to encourage higher quality of breast milk (16). Female Elders played important roles in advising pregnant women and new mothers, providing advice, and sharing knowledge (17). Many of these traditional practices, however, were lost as a result of colonization. The residential school experience strongly inhibited the transfer of traditional knowledge about childbirth, including breastfeeding (18). As a result of their forced removal, residential school survivors were forced to raise children without having experienced parenting skills. These deficits were passed on to their children, thus becoming another intergenerational trauma. Colonization also impacted family structures, reducing the company of female relatives and communal support (14). Land designations also went to males as a result of colonization, dismantling females' family roles and undermining caregiving (16).

In tandem with these colonial losses, the infant formula industry has exerted its enormous economic power to feed on parents' anxieties around normal infant behaviors, positioning infant formula as a solution to a range of babies' health and development challenges with little actual evidence. Rapidly growing into a $55 billion industry, the industry now spends more than $3 billion on marketing annually (19). Through a well-refined playbook, it seeks to influence families, health professionals, science, and policy processes. This occurs via advertising and promotion, the funding of professionals and science groups, lobbying, and through industry front groups (19). It is increasingly difficult for parents to find objective, industry-free information on breastfeeding, with new parents commonly seeing dozens of infant formula advertisements within the first year of their children's birth. This problem has become even more acute with the advent of digital marketing, with companies now able to target parents with algorithm-driven marketing at the precise moments when they are in their most vulnerable or concerned states around difficulties breastfeeding (13). Underlying these tactics, Nestlé and other infant formula corporations

have effectively used their status as biomedical experts, taking advantage of – and perpetuating – colonial notions of scientific dominance over Indigenous knowledges and wisdom in order to promote infant formula (15).

Loss of traditional diets and the ultra-processed food industry

Indigenous Peoples are nearly twice as likely to be obese than non-Indigenous individuals in Canada, with a significantly higher prevalence of type 2 diabetes and cardiovascular diseases (20). First Nations, Métis and Inuit communities' greater risks are rooted in a range of intersecting and combined factors, including the history of colonialism; poor access to healthy and affordable food; and an overall genetic risk for type 2 diabetes (9). Many of these disparities, however, can be traced to Indigenous communities' loss of traditional diets and to the residential school system, with Indigenous women connected to traditional ways up to 16 times more likely to breastfeed (21).

Indigenous communities' diets in the pre-colonial and early colonial periods largely consisted of traditional foods, containing a diversity of wild foods such as fish, game, and berries and other plants gathered off of the land (22). This diet was overall cost-effective, provided a range of nutrients, and served as a form of social cohesion through food preparation and sharing customs (22). The legacies of colonialism, however, have significantly disrupted this way of eating, including a nutritional shift to market or store-bought foods that emphasized high-energy, nutrient-lacking foods, and shifted customary practices away from traditional food harvesting and eating (23).

Food was also weaponized in the residential school system. Students were commonly fed scraps and 'porridge with worms in it,' and the federal government knowingly underfunded kitchens and food, leading to starvation (24). Residential school survivors reported a severe culture of socialization and assimilation, in which students were stripped of their identities, including in their relationships to food. One survivor shared, 'I can't cut up caribou meat; I can't cut up moose meat; work with fish and speak my language. So I was starting to become alienated from my parents and my grandparents; everything' (24).

Beginning in the second half of the 20th century, the loss of traditional foods has given way to a shift in dietary practices that emphasized particularly refined and industrial-formulated substances, often labelled as 'ultra-processed foods' (UPFs) (22). The concept of UPFs refers to industrial creations of mostly inexpensive ingredients and nutrients that are manufactured using a series of processes (thus 'ultra-processed') and contain limited whole foods, if any (25). Indigenous diets are now disproportionately made up of ultra-processed foods, with approximately 54% of Indigenous energy consumption coming from UPFs (22). This consumption of UPFs is of particular concern: international health organizations, including the Pan American Health Organization and the World Health Organization, have recommended using diets' energy share of UPFs as overall measurements of diet quality (26).

Intersecting with and exacerbating these changes to Indigenous diets is a food industry that has been repeatedly shown to heavily push UPFs at the expense of global health (27). This push operates through a range of strategies, including influencing governmental dietary advice, heavily marketing UPFs, promoting unhealthy foods in schools, lobbying policymakers, fighting efforts to promote healthy eating, and maintaining a relative monopoly over the global food system, multinational food and beverage companies have had a significant impact on UPFs, particularly in terms of UPFs (28). Lower childhood obesity is now clearly associated with stronger regulations on sales of unhealthy food and restrictions on food advertisements in schools (29). Moreover, the impacts of an overabundance of availability of UPFs and few restrictions on marketing of unhealthy foods is particularly likely to disproportionately impact marginalized communities, especially children that do not have the same abilities to critically push back at industry messaging (27).

Researchers have found that transnational companies, such as Nestlé and Coca Cola, continue to engage in corporate social responsibility initiatives that build brand images in Indigenous communities via sponsored scholarships and employment opportunities for Indigenous youth (10). Yet these same industries have shown little interest in reducing their role in exacerbating childhood obesity-related and diet-related diseases among Indigenous communities. UPF industries continue to engage in

lobbying, selective pricing, and marketing in order to drive consumption.

Loss of autonomy and the alcohol industry

Alcohol continues to plague traditional ways of life within Indigenous communities. Today, Indigenous youth are 43% more likely to report using alcohol than non-Indigenous youth, and begin drinking on average at earlier ages (30). In addition, alcohol use is disproportionately reported to be a result of 'depressive' symptoms, such as drinking to cope and binge drinking. Seventy-three percent of First Nations community members report that alcohol is a problem in their communities (31).

Alcohol was first introduced to First Nations People by the Hudson's Bay Company fur traders (32). Prior to the first wave of European colonization, few Indigenous cultures in North America had encountered alcohol (33). It quickly became standard practice to offer alcohol to Indigenous traders. Frank *et al*. (34) puts the crisis more bluntly, arguing:

> [The] roots of the epidemic of alcohol-related problems among many Native North Americans are sought in cultural responses to European arrival, the role of alcohol in frontier society, and colonial and postcolonial policies (p.344).

With the expansion of the liquor trade, the negative stereotype of the 'drunken Indian' began to take hold. European traders documented the harmful effects of alcohol on their Indigenous trading partners (33). Traders reported heavy drinking among Indigenous peoples, including consumption of large quantities of alcohol in short periods of time, and frequent bouts of violence and promiscuity. These incidents soon led to demands for an end to the liquor trade. The prevailing perception was that alcohol unleashed the 'savage' nature of First Nations peoples, rendering them completely incapable of holding their liquor and therefore unsuitable to drink at all (33).

As a result, European traders attempted to ban alcohol via the Indian Act. A hierarchy of Superintendents, Deputy Superintendents, Commissaries, Interpreters, and Missionaries was established in 1775, with a clear set of duties, including that: 'No Trader shall sell or otherwise supply the Indians with Rum, or other spirituous liquors, swan shot or rifled barrel led guns' (35). That set the tone for federal government's policies regarding First Nations communities and alcohol: through an amendment to the Indian Act in 1884, it became a felony for Indians to purchase, consume, or enter a licensed liquor establishment. The intention behind this law was largely commercial: it was anticipated that Indigenous people would more diligently focus on farming their land if they did not have access to alcohol (35).

In tandem with the impacts of colonization, the alcohol industry utilizes sophisticated marketing and pricing strategies to drive consumption (36). Alcohol marketing is associated with earlier initiation rates of drinking, higher rates of consumption, and positive expectations among youth populations (37). Despite this, alcohol companies continue to design new products and related campaigns with youth-friendly attributes. The industry has also used a range of tactics to influence policies and policymaking, including public campaigns that emphasize the individual and de-emphasize the corporation (38), attempting to push the responsibility of safe drinking squarely onto individuals and away from communal responsibility (36). Industry systematically encourages an emphasis on individual-level education and industry self-regulation, in combination with a 'personal responsibility' narrative (39). This has resulted in the industry averting warnings about alcohol use and pregnancy, as well as circumventing restrictions on availability and price (40). In combination, this has led to the targeted marketing of alcohol towards Indigenous populations, heavy lobbying, and an absence of community consultation by the alcohol industry when building alcohol outlets near Indigenous communities (10).

Loss of traditional ceremony and the tobacco industry

The recreational abuse and addiction epidemic of tobacco among Indigenous people remains one of the primary causes of premature death in Indigenous communities (41). There is a growing awareness of the disproportionate impacts that commercial tobacco use has on Indigenous communities, with Indigenous individuals more than twice as likely to smoke commercial tobacco (35.8–59.8%) than the

general Canadian population (18%) (41). The tobacco epidemic within Indigenous communities is of particular concern because of the ways in which the industry has seized on well-meaning harm reduction narratives within tobacco. Rather than truly investing in harm reduction strategies, the industry has seized on efforts to further cement its product in marginalized communities (42).

Many First Nations communities have had a respectful relationship with traditional tobacco, which is often used in ceremony, as well as ritual, prayer, in trade, and as a form of a contract (43). But this use of tobacco was absent from the commercialization and current mass production tobacco that has the chemicals, nicotine, and addictive properties it has in it today (43).

When the settlers discovered First Nations people interacting with tobacco, the voyagers were curious and brought it back to Europe with them. In the 16th century, Europe, East Asia, and West Africa were growing tobacco from the Americas because the Spanish were transporting the tobacco plant all over the world on their commercial voyages. The 17th century saw a further rise in the growth, harvesting, and exportation of tobacco as a recreational drug (44). Mark (45) explains 'As British colonialism in North America expanded, so did the tobacco plantations and, in time, tobacco served not only as the economic foundation of the colonies but as currency' (para. 3). The governments of Europe established monopolies on the sale of tobacco products and from there the tobacco industry in England was a privately owned business that received government subsidies in the form of higher tobacco taxes, thus making it a cash crop in colonial America (45). Tobacco farming needed to be expanded because of the high demand.

When establishing themselves in the Americas, farmers and settlers bartered with tobacco. With the advent of Bills of Credit, however, that practice was discontinued (45). While the colonies were fighting for independence from Europe, tobacco was used as collateral for loans received from France. Once the British discovered this, they began setting fires to destroy the crops and this continued until the end of the war.

There is abundant evidence that the tobacco industry has systematically promoted and targeted Indigenous peoples with commercialized nicotine products (41). The industry has employed a wide range of strategies, including lobbying against health-protecting regulations, exploiting tribal sovereignty through tax-exempt cigarette sales, targeted marketing, and ensuring widespread access to its products (41). The industry has also regularly used depictions of Indigenous people to promote its products, including using slogans such as 'Australians answer to the peace pipe.' In the United States, tobacco is frequently marketed with carved wooden Native American male figures outside of smoke shops, with an ongoing effort to create a commercial association between Native Americans and tobacco (46). These images were to represent the native crop used by First Nations Peoples who planted, cultivated, and harvested the plant for traditional, health, and spiritual uses.

More recently, the industry has increasingly tried to connect with Indigenous communities to promote e-cigarettes and non-combustible tobacco (47). Rothmans, Benson & Hedges hosted a 'Harm Reduction' forum to ostensibly help Indigenous people facing addiction (42). Yet as both Cree-Metis and settler allies have pointed out, there is a fundamental tension in the industry hosting an Indigenous health conference (48). The industry has a long, sordid history of appropriation and targeting marginalized groups with their products. The strategies also serve to downplay other strategies (with less commercial backing) that need to be put in place to help smokers quit – ranging from financial incentives to therapy – that do not benefit the industry and therefore fail to elicit their attention (49). Finally, it downplays Rothman, Benson & Hedges' actions in the Global South – while British American Tobacco and its related companies promote forms of 'harm reduction' in areas where tobacco control is strong, they continue to promote their products to Indigenous communities in the Global South, where there are fewer restrictions, and they have more financial freedom (41).

Conclusion

To date, there has been scarce effort to consider the intertwining of colonization and the commercial determinants of Indigenous health. This is a vital omission, and one that this paper proposed to address. These intersections have enormous consequences for Indigenous communities globally, particularly given

the frequent relegation of Indigenous priorities in health policymaking.

In this initial paper, we have outlined four areas in which we argue that the legacies of colonization and industry interests have intersected: 1) loss of traditional diets and the UPF industry; 2) loss of traditional support networks and the alcohol industry; 3) loss of traditional ceremony and the tobacco industry; and 4) loss of traditional knowledge and the infant formula industry. Each of these four examples illustrates how Indigenous communities have had to negotiate their relationship to health in the face of both colonization and the increasingly outsized influence of health-harming industries. Building on Indigenous efforts to decolonize spaces and assert control over their own lives, we argue that analyzing the mechanisms through which industry activities intersect with colonial legacies will improve broader understandings of Indigenous health disparities.

Author contribution

Both authors have made a substantial contribution to (a) the conception and design and/or the analysis and interpretation of data, (b) drafting the article or revising it critically for intellectual content, and (c) both authors approve the version submitted to *Global Health Promotion*.

Declaration of conflicting interests

The authors have no conflicts of interest to declare.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

ORCID iD

Daniel Eisenkraft Klein https://orcid.org/0000-0002-9451-9668

References

1. Lee K, Freudenberg N. Public health roles in addressing commercial determinants of health. Annu Rev Public Health. 2022; 43: 375–395.
2. Madureira Lima J, Galea S. Corporate practices and health: a framework and mechanisms. Global Health. 2018; 14: 21.
3. Mialon M. An overview of the commercial determinants of health. Global Health. 2020; 16: 74.
4. Kolahdooz F, Sadeghirad B, Corriveau A, Sharma S. Prevalence of overweight and obesity among indigenous populations in Canada: A systematic review and meta-analysis. Crit Rev Food Sci Nutr. 2017; 57: 1316–1327.
5. Orisatoki R. The public health implications of the use and misuse of tobacco among the aboriginals in Canada. Glob J Health Sci. 2013; 5: 28–34.
6. Weatherall TJ, Conigrave KM, Conigrave JH, Lee KSK. What is the prevalence of current alcohol dependence and how is it measured for Indigenous people in Australia, New Zealand, Canada and the United States of America? A systematic review. Addict Sci Clin Pract. 2020; 15: 32.
7. Freudenberg N. Lethal But Legal: Corporations, Consumption, and Protecting Public Health. Oxford: Oxford University Press; 2014, 346 p.
8. Carson B, Dunbar T, Chenhall RD, Bailie R. Social Determinants of Indigenous Health. London: Routledge; 2020, 256 p.
9. Kolahdooz F, Nader F, Yi KJ, Sharma S. Understanding the social determinants of health among Indigenous Canadians: priorities for health promotion policies and actions. Glob Health Action. 2015; 8: 27968.
10. Crocetti AC, Cubillo (Larrakia) B, Lock (Ngiyampaa) M, Walker (Yorta Yorta) T, Hill (Torres Strait Islander) K, Mitchell (Mununjali) F, et al. The commercial determinants of Indigenous health and well-being: a systematic scoping review. BMJ Glob Health. 2022; 7: e010366.
11. Reading C, Wien F. Health Inequalities and Social Determinants of Aboriginal Peoples' Health [Internet]. National Collaborating Centre for Aboriginal Health; 2009. Available from: http://www.nccah-ccnsa.ca/docs/social%20determinates/NCCAH-Loppie-Wien_Report.pdf
12. The Lancet. Unveiling the predatory tactics of the formula milk industry. Lancet. 2023; 401: 409.
13. WHO. Scope and impact of digital marketing strategies for promoting breastmilk substitutes [Internet]. 2022 [cited 2023 February 10]. Available from: https://www.who.int/publications/i/item/9789240046085
14. AHS. Practical considerations for working with Indigenous mothers [Internet]. 2019. [cited 2023 February 12]. Available from: https://www.albertahealthservices.ca/assets/info/hp/hcf/if-hp-hcf-bf-indigenous-mothers-printable.pdf
15. Tomori C, Palmquist AEL. Racial capitalism and the US formula shortage: a policy analysis of the formula industry as a neocolonial system. Front Sociol [Internet]. 2022 [cited 2023 March 3]; 7. Available from: https://www.frontiersin.org/articles/10.3389/fsoc.2022.961200
16. Schroeder D, Larsen P, Byrd NJ. Rediscovering empowerment with breastfeeding in an urban First Nation's population. BMC Pregnancy Childbirth. 2019; 19: 509.
17. Moffitt P, Lakhani SA, Cruz S. Infant feeding teachings from Indigenous grandmothers: generating knowledge through sharing circles. In: Northern and Indigenous Health and Healthcare [Internet]. 2018 [cited 2023 March 28]. Available from: https://openpress.usask.ca/northernhealthcare/chapter/chapter-19-infant-feeding-teachings-from-indigenous-grandmothers-generating-knowledge-through-sharing-circles/

18. Wilson D, Ronde S de la, Brascoupé S, Apale AN, Barney L, Guthrie B, et al. Health professionals working with First Nations, Inuit, and Métis consensus guideline. J Obstet Gynaecol Can. 2013; 35: 550–553.
19. Rollins N, Piwoz E, Baker P, Kingston G, Mabaso KM, McCoy D, et al. Marketing of commercial milk formula: a system to capture parents, communities, science, and policy. Lancet. 2023; 401: 486–502.
20. Batal M, Decelles S. A scoping review of obesity among Indigenous peoples in Canada. J Obes. 2019; 2019: e9741090.
21. Rhodes KL, Hellerstedt WL, Davey CS, Pirie PL, Daly KA. American Indian breastfeeding attitudes and practices in Minnesota. Matern Child Health J. 2008; 12(Suppl 1): 46–54.
22. Batal M, Johnson-Down L, Moubarac JC, Ing A, Fediuk K, Sadik T, et al. Quantifying associations of the dietary share of ultra-processed foods with overall diet quality in First Nations peoples in the Canadian provinces of British Columbia, Alberta, Manitoba and Ontario. Public Health Nutr. 2018; 21: 103–113.
23. Kuhnlein HV, Erasmus B, Spigelski D, Burlingame B. Indigenous peoples' food systems and well-being: interventions and policies for healthy communities [Internet]. 2013 [cited 2022 September 29]. Available from: https://www.cabdirect.org/cabdirect/abstract/20133239133
24. TRC. The Survivors Speak: A Report of the Truth and Reconciliation Commission of Canada. CreateSpace Independent Publishing Platform; 2015, 260 p. [cited 2023 January 5].
25. Statistics Canada. Consumption of ultra-processed foods in Canada [Internet]. 2020 [cited 2022 September 29]. Available from: https://www150.statcan.gc.ca/n1/pub/82-003-x/2020011/article/00001-eng.htm
26. Vandevijvere S, Monteiro C, Krebs-Smith SM, Lee A, Swinburn B, Kelly B, et al. Monitoring and benchmarking population diet quality globally: a step-wise approach. Obesity Reviews. 2013; 14(S1): 135–149.
27. Nestle M. Food politics. In: Food Politics. University of California Press; 2013. [cited 2023 February 10].
28. Stuckler D, Nestle M. Big food, food systems, and global health. PLOS Med. 2012; 9: e1001242.
29. Palakshappa D, Fiks AG, Faerber JA, Feudtner C. Association between state school nutrition laws and subsequent child obesity. Prev Med. 2016; 90: 107–113.
30. Sikorski C, Leatherdale S, Cooke M. Tobacco, alcohol and marijuana use among Indigenous youth attending off-reserve schools in Canada: cross-sectional results from the Canadian Student Tobacco, Alcohol and Drugs Survey. Health Promot Chronic Dis Prev Can. 2019; 39: 207–215.
31. Stewart SH, Sherry SB, Comeau MN, Mushquash CJ, Collins P, Van Wilgenburg H. Hopelessness and excessive drinking among aboriginal adolescents: the mediating roles of depressive symptoms and drinking to cope. Depress Res Treat. 2011; 2011: 970169.
32. Waldram JB, Herring DA, Young TK. Aboriginal Health in Canada: Historical, Cultural, and Epidemiological Perspectives. Toronto: University of Toronto Press; 2006, 385 p.
33. Duran B. Indigenous versus colonial discourse: alcohol and American Indian identity. In: Bird SE (ed.). Dressing in Feathers. New York, NY: Routledge; 1996.
34. Frank JW, Moore RS, Ames GM. Historical and cultural roots of drinking problems among American Indians. Am J Public Health. 2000; 90: 344–351.
35. ICT. A Look at First Nations Prohibition of Alcohol [Internet]. Indigenous Corporate Training; 2016 [cited 2022 October 30]. Available from: https://www.ictinc.ca/blog/first-nations-prohibition-of-alcohol
36. Hawkins B, Holden C, Eckhardt J, Lee K. Reassessing policy paradigms: a comparison of the global tobacco and alcohol industries. Glob Public Health. 2018; 13: 1–19.
37. Mart SM. Alcohol marketing in the 21st century: new methods, old problems. Subst Use Misuse. 2011; 46: 889–892.
38. McCambridge J, Mialon M, Hawkins B. Alcohol industry involvement in policymaking: a systematic review. Addiction. 2018; 113: 1571–1584.
39. Hoe C, Weiger C, Minosa MKR, Alonso F, Koon AD, Cohen JE. Strategies to expand corporate autonomy by the tobacco, alcohol and sugar-sweetened beverage industry: a scoping review of reviews. Global Health. 2022; 18: 17.
40. Martino FP, Miller PG, Coomber K, Hancock L, Kypri K. Analysis of alcohol industry submissions against marketing regulation. PLoS One. 2017; 12: e0170366.
41. Minichiello A, Lefkowitz ARF, Firestone M, Smylie JK, Schwartz R. Effective strategies to reduce commercial tobacco use in Indigenous communities globally: a systematic review. BMC Public Health. 2016; 16: 21.
42. Waa A, Maddox R, Henderson PN. Big tobacco using Trojan horse tactics to exploit Indigenous peoples. Tob Control. 2020; 29: e132– e133.
43. Maron DF. The fight to keep tobacco sacred. Scientific American [Internet]. 2018 March 29 [cited 2022 October 30]. Available from: https://www.scientificamerican.com/article/the-fight-to-keep-tobacco-sacred/
44. Brandt AM. The Cigarette Century: The Rise, Fall, and Deadly Persistence of the Product That Defined America. Reprint ed. New York, NY: Basic Books; 2009, 640 p.
45. Mark JJ. Tobacco & colonial American economy. In: World History Encyclopedia [Internet]. 2021 [cited 2022 October 30]. Available from: https://www.worldhistory.org/article/1681/tobacco–colonial-american-economy/
46. Elliott C. 'Big food' and 'gamified' products: promotion, packaging, and the promise of fun. Crit Public Health. 2015; 25: 348–360.

47. Maddox R, Waa A, Lee K, Henderson PN, Blais G, Reading J, et al. Commercial tobacco and indigenous peoples: a stock take on Framework Convention on Tobacco Control progress. Tob Control. 2019; 28: 574–581.
48. Thompson S, Smith J, Lee K, Thompson S. Industry sponsored harm reduction conference courts Indigenous peoples in Canada. Tob Control [Internet]. 2020 May 27 [cited 2020 September 26]; 29. Available from: https://tobaccocontrol.bmj.com/content/early/2020/05/27/tobaccocontrol-2020-055669
49. Shaik SS, Doshi D, Bandari SR, Madupu PR, Kulkarni S. Tobacco use cessation and prevention – a review. J Clin Diagn Res. 2016; 10: ZE13–ZE17.

Original Article

Grandmothers – a cultural resource for women and children's health and well-being across the life cycle

Judi Aubel

Abstract: Grandmothers exist in all societies. Especially in the non-western Majority World, where Elders are both highly respected and responsible for transmitting their knowledge to younger generations, there is extensive anecdotal evidence of Grandmothers' role in health promotion and healing. However, due to Eurocentric and reductionist views of families and communities, in the extensive past research on maternal, child and adolescent health issues across Africa, Asia, Latin America and the Middle East, and in Indigenous societies in North America, Australia and New Zealand, scant attention has been given to the role of Grandmothers. This paper addresses this oversight and supports the imperative to decolonize health promotion in the non-western world by building on non-western worldviews, roles and values. Based on an eclectic body of both published and gray literature, this review presents extensive evidence of Grandmothers' involvement across the life cycle of women and children and of the similar core roles that they play across cultures. While in some cases Grandmothers have a negative influence, in most cases their involvement and support to younger women and children is beneficial in terms of both their advisory and their caregiving roles. For future research and interventions addressing maternal, child and adolescent health, the conclusions of this review provide strong support for: adoption of a family systems framework to identify both gender-specific and generation-specific roles and influence; and the inclusion of Grandmothers in community health promotion programs dealing with different phases of the life cycle of women and children.

Keywords: family systems, grandmothers, culture, socio-cultural context, child health, maternal health, social norms, adolescent health

Introduction

Grandmothers exist in all societies. Especially in non-western cultures, where the influence of the extended family endures, Grandmothers are involved in many aspects of family life. Within family systems, they influence the health and well-being of women and children due to their social status, experience, motivation and proximity. Evolutionary anthropologists inform us that since the earliest human existence, Grandmothers have played a central role in family systems as key actors in collective childrearing (1). There is a growing body of recent literature primarily from public health (2) but also from neuroscience (3) regarding the involvement and impact of Grandmothers on the growth and development of younger generations.

Despite the increasing evidence of Grandmothers' role in the non-western world, most programs promoting the health of women, children and adolescents totally ignore the role of senior women, or *Grandmothers*. Across the non-western world, Grandmothers' role is rooted in the cultural systems of which they are a part and thus determined by the

Grandmother Project – Change through Culture, Mbour, Senegal.

Correspondence to: Judi Aubel, Executive Director, Grandmother Project – Change through Culture, Via Carlo Conti Rossini 115, Rome, 00145, Italy. Email: judiaubel@grandmotherproject.org

(This manuscript was submitted on 11 April 2023. Following blind peer review, it was accepted for publication on 6 July 2023.)

Global Health Promotion 1757-9759; Vol 31(2): 23–33; 1191494 DOI: 10.1177/17579759231191494 journals.sagepub.com/home/ghp

structure and values of those non-western societies. The structure of those societies is characterized by: gender and age specific roles; hierarchies based on gender and age; and Elders' responsibility to transmit their knowledge and practice to younger generations.

At the global level, there is a growing consensus that culture should be the foundation for development of strategies to promote health and development in all communities. This was a key theme of the 2019 World Health Promotion Conference in Rotorua, New Zealand, where there was discussion of the important distinction between the dominant Eurocentric worldview and values and those of Māori and other non-western, Indigenous cultures (4). Māori core values are similar to those of other non-western cultures, namely, the importance of intergenerational relationships, interconnectedness and strong cultural identity. Indigenous participants appealed to the international health promotion community to recognize the critical importance of Indigenous philosophy and values in development of health promotion strategies around the globe.

These concerns for the cultural grounding of health promotion efforts echo those articulated by Nigerian Airhihenbuwa (5) in his seminal book *Health and Culture: Beyond the Western Paradigm*, in which he too discussed the centrality of culture in African societies vis-à-vis all health-related issues and the need for greater understanding of non-western cultural realities, including the preeminent role of Elders. Likewise, Aubel and Chibanda (6) drew attention to the superficial consideration of culture in health promotion while Asian researchers Kumar *et al*. (7) expressed concern that many community health interventions are culturally blind. Historically, the World Health Organization has given limited attention to cultural aspects; however, a 2017 policy brief, *Culture Matters*, states that a major barrier to improving health worldwide is 'the systematic neglect of culture (8, p.xi)'.

Development of culturally-grounded health promotion strategies requires an in-depth understanding of cultural context and can be supported with the use of an assets-based approach that strengthens socio-cultural resources within families and communities. Building community capacity, a health promotion priority, requires the identification of the roles of all family and community actors, including those of Elders.

The purpose of this paper is to present evidence on the role and influence of Grandmothers across the life cycle of women, children and adolescents, based on research from Africa, Asia, Latin America, and among Indigenous peoples in Australia and North America. Before presenting this evidence, the rationale for a family systems framework for understanding the roles and influence of different family members is explained, and the contrasting features of western individualist and non-western collectivist cultures are described.

The conceptual framework: family systems

In all cultures, family systems share certain fundamental characteristics: family members are interconnected; different family members play different roles; patterns of communication and decision-making depend on age and gender; there are rules, or norms, that define acceptable and unacceptable behavior; there are cultural traditions; and there are coping strategies to deal with problems that arise.

A family systems framework is thus eminently relevant for understanding family health issues in the non-western world, but there is scant evidence of its use in global health research and practice. In the Global South, most community health research narrowly focuses on risk groups and their cognitive attributes, for example, knowledge, attitudes and practices (KAP) related, for example, to maternal, child and adolescent health (MCAH) (9). The nuclear family is an artifact of western culture and is not the most prevalent pattern of family organization in the Global South (5,6,9). The erroneous assumption of its universality and the concomitant inadequate understanding of family structures in collectivist cultures in the non-western world adds to the limited appreciation of Grandmothers' roles in families. Numerous studies on MCAH issues are not based on a family systems framework and do not examine the constellation of actors within families, inadvertently masking Grandmothers' role (9). In addition, institutional ageist and sexist biases against Grandmothers further mitigate against recognition of Grandmothers' role in family health strategies.

Characteristics of non-western, collectivist cultures

In contrast to more individualist western cultures, salient features of family systems in non-western cultures in the South include: hierarchy of authority based on age and experience; the role of Elders in teaching younger generations; gender-specific roles in different domains of family life; multi-generational families and collective child-rearing; collective decision-making on important family issues; the belief that children belong to and are the responsibility of the extended family; and social norms that are set by Elders that younger people are expected to follow (10).

In such collectivist cultures, in extended families, 'people from birth onwards are integrated into strong, cohesive in-groups which, throughout people's lifetimes, continue to protect them in exchange for unquestioning loyalty (11, p.51)'. These characteristics of collectivist cultures underpin the role of Grandmothers concerning MCAH within family systems in several ways: the experience of Grandmothers dealing with MCAH issues is recognized by other family members; Grandmothers' role is to advise and supervise younger family members related to their domains of expertise; other family members are expected to respect Grandmothers and follow their advice; Grandmothers participate in collective caring for women, children and adolescents; they participate in, or lead, decision-making related to their domains of expertise; and they are responsible for defining and enforcing social norms.

Most public health research and programs dealing with MCAH continue to reflect an epidemiological and social psychological reductionist focus on individuals in priority risk groups (12). To adequately understand the roles of different family members as a basis for targeting health promotion strategies, a holistic, or systemic, view of the family is needed. The prevailing linear and risk group focus conceals the role and influence of other categories of family members, notably that of Grandmothers.

Currently, there is widespread discussion of the influence of context on behavior and the need for a socio-ecological framework for community health research, policies and programs. However, often this rhetoric is not operationalized as a basis for understanding family and community contexts (12).

Research on Grandmothers' role across the life cycle of women, children and adolescents

This paper is an argumentative review, that is, a presentation of selected literature that refutes mainstream thinking and provides an alternative perspective about an issue, in this case, Grandmothers' role in the health of women and children. The conceptual framework for this review, presented in Figure 1, is based on my research regarding Grandmothers' role over the past 20 years. It indicates the role of Grandmothers at key stages in the life cycle: pregnancy; birth; newborns; young children; school age children; adolescence; and young married women. For this review, I conducted manual searches of literature from 1995 to 2022 in Google Scholar, ResearchGate and PubMed using the keywords: child health; Grandmothers; health-seeking; family health; MCH; and adolescent health. I identified more than 100 studies from 50 countries in Africa, Asia and Latin America and from Indigenous cultures in Australia and North America, consisting of published articles but also gray literature from international organizations. Due to space limitations, in this paper I refer to 65 of those

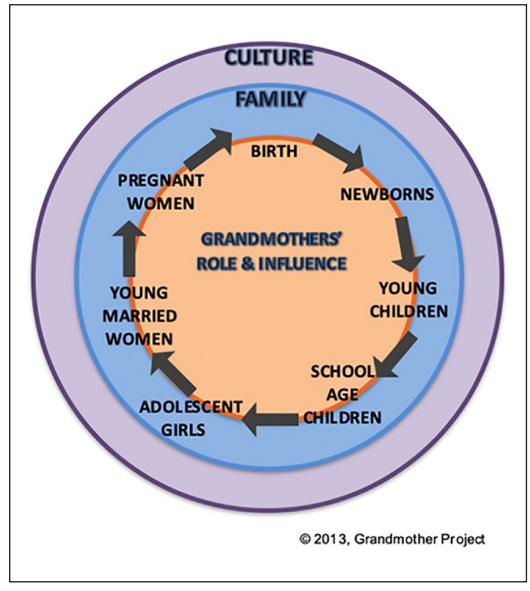

Figure 1. Grandmothers' role and influence throughout the life cycle of women and children.

studies. Based on an eclectic body of research, this review of evidence of *Grandmothers' role in non-western cultural contexts* is the first known compilation of evidence on this topic.

Findings of the review

This review reveals that across non-western cultures Grandmothers play similar *core roles* in family systems related to the health and well-being of women, children and adolescents. While their core roles are similar, there is great diversity in their culture-specific practices, for example, the involvement of Grandmothers with newborns is universal while their practices vary greatly. Examples from research in Africa and Asia illustrate the commonalities in the core roles played by Grandmothers with women and children across non-western societies.

First, in a study in a peri-urban area of the Mauritanian capital on child health, researchers concluded:

> 'Grandmothers play a multi-faceted and central role in families. Their extensive role is based first, on their vast knowledge and experience and second, on their culturally-designated status as family advisors on issues related to women and children. Young women are expected to observe their lead advisors, the Grandmothers, and to master those practices over time (13, p.7)'.

Second, researchers Karmacharya *et al*. concluded that across Southeast Asia, 'Grandmothers are considered storehouses of knowledge and wisdom on a range of household topics. Given their revered status, Grandmothers often serve as advisors and supervisors to the next generation (14, p.2115)' vis-à-vis children's health and well-being.

Further examples of Grandmothers' role and influence at different stages in the life of women and children in numerous different non-western contexts, rural and urban, are presented below.

Grandmothers' role during pregnancy

Numerous studies on pregnancy, from both rural and urban contexts, provide evidence of Grandmothers' influence, either positive or negative, on women's diet, work, rest and prenatal visits. Evidence of Grandmothers' supervisory role is reported from research in urban settings: in Africa, in Cameroon (15), Burkina Faso (16) and Ghana (17); and in Asia in Cambodia (18), Bangladesh (19) and from rural contexts in Pakistan (20,21). Based on a study in rural Mali researchers concluded, 'at the family level, the *muso koroba* (Grandmothers) are the main resource persons for all issues related to pregnancy given both their knowledge and experience within families and the advisory role assigned to them by the culture (22, p.9)'. In the Malian capital, where health services are geographically accessible, 90% of Bambara women reported that their primary advisor during pregnancy was their own mother or mother-in-law while the remaining 10% reported that it was a Grandmother neighbor (23). In peri-urban Dhaka, Pike and colleagues found that during pregnancy, married adolescents receive vital support from older female family members, especially from their mothers and mothers-in-law (19).

In rural Pakistan, researchers examined intra-household decision-making around pregnancy (20). They concluded that pregnancy is the normative domain of older women and that powerful mothers-in-law have primary responsibility for key decisions concerning prenatal care and delivery location. They also reported that in the gendered context of pregnancy, men's role is limited. Asim and colleagues (21) looked at diet during pregnancy and referred to mothers-in-law as 'the nexus of dietary control within the household (p.8)'. Research in Nepal on intra-household food allocation (24) documented the influence of authoritative mothers-in-laws on pregnant women's work and diet, and their harmful belief that young daughters-in-law should *eat less and eat last*.

In rural Ghana, Gupta *et al*. (17) documented Grandmothers' influential role with pregnant women providing emotional support, information and coaching, particularly with first-time mothers, to ensure transmission of cultural traditions, some of which are harmful.

Grandmothers' role before and after delivery

In the Global South, home deliveries are frequent, and research reveals that in many contexts, older women are present after delivery to care both for the mother and the newborn, reflecting their cultural

responsibility to usher the baby into the world. Grandmothers' involvement is also documented in studies from West Africa (25), India (26) and Aboriginal Australia (27).

In rural Ghana, Moyer *et al*. (28) found that Grandmothers are present at both home and facility deliveries and play a key role in post-delivery care, for example, bathing the newborn and mother, cord cutting and care. They found that when the advice of health workers and Grandmothers differs, new mothers feel obliged to respect authoritative Grandmothers. Kane's research in five West African countries (25) indicated that with facility deliveries, older women are often present and use their authority to execute culturally-prescribed practices concerning hygiene and breastfeeding initiation. In Karnataka, Kesterton and Cleland (26) documented a similar pattern regarding the involvement of Grandmothers after delivery, when they implement various socio-cultural traditions including potentially harmful ones, for example, administering prelacteals and delaying breastfeeding.

Lowell *et al*. (27) reported that for Aboriginal Australian communities, the presence of Elder women at the time of delivery is of momentous cultural significance. Furthermore, 'exclusion of these key senior women from the birthing process is considered to have serious consequences on the health and well-being of both mother and baby (p.5)' mainly because this limits the ability of Grandmothers to pass on critical knowledge and traditions to younger mothers.

Grandmothers' role in the care of newborns

Reflecting global concern with neonatal mortality, numerous studies have been carried out on newborn care. However, very few provide insight into the roles of family actors and most focus on individual KAP. In an earlier review of evidence regarding Grandmothers' role with newborns, Aubel (29) identified research from more than 70 non-western cultural settings that make some reference to the involvement of family members in newborn care, including the role of Grandmothers, both as advisors to young mothers and as direct caregivers. In this review, I am citing a small selection of articles and reports providing in-depth evidence of Grandmothers' role in newborn care from across the Global South: from Africa: Ghana (30) and Mauritania (31); from Asia: India (14), Uzbekistan (32) and Bangladesh (33); from Latin America: Brazil (34) and Mexico (35); and from Indigenous contexts in Australia (27) and Canada (36).

The earlier review of research concluded: 'The central role of Grandmothers in newborn care across non-western societies, emanates from the structure and core values of collectivist cultures (29, p.6)'. These include reciprocity, solidarity, hierarchy and collective responsibility for children especially among female caregivers. The predominant pattern across cultures is recognition by families of the precarity of the neonatal period, and confidence in the expertise of Grandmothers. The 2021 review (29) also noted that men are rarely directly involved in newborn care and 'more often are advisees within the family (p.5)' rather than advisors. For example, in Ghana, Gupta *et al*. (17) found that it is the husband's mother who coordinates newborn care. During the newborn period, families are concerned about ensuring newborn survival, but also about transmitting priority cultural values to young mothers. In many cultures, there is an initial period of seclusion during which Grandmothers ensure protection of mothers and newborns and inculcate priority traditions, for example, in Uzbekistan (37), Senegal (38) and Nepal (39).

Grandmothers' role in infant and young child health

Numerous studies have documented the influence of Grandmothers on breastfeeding practices, especially of primiparas. For example, in: Africa from Mauritania (31) and South Africa (40); Asia from Bihar (41), Bhutan (42) and China (43); Latin America from Mexico (44), Colombia (45) and Ecuador (46); and the Pacific from Samoa (47).

A 2016 global review of Grandmothers' role in breastfeeding found extensive evidence of universal support for the practice (48); however, they often advise introducing complementary foods and liquids before the recommended age of six months. Research in many settings, rural and urban, reveals that young mothers often depend on older, more experienced women to advise them on when and how to breastfeed. For example, a study on breastfeeding in American Samoa revealed 'the importance of family members to Samoan mothers, particularly older, female family members (47, p.84)'. In urban

Ecuador, most new mothers (84%) identified Grandmothers as their main newborn care and breastfeeding advisors, while 16% stated that their primary advisors were other older female kin or non-kin (46).

Introducing complementary foods to children at six months is recommended, and many researchers have investigated this important step. However, most studies reflect the assumption that infant feeding is the sole responsibility of mothers and focus on their KAP while very few examine the roles of other family members. Nevertheless, there is a growing body of evidence of Grandmothers' role in deciding when and what types of first foods should be given, for example: in Africa, from South Africa (40) and Rwanda (49); in Asia from Nepal (14) and China (43); and in Latin America from Colombia (50) and Mexico (44). For example, in Nairobi, Faye et al. (51) found that mothers are not solely responsible for infant feeding, that Grandmothers both participate and coach younger women, and that fathers are not involved.

While numerous studies have been conducted to investigate issues concerning child nutrition, most narrowly focus on the mother–child dyad. Concha and Jovchelovitch (45) offered a good example of a study based on a family systems framework in urban Colombia. Their findings revealed that 'Grandmothers play a central role in decision-making and in enabling a holistic support system for the [mother–child] dyad (45, p.1)'. An analysis of Demographic and Health Survey (DHS) data on child nutrition from 31 countries by Schrijner and Smits (52) provides another example of a family systems perspective. They found that co-residence of Grandmothers with young children is positively associated with reduced stunting. Earlier research in The Gambia (53) and Ethiopia (54) found that maternal Grandmothers have a positive effect on children's nutritional status and survival.

Extensive research has been conducted on major childhood illnesses; however, most studies narrowly focus on the mother–child dyad. Various studies, however, from Indonesia (55), India (56) and Ghana (57) show that Grandmothers play a key role in initial diagnosis of childhood illnesses, home treatment and decision-making regarding the need to consult either traditional or formal health care providers. In Rajasthan, Mohan *et al.* (56) examined family caregiving during childhood illnesses and concluded that Grandmothers, and other older women, have more influence on care-seeking decisions than do biological mothers.

In the field of Early Childhood Development (ECD), research on Grandmothers' role is very limited. Recent research in Pakistan (58) documented 'the beneficial roles Grandmothers have on early child cognitive, motor and socioemotional development (p.10)'. The researchers concluded that ECD research and interventions need to consider other family actors beyond the mother–child dyad.

Grandmothers' role with school age children

Few researchers have investigated Grandmothers' role with school age children. Littrell *et al.* (59) reported that in sub-Saharan Africa, 'Grandmothers have long played a role in ensuring child health and well-being (p.20)' and this appears to be true across the Global South. Schrijner and Smits' (60) analysis of DHS data from 33 sub-Saharan African countries found that co-residency of Grandmothers with children has a positive effect on their schooling through the support they provide to families and directly to children. These researchers found that all children benefit from the presence of Grandmothers, but that 'girls profit more from a co-residing Grandmother than boys (p.82)'. Research in Sierra Leone by MSD Consulting (61) concluded, 'Grandmothers are performing various crucial roles related to healthcare, education, protection and moral development of grandchildren, mainly at the household level (p.iv)'. This study found that most children have very close relationships with their Grandmothers who are their *teachers and protectors* and who 'show them more love than their biological parents (p.13)'. The study revealed frequent communication between Grandmothers and children not only during the day, but also at night as many children sleep with their Grandmothers for many years while growing up. In AIDS-prevalent areas in Africa, there has been research about the important caregiving role of Grandmothers with AIDS orphans, as reported by Littrell *et al.* (59) and others, illustrating Grandmothers' commitment to the health and development of all children.

Grandmothers' role with adolescent girls

There is extensive anecdotal information from Africa and Asia regarding Grandmothers' role in the

socialization of adolescent girls. Empirical research on this topic is scant, however. Cattell's research in South Africa revealed the role of Zulu Grandmothers in socializing girls (62) and Grandmothers' moral imperative to transmit their knowledge to younger generations, especially to granddaughters. Echoing Cattell's findings, Zimbabwean psychiatrist Chibanda (63) stated that 'within family systems in Africa, Grandmothers have primary responsibility for the socialization of girls.' Based on research in Malawi, Limaye *et al*. (64) reported that educating girls about reproductive health and sexuality has traditionally been the responsibility of Grandmothers. Similarly, based on data from six east and southern African countries, Bray and Dawes (65) found that Grandmothers and aunts play an important role in reproductive health education of adolescents. In Cameroon, anthropologist Notermans (15) also found that girls sleep with their Grandmothers for many years and that co-sleeping strengthens the physical and emotional bonds between them. She found that most adolescent girls have stronger relationships with their Grandmothers than with their mothers. Two studies in Mali by Kane (66) and Save the Children (67) found that Grandmothers have close relationships with granddaughters and that sexuality is a key topic of discussion between them. Kane concluded that communication between girls and their Grandmothers is generally more open than with their mothers.

In cultural contexts where female genital mutilation (FGM) is practiced, elder women play a central role in carrying out this traditional and harmful practice (68). Ahmadu (69) contends that the role of senior women in FGM is an expression of their power and leadership among women in the community and their commitment to passing on cultural traditions to younger women.

Grandmothers' role with young married women

Young married women need support as they assume new responsibilities in married life. In non-western collectivist cultures, their lives are affected by support from, and the expectations of, other family members. Most studies on this phase of life focus on reproductive health issues and few examine the influence of other family actors, including senior women, on the attitudes and practices of younger women. Evidence of the role and influence of older women on younger women's work and reproductive health is reported from: Asia, from Madhya Pradesh, India (70); Africa, from Senegal (71) and Ghana (72); and Latin America from Colombia (73). These studies deal mainly with the influence of mothers-in-law on daughters-in-law regarding domestic tasks, contraception, access to reproductive health services, and the attitudes of husbands towards the reproductive health needs of their wives.

Most of these studies describe the authoritative role of mothers-in-law who delegate work to young brides and who expect them to conform to their advice. This pattern is further documented in Uzbekistan (32), Mali (22) and Sierra Leone (2). In Mali, White *et al*. (74) investigated intrafamilial power relations related to women's reproductive health behavior and found that while Mali is a patriarchal society, it is mothers-in-law who have the most influence on decision-making concerning younger women's reproductive health.

Discussion

This review of research from Africa, Asia, Latin America and Indigenous cultures in Australia and North America on Grandmothers' involvement in MCAH provides extensive evidence of their prominent role in teaching, advising and caregiving in families and communities. This is the first compilation of research on the role and influence of senior women, or Grandmothers, on the health and well-being of women and children in non-western societies. The studies reviewed, from many and varied cultural contexts, both rural and urban, support the conclusion that at key stages in the lives of women and children, Grandmothers play *similar core roles* across cultures, while promoting *culture-specific practices* at each phase of the life cycle of women and children. Factors that contribute to Grandmothers' involvement and influence include: gender and generation-specific roles assigned to older women within family and cultural systems; family recognition of Grandmothers' experience caring for women and children of all ages; younger women's need for support, especially regarding child-rearing; and Grandmothers' commitment to the transmission of cultural values and practices to younger generations. The research reviewed provides clear evidence that Grandmothers are actively involved in MCAH across cultures and that in most cases their support is beneficial.

Conclusions

This review of research from across the non-western world provides extensive evidence that key family members, senior women, or *Grandmothers*, are active influencers on multiple aspects of MCAH. Most behavioral and public health researchers and practitioners continue to ignore evidence of the ubiquitous and culturally determined role of Grandmothers with younger generations, both from evolutionary anthropology (1) and from recent research in numerous contexts. Various factors contribute to the incongruity between Grandmothers' multiple roles in family life and their very limited involvement in MCAH interventions. These include: the fact that some of their practices are harmful, engendering the perception that they are an obstacle to promoting MCAH; assumptions that they are entrenched in tradition and resist change; ageist and sexist attitudes towards them; dominant Eurocentric conceptual models of health that overlook the structure and influence of the extended family prevalent in non-western collectivist societies; and third-wave feminism that focuses on younger women and girls while disregarding the role and wisdom of the older members of the sisterhood (75).

The results of this review support the growing conviction that health promotion research and interventions must be rooted in cultural context, as asserted by Cameroonian psychologist Nsamenang, 'to intervene appropriately is to ground theory, research and practice in the local cultural context (76, p.75)'. His thinking is echoed in current calls for decolonization of the dominant western values and approaches in global health. In a critique of dominant models in global health research and practice, Aubel and Chibanda (6) argued that 'conceptual models of health and illness based on Eurocentric individualist values and the nuclear family overlook numerous culturally determined facets of family systems in non-western cultures (p.3)', including the role and experience of Elders. A socio-ecological perspective also supports conceptualization of health within family, community and cultural systems. Nsamenang's work suggests some practical implications for the decolonization of community health programs. He argued that 'the starting point for all development initiatives should be to understand culturally constructed family and community systems including the cultural resources that they embody (7, p.3)'.

As the basis for program design, from a systems perspective, formative research should identify the constellation of actors within family and community systems who influence the issues addressed and who should, therefore, be targeted in interventions. Most formative research on MCAH narrowly focuses on cognitive factors, for example, KAP, of risk groups and thereby overlooks other influencers within family systems, such as Grandmothers.

Most MCAH programs have not fully recognized Grandmothers' role, nor viewed them as a strategic cultural resource for change. Several Grandmother-inclusive strategies have demonstrated Grandmothers' openness to change and have contributed to positive program results in communities, for example, in: Laos, addressing child health (77); Malawi, both on newborn care (78) and HIV-AIDS (64); Sierra Leone on child nutrition (2); Zimbabwe on mental health (79); and Senegal on MCH (80) and on child marriage and FGM (81). In all of these programs, Grandmothers countered the assumption that they are too old to learn and to modify their practices.

The impact of many health promotion efforts in the Global South has indubitably been limited by the failure to comprehensively understand, respect and build on the worldviews, roles and values inherent in specific cultural contexts. Decolonizing global health in the non-western world requires scrutinizing dominant Eurocentric health concepts and models and development of alternative, culturally-grounded frameworks. This paper contributes to decolonization efforts by illustrating and emphasizing the importance of understanding and building on the culturally-engrained roles and strategies of non-western families related to their health and well-being. Long ago, medical anthropologists Chrisman and Kleinman (82) discussed the primacy of the family arena where lay advisors play a central role in health promotion and healing. They expressed concern that public health planners focus primarily on formal health systems while neglecting the crucial influence of the family health system. Their concerns are still relevant today. This current review sheds light on a ubiquitous yet neglected category of family actors, Grandmothers, and it calls our attention, once again, to the need for greater understanding of the family health system as the basis for development of community health promotion efforts. Commitment to developing more culturally-grounded health promotion strategies in the Global South calls on researchers and planners to adopt a family systems framework (83) to increase their understanding of

family members' roles, influence and resources for promoting family health.

Declaration of conflicting interests

The author has no conflicts of interest to declare.

Funding

The author received no financial support for the research, authorship, and/or publication of this article.

ORCID iD

Judi Aubel https://orcid.org/0000-0003-2304-6100

References

1. Sear R, Coall D. How much does family matter? Cooperative breeding and the demographic transition. Pop Dev Rev. 2011; 37: 81–112.
2. MacDonald C, Aubel J, Aidam B, Webb-Girard A. Grandmothers as change agents. Curr Dev Nutr. 2020; 4: 1–9.
3. Rilling JK, Gonzalez A, Lee M. The neural correlates of grandmaternal caregiving. Proc Biol Sci. 2021; 288: 1–10.
4. Ratima M. Leadership for planetary health and sustainable development: health promotion community capacities for working with Indigenous peoples in the application of Indigenous knowledge. Glob Health Promot. 2019; 26: 3–5.
5. Airhihenbuwa CO. Health and Culture: Beyond the Western Paradigm. New York, NY: Sage; 1995.
6. Aubel J, Chibanda D. The neglect of culture in global health research and practice. BMJ Global Health. 2022; 7: e009914.
7. Kumar V, Kumar A, Ghosh AK, Samphel R, Yadav R, Yeung D, et al. Enculturating science: community-centric design of behavior change interactions for accelerating health impact. Semin Perinatol. 2015; 39: 393–415.
8. Napier AD, Ancarno C, Butler B, Calabrese J, Chater A, Chatterjee H, et al. Culture and health. Lancet. 2014; 384: 1607–1639.
9. Aubel J, Martin S, Cunningham K. Introduction: a family systems approach to promote maternal, child and adolescent nutrition. Matern Child Nutr. 2021; 17(S1): e13228.
10. Sudarkasa N. African and Afro-American family structure: a comparison. Black Scholar. 1980; 11: 37–60.
11. Hofstede G. Culture and Organizations: Software of the Mind. London: McGraw-Hill; 1991.
12. Glass TA, McAtee MJ. Behavioral science at the crossroads in public health: Extending horizons, envisioning futures. Soc Sci Med. 2006; 62: 1650–1671.
13. World Vision. Le context sociocultural de la malnutrition à Arafat, un milieu périurbain de Nouakchott, Mauritania. 2006.
14. Karmacharya C, Cunningham K, Choufani J, Kadiyala S. Grandmothers' knowledge positively influences maternal knowledge and infant and young child feeding practices. Public Health Nutr. 2017; 20: 2114–2123.
15. Notermans C. Sharing home, food and bed: paths of grandmotherhood in East Cameroon. Africa. 2004; 74: 6–26.
16. Ouoba D. Rôle et influence des grand-mères en matière de santé maternelle et infantile. Université Joseph Ki-Zerbo, Ouagadougou, 2021.
17. Gupta M, Aborigo R, Adongo P, Rominski S, Hodgson A, Engmann C, et al. Grandmothers as gatekeepers? The role of Grandmothers in influencing health-seeking for mothers and newborns in rural northern Ghana. Glob Public Health. 2015; 10: 1078–1091.
18. World Vision. Formative Study: Grandmothers as the Living God. Phnom Penh, Cambodia, 2020.
19. Pike V, Ramage AK, Bhardwaj A, Busch-Hallen J, Roche ML. Family influences on health and nutrition practices of pregnant adolescents in Bangladesh. Matern Child Nutr. 2021; 17(S1): 1–12.
20. Mumtaz Z, Salway SM. Gender, pregnancy and the uptake of antenatal care services in Pakistan. Sociol Health Illn. 2007; 29: 1–26.
21. Asim M, Ahmed ZH, Nichols AR, Rickman R, Neiterman E, Mahmood A, et al. What stops us from eating: a qualitative investigation of dietary barriers during pregnancy in Punjab, Pakistan. Public Health Nutr. 2021; 25: 760–769.
22. HKI. Une étude qualitative sur la préparation de la naissance et la santé néonatale. Bamako; 2002.
23. Diarra D. L'étude du rôle des grand-mères bambara dans la prise en charge socio-éducative des femmes et des nouveau-nés dans le milieu urbain. Bamako. INFTS; 2009.
24. Morrison J, Dulal S, Harris-Fry H, Basnet M, Sharma N, Shrestha B, et al. Formative qualitative research to develop community-based interventions addressing low birth weight in the plains of Nepal. Public Health Nutr. 2018; 21: 377–384.
25. Kane H. Soins des nouveaux-nés: les recommandations internationales face aux enjeux sociaux de la naissance. Santé Publique. 2020; 32: 17–27.
26. Kesterton AJ, Cleland J. Neonatal care in rural Karnataka: healthy and harmful practices, the potential for change. BMC Pregnancy Childbirth. 2009; 9: 20.
27. Lowell A, Kildea S, Liddle M, Cox B, Paterson B. Supporting aboriginal knowledge and practice in health care: lessons from a qualitative evaluation of the strong women, strong babies, strong culture program. BMC Pregnancy Childbirth. 2015; 15: 19.
28. Moyer CA, Aborigo RA, Logonia G, Affah G, Rominski S, Adongo PB, et al. Clean delivery practices in rural northern Ghana: a qualitative study of community and provider knowledge, attitudes, and beliefs. BMC Pregnancy Childbirth. 2012; 12: 50.

29. Aubel J. Grandmothers – a neglected family resource for saving newborn lives. BMJ Glob Health. 2021; 6: 1–9.e00380.
30. Bazzano AN, Kirkwood BR, Tawiah-Agyemang C, Owusu-Agyei S, Adongo PB. Beyond symptom recognition: care-seeking for ill newborns in rural Ghana. Trop Med Int Health. 2008; 13: 123–128.
31. Diagan MM, Kane H. Alimentation des nourrissons à Nouakchott: entre recommandations médicales et instructions des grand-mères. Santé Publique. 2016; 28: 235–343.
32. Project Hope. The role of Grandmothers and other household actors in maternal and child health. Navoi, Uzbekistan; 2003.
33. Hillenbrand E. Maternal Malnutrition and Poverty as Perceived Barriers to Exclusive Breastfeeding in Rural Bangladesh. New York, NY: Helen Keller International; 2012, pp.1–16.
34. Gross F, Pacheco IC, Oliveira NM, Beheregaray F. Influence of grandmothers on infant feeding: what they say to their daughters and granddaughters. Acta Paul Enferm. 2011; 24: 534–540.
35. Banda-Perez AJB, Alvarez-Aguirre A, Manchay RJD. Rituales para cuidar al neonato segùn la cosmovición de comunidades Nahuas. Eureka. 2021; 18: 221–237.
36. Kandasamy MV, Oremus M, Hill T, Wahi G, Wilson J, Davis A, et al. Elder women's perceptions around optimal perinatal health: a constructivist grounded-theory study with an Indigenous community in southern Ontario. CMAJ Open. 2017; 5: E411–E416.
37. Barrett JB. Doctors, clerics, healers, and neighbors: religious influences on maternal and child health in Uzbekistan. Dissertation, University of Texas, Austin, 2008.
38. Niang CI. Recherche formative sur la santé péri/néonatale a Kébémere, Senegal. Dakar: BASICS/USAID; 2003.
39. Lama TP, Khatry SK, Katz J, Le Clerq SC, Mullany LC. Illness recognition, decision-making, and care-seeking for maternal and newborn complications: a qualitative study in Sarlahi District, Nepal. J Health Popul Nutr. 2017; 36(Suppl 1): 1–14.
40. Wrottesley SV, Prioreschi A, Slemming W, Cohen E, Dennis C-L, Norris SA. Maternal perspectives on infant complementary feeding practices in Soweto, South Africa. Public Health Nutr. 2020; 24: 3602–3614.
41. Alive & Thrive. Nutrition practices in Bihar: results of a formative research study. FHI360. Washington, DC, 2017.
42. Pemo K, Phillips D, Hutchinson AM. An exploration of breastfeeding practices of Bhutanese women. J Hum Lact. 2019; 35: 181–191.
43. Yue A, Zhang N, Liu X, Tang L, Luo R, Yang M, et al. Do infant feeding practices differ between Grandmothers and mothers in Rural China? Evidence from Rural Shaanxi Province. Fam Community Health. 2018; 4: 233–243.
44. Reyes LI, Frongillo EA, Moore S, Blake CE, Gonzalez W, Bonvecchio A. Functions of social networks in maternal food choice for children in Mexico. Matern Child Nutr. 2021; 30: 1–11.
45. Concha N, Jovchelovitch S. Grandmothers: central scaffolding sources impacting maternal and infant feeding practices in Colombia. Matern Child Nutr. 2021; 17(Suppl 1): e13162.
46. Buitron F, Sandoval M. Cambios biológicos y socio culturales en el puerperio desde las experiencias de las abuelas, madres y futuras madres. Universidad del Ecuador, Quito, 2018.
47. Hawley NL, Rosen RK, Strait EA, Raffucci G, Holmdahl I, Freeman JR, et al. Mothers' attitudes and beliefs about infant feeding highlight barriers to exclusive breastfeeding in American Samoa. Women Birth. 2015; 28: e80–e86.
48. Negin J, Coffman J, Vizintin P, Raynes-Greenow C. The influence of Grandmothers on breastfeeding rates: a systematic review. BMC Pregnancy Childbirth. 2016; 16: 1–11.
49. Ahishakiye J, Bouwman L, Brouwer ID, Matskio E, Armar-Klemesu M, Koelen M. Challenges and responses to infant and young child feeding in rural Rwanda: a qualitative study. J Health Popul Nutr. 2019; 38: 1–10.
50. Olaya & Fonseca. Relación entre el inicio temprano de la alimentación complementaria y la incidencia de diarrea y/o estreñimiento en niños menores de 4 meses. Lecturas Sobre Nutrición. 2004; 11: 72–84.
51. Faye CM, Fonn S, Kimani-Murage E. Family influences on child nutritional outcomes in Nairobi's informal settlements. Child Care Health Dev. 2019; 45: 509–517.
52. Schrijner S, Smits J. Grandparents and children's stunting in sub-Saharan Africa. Soc Sci Med. 2018; 205: 90–98.
53. Sear R, Mace R, McGregor IA. Maternal grandmothers improve nutritional status and survival of children in rural Gambia. Proc Biol Sci. 2000; 267: 1641–1647.
54. Gibson MA, Mace R. Helpful grandmothers in rural Ethiopia: a study of the effect of kin on child survival and growth. Evol Hum Behav. 2005; 26: 469–482.
55. Gryboski KL. Household management of infant health: Java, Indonesia. Dissertation, Boston University, 1995.
56. Mohan P, Iyengar SD, Agarwal K, Martines JC, Sen K. Care-seeking practices in rural Rajasthan: barriers and facilitating factors. J Perinatol. 2008; 28: S31–S37.
57. McGadney-Douglass BF, Douglass R, Apt NA, Antwi P. Ghanaian mothers helping adult daughters: the survival of malnourished grandchildren. J Assoc Res Mothering. 2008; 7: 112–124.
58. Chung EO, Hagaman A, LeMasters K, Andrabi N, Baranov V, Bates LM, et al. The contribution of Grandmother involvement to child growth and development: an observational study in rural Pakistan. BMJ Glob Health. 2020; 5: e002181.
59. Littrell M, Murphy L, Kumwenda M, Macintyre K. Gogo care and protection of vulnerable children in rural Malawi: changing responsibilities, capacity to provide, and implications for well-being in the era of HIV and AIDS. J Cross Cult Gerontol. 2012; 27: 335–355.

60. Schrijner S, Smits J. Grandmothers and children's schooling in Sub-Saharan Africa. Hum Nat. 2018; 29: 65–89.
61. MSD Consulting. Assessment of the role and influence of Grandmothers on children's lives. Freetown, Sierra Leone. 2018.
62. Cattell MG. Zulu grandmothers' socialization of granddaughters. S Afr J Gerontol. 1997; 6: 14–16.
63. Chibanda D. Personal Communication, 23 October 2019, Toronto, Canada.
64. Limaye RJ, Rimal RN, Mkandawire G, Kamath V. Tapping into traditional norms for preventing HIV and unintended pregnancy: harnessing the influence of grandmothers (Agogos) in Malawi. Int Q Community Health Educ. 2015; 36: 53–70.
65. Bray R, Dawes A. Parenting, family care and adolescence in East and Southern Africa; an evidence-focused literature review. Innocenti Discussion Paper. UNICEF Office of Research, Innocenti, Florence, 2016.
66. Kane F. La communication en matière de santé sexuelle et reproductive des adolescentes de 10 à 19 ans à Kangaba. Ecole Nationale des Travailleurs Sociaux. Bamako, Mali, 1998.
67. Save the Children. Recherche formative de l'approche grand-mère. Bamako, Mali, 2018.
68. Shell-Duncan B, Moreau A, Wander K, Smith S. The role of older women in contesting norms associated with female genital mutilation/cutting in Senegambia: a factorial focus group analysis. PLoS One. 2018; 13: e0199217.
69. Ahmadu S. Cutting the Anthill: the symbolic foundations of female and male circumcision rituals among the Mandinka of Brikama, The Gambia. PhD thesis, Anthropology Department, LSE, London, 2005.
70. Char A, Saavala M, Kulmala T. Influence of mothers-in-law on young couples' family planning decisions in rural India. Reprod Health Matters. 2010; 18: 154–162.
71. Babalola S, Gueye A. Etude qualitative sur les comportements liés à la SMNI/SR. NNEMA/USAID, Dakar, Senegal, 2017.
72. Yakong VN. Rural Ghanaian women's experiences of seeking reproductive health care. Thesis. College of Graduate Studies, University of British Columbia, Okanagan, 2008.
73. Martinez TY, Garzon LP, Calvo CF. Salud reproductiva femenina en el sur de la Amazonia colombiana. Anthropologica. 2019; 43: 203–226.
74. White D, Dynes M, Rubardt M, Sissoko K, Stephenson R. The influence of intrafamilial power on maternal health care in Mali: perspectives of women, men and mothers-in-law. Int Perspect Sex Reprod Health. 2013; 39: 58–68.
75. Lipman V. The invisibility of older women in international development. In: Bamford S-M, Watson K (eds). Has the Sisterhood Forgotten Older Women? London: ILC; 2013, pp.111–114.
76. Nsamenang AB. Culture and human development. Int J Psychol. 2008; 43: 73–77.
77. Aubel J, Sihalathavong D. Participatory communication to strengthen the role of grandmothers in child health. J Int Commun. 2001; 7: 76–97.
78. Aubel J. Custodians of tradition promote positive changes for the health of newborns. SCF, Malawi, 2006.
79. Chibanda D, Weiss HA, Verhey R, Simms V, Munjoma R, Rusakaniko S, et al. Effect of a primary care–based psychological intervention on symptoms of common mental disorders in Zimbabwe. JAMA. 2016; 316: 2618–2626.
80. Aubel J, Toure I, Diagne M. Senegalese grandmothers promote improved maternal and child nutrition practices: the guardians of tradition are not averse to change. Soc Sci Med. 2004; 59: 945–959.
81. Institute for Reproductive Health. Grandmothers project - Change through culture: program for girls' holistic development: qualitative research report. Institute for Reproductive Health, Georgetown University, Washington, DC, 2019.
82. Chrisman NJ, Kleinman A. Popular health care, social networks and cultural meanings: the orientation of medical anthropology. In: Mechanic D (ed.). Handbook of Health, Health Care & Health Professions. New York, NY: Free Press; 1983, pp.569–590.
83. Denham S. Family Health: A Framework for Nursing. Philadelphia, PA: Davis Publishers; 2003.

Original Article

Defining health through a critical materialist political economy lens

Stella Medvedyuk[1] and Dennis Raphael[2]

Abstract: It has been recognized since antiquity that the organization of society and how it distributes resources are the primary determinants of health. Yet most definitions of health in the academic and practice literatures limit their focus to the individual's experience of health and functional abilities, neglecting the structures and processes of societies in which the individual is embedded. We draw upon developments in the critical health communication and critical materialist political economy of health literatures to provide a definition of health that directs attention to the role that economic and political systems play in either equitably or inequitably distributing the resources necessary for health. Since these distributions interact with the individual's unique biological and psychological dispositions and situations to produce health, it is important to identify their sources and means of making their distributions more equitable. Because it is through communication that humans interpret society, themselves, and others, a concise definition of health that draws attention to these societal features and their roles on a day-to-day basis in promoting or threatening health is essential.

Keywords: health definition, political economy, critical health communication, critical analysis

Introduction

In 1948, the World Health Organization (WHO) provided its iconic definition of health which continues to influence contemporary discourses in health (1). Its definition, like most others, is focused on the individual rather than the environment in which the individual is embedded. This was not completely inappropriate considering the attention paid to promoting well-being during the immediate post-World War II era. However, much has changed since the 'Golden Age of Capitalism' which provided many of the resources necessary for health (2). It seemed to us that in the current era of unbridled capitalism, global acceptance of neo-liberal approaches to governance, and imposition of austerity, a definition of health that incorporates contemporary political and economic trends was in order. In this article we provide such a definition within a critical materialist political economy perspective with the purpose of spurring recognition of these forces and the threats they pose to health (3). Such effort is important since, as pointed out by Leonardi (4):

> The definition of health is not just a theoretical issue, because it has many implications for practice, policy, health services, and health promotion. The definition of health affects health professionals, and in turn they strongly affect how health is socially constructed in modern societies. The social representations of health influence the demands and expectations of health, the health care systems, the policy makers, and many other key aspects of health (p.736).

1. Graduate Program in Health Policy and Equity, York University, Toronto, Canada.
2. School of Health Policy and Management, York University, Toronto, Canada.

Correspondence to: Stella Medvedyuk, Graduate Program in Health Policy and Equity, York University, 4700 Keele St., Toronto, ON M3J 1P3, Canada. Email: stellam2@yorku.ca

(This manuscript was submitted on 26 February 2023. Following blind peer review, it was accepted for publication on 27 July 2023.)

Global Health Promotion 1757-9759; Vol 31(2): 34–42; 1194600 DOI: 10.1177/17579759231194600 journals.sagepub.com/home/ghp

The most widely used definitions of health focus on the individual and their subjective sense of health and functional abilities. We draw upon a critical health communication approach that recognizes that since language shapes our understandings of health and means of promoting it, a definition of health that moves beyond the individualistic approaches that dominate health care, health promotion, and health messaging towards one that makes explicit how societal structures and processes shape health is necessary.

To do so, we apply a critical materialist political economy analysis of health that directs attention to the economic and political structures that shape health. Conveying this concept within a definition of health will stimulate recognition and understanding of the forces that shape 'society, nature, themselves, and each other' (5, p.85). Ultimately, we aim to contribute to 'an emancipatory politics that seeks structural transformation' in the service of health (6, p.1).

Critical materialist political economy

A critical materialist political economy analysis of health considers health to be an outcome of economic and political systems as well as societal structures and processes (7), and is explicitly concerned with the imbalances of influence and power amongst societal sectors that shape these forces (8). The mediating mechanism between these structures, processes, and forces is the quality and distribution of social determinants of health such as income, employment security, working conditions, food and housing security, and health and social services (9).

In addition to their material effects upon health, these structures, processes, and forces also shape the ideas a society holds about health and the means of promoting it (9). More specifically, a critical materialist analysis identifies how the power and influence of specific societal sectors – usually the corporate and business sector – create public policies that lead many to lack the economic, political, and social resources necessary for health. Through a definition of health that considers these issues, new ways of thinking about health and the means of promoting it can be communicated.

Critical health communication

Health communication theory and research is dominated by traditional approaches that do little to question existing structures of domination and influence (10). Critical health communication theory aims to rectify this.

Lupton (11, p.57) considers the role culture plays in health communication with culture including 'ideas, beliefs, language, institutions, and structures of power' such that 'health, illness, and disease may be considered products of cultural practices.' For Lupton (11), then, the critical health communication approach sees health as a product of social systems and ideological processes (p.58), a point more recently made by Ellingson (12, p.2): 'Body-selves are constituted both through relationships within others – interpersonally, organizationally, in communities – and within larger social and political structures.'

Critical health communication studies 'focus on how communication constructs ideology, taken for granted assumptions about reality that structure social decision making and everyday life in ways that systematically reinforce the interest of dominant groups' (13, p.351). Zoller and Kline (14, p.119) argue that critical health communication research 'addresses issues of health meanings', 'articulates... linkages among communication and politics, policy and social power; deconstructs taken-for-granted assumptions about health and illness and conceptualizing alternatives; and describes direct implications for practice.'

Dutta (15) concurs, stating critical health communication scholarship seeks to uncover 'the structures within which meanings of health are constituted' (p.534), urging scholars to be critical of power, structures, processes, and practices that create and disseminate knowledge.

The WHO definition of health

The WHO's definition of health was first articulated in 1948 (1): 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.' This definition helped broaden understanding of health and its determinants, opening the concept to a wider

community where previously it had been the sole domain of the healthcare system and its professionals.

The core criticisms of the WHO's definition as 'difficult to measure and impossible to achieve' is presented by Blaxter (16, p.2). The WHO definition is a product of its times, situated within the immediate post-World War II period where Keynesian reforms were dominant, market forces were subject to state management, and the modern welfare state established. The post-war period was also characterized by a demand for globally recognized human rights including the right to health (17).

Indeed, Nobile (18) argues that during the era of the WHO definition, global peace and health were inseparable, with recognition that health was related to economic and political conditions and an apparent willingness on the part of governments to act on these understandings to promote the health of populations. While the WHO's definition of health has been contested, most of the new definitions do not take account of changing political and economic conditions.

Methods

We used Google Scholar™ to identify existing definitions of health in the academic literature from 1948 – the year of the WHO definition – to the present by searching the terms 'definitions of health,' 'defining health,' and 'health definitions.' Martín-Martín *et al*. (19) show that Google Scholar™ yields significantly more citations than Scopus™, WoS Core Collection™, and Web of Science™ in the coverage of academic literature in humanities and social sciences. We did the same search using Google™ to identify definitions created by agencies and organizations.

We reviewed these definitions to determine their foci and the extent to which they were concerned with the individual versus broader societal factors that shape health. Of particular interest was their consideration of how economic and political systems and structures and processes of society and the power and influence of specific sectors such as the corporate and business sector shape the quality and distribution of a variety of social determinants of health.

Findings indicated the need for a definition of health that considered how economic and political systems and the power imbalances inherent in them create the living and working conditions that determine health. The following sections provide details on how we did so.

Findings

Additional definitions – individualistic approach to health

We found numerous definitions of health in the academic and practice literature. Most focus on the individual and set parameters around the meaning of health as experienced by an individual. Many of these – like the WHO definition – continue to have the individual as their focus (see examples in Table 1 (1,4,20–26)).

Most definitions focused on the individual (25,26) with what Kelman (27) identified as experiential and functional components. Kelman (27) defines experiential health as 'freedom from illness, the capacity for human development and self-discovery, and the transcendence of alienating social circumstances' (p.7) and uses Parson's definition for functional health: 'State of optimum capacity of an individual for the effective performance of the roles and tasks for which he has been socialized' (27, p.14). The functional approach is open to the critique that health can be primarily defined as being able to contribute to existing modes of production in capitalist society.

A *Lancet* editorial (28) enthusiastically endorses Canguilhem's (20) definition of health as the ability to adapt to environmental demands and while emphasizing important aspects of personal agency is also somewhat limited: 'It puts the individual patient, not the doctor, in a position of self-determining authority to define his or her health needs.' It is limited in that it removes from explicit attention the structures and processes of society and consideration that the individual may have mistaken understandings of these structures and processes that impede their health.

The decoupling of health from the presence or absence of disease in many of these definitions has certainly advanced understanding of the experience of chronic illness and disability and removed medical stigma from those experiencing these states. Yet, the continuing focus on the individual in these definitions, rather than the political and economic systems in which individuals are embedded, does not direct attention towards the structures and processes of

Table 1. Examples of health definitions that focus on the individual.

Canguilhem (20)	Man feels in good health – which is health itself – only when he feels more than normal – that is, adapted to the environment and its demands – but normative, capable of following new norms of life.
WHO (1)	Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
Schulkin (21)	Health is dynamic adaptation to stressors akin to resilience.
Sartorius (22)	Health is a state of balance whereby individuals with disease or impairment are considered healthy by their ability to establish an internal equilibrium that allows them to get the most they can from their life despite the presence of disease or infirmity.
Huber *et al*. (23)	Health is dynamic based on one's ability to adapt and to self-manage to maintain and restore one's sense of integrity, equilibrium and sense of wellbeing.
Card (24)	Health is the experience of physical and psychological well-being. Good health and poor health do not occur as a dichotomy, but as a continuum.
Leonardi (4)	Health is the capability to cope with and to manage one's own malaise and well-being conditions.
McCartney *et al*. (25)	A structural, functional, and emotional state that is compatible with effective life as an individual and as a member of society.
Krahn *et al*. (26)	Health is the dynamic balance of physical, mental, social, and existential well-being in adapting to conditions of life and the environment.

Table 2. Examples of definitions of health moving beyond the individual.

WHO (29)	Health is a positive concept emphasizing social and personal resources, as well as physical capacities.
Shilton *et al*. (30)	Health is created when individuals, families, and communities are afforded the income, education and power to control their lives, and their needs and rights are supported by systems, environments and policies that are enabling and conducive to better health.
Scott-Samuel (31)	Health is a condition in which people achieve control over their lives because of the equitable distribution of power and resources. Health is thus a collective value; my health cannot be at the expense of others nor through the excessive use of natural resources.
Bircher and Kuruvilla (32)	Health is a state of well-being emergent from conducive interactions between individuals' potentials, life's demands, and social and environmental determinants.

society that determine health. The following section provides examples of attempts to do so.

Additional definitions – moving beyond the individual

Table 2 (29–32) provides some exemplars of definitions moving beyond the individual and most do so by mentioning various social determinants of health. In 1986, the *Ottawa Charter for Health Promotion* (29) brought social resources into its definition of health and identified important pre-requisites of health, peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity. These features are now commonly referred to as social determinants of health; factors incorporated into Shilton and colleagues' (30) definition of health.

Scott-Samuel (31) employed aspects of a critical materialist analysis to chide Shilton *et al*. (30) for

neglecting the role neo-liberal capitalism plays in threatening health: 'They also fail to point out that the inequity which as they say, rations global access to health, is a systematic product of the neoliberal capitalism which so dominates global public policies and international relations.'

More recently, Bircher and Kuruvilla (32) made the role of social and environmental factors more explicit, but even then, their definition does not draw attention to the structures and processes of economic and political systems that shape the living conditions they identify such as housing, food security, income, working conditions such as employment security, wages and benefits, work demands and control; and other supports and services like health care, social services, and universal benefits.

The contribution of civil society and non-governmental organizations

We also found a variety of discussions that make explicit some of the economic and political forces that shape health, although none of these examinations provide a precise definition of health that could serve the purpose of shifting day-to-day discourse around health and the forces that shape it. The People's Health Movement's (33) People's Charter for Health states:

> Health is a social, economic and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill-health and the deaths of poor and marginalised people. Health for all means that powerful interests have to be challenged, that globalisation has to be opposed, and that political and economic priorities have to be drastically changed (p.2).

UBC Health's (34) definition is also helpful: 'Health is an attribute of individuals, communities, and societies and is a fundamental resource for daily living.' The Lincy Institute (35) states: 'A person's health is a product of their environment. As such, a healthy community is one in which all residents have access to a quality education, safe and healthy homes, adequate employment, transportation, physical activity, and nutrition, in addition to quality health care.' However, neither the People's Health Movement nor the other agencies provide a concise definition of health that considers the role played by economic and political structures in determining the quality and distribution of these resources.

A critical materialist political economy analysis

From a critical materialist political economy perspective, the primary issue with individually focused definitions of health is their lack of recognition of how economic, political, and social forces enable or threaten health. Second, these definitions usually assume that the state or the government – can and will – take some responsibility for the health of its people through public policy action. Increasingly, this is not the case (9).

We offer a definition that makes explicit that health is dependent on four interconnected and interdependent conditions: economic, political, social, and individual. We employ a critical realist analysis to identify what has been termed the real, actual, and empirical levels of reality (36). Such an analysis allows for consideration of what is possible in addition to what currently exists.

In our analysis, the *real* involves an explication of the societal structures and powers of the economic and political systems that have the capacity to promote or threaten health. This focuses attention on the means of production and distribution in a society and how the political system facilitates or inhibits these processes. The *actual* in our present effort are the forces that activate these structures and processes. What are the means by which some jurisdictions act to support health through the equitable and health promoting provision of economic, political, and social resources while others do not? Finally, the *empirical* is the world of experience or the observable with regard to the provision of the resources necessary for health. These involve the distribution of what have been termed the social determinants of health as well as the experience of health itself.

Economic conditions

Any analysis of economic conditions can begin either with examination of the structures and processes of the economic system, the forces that activate or inhibit these structures and processes, or their manifestations in concrete lived experience (3). Most nations produce and distribute economic resources under the aegis of capitalism (the real) and analyses of their structures and processes are abundant. In some forms, the capitalist system is managed (the actual) such that arguably almost all have access to the resources necessary for health. The forces leading to the actual are working class power, extent of unionization and collective agreement coverage, and dominant political parties, usually influenced by the presence of proportional representation in the electoral process (37).

The empirical are the working conditions and work environments that either promote or threaten health. These can include gender pay equity, protection against child labor and exploitation of young workers, protection against racism in the workplace, access to parental leave compensation, access to wage compensation in the case of loss of or change in ability (for oneself or of dependents), and compensation for caregiving supports, among others.

Political conditions

The structures and processes of the political system constitute the real level, with how these come to shape the distribution of power through the enactment of laws and regulations constituting the actual (38). The extent of political expression, participation, and influence among those of differing social locations represents the empirical.

At the level of the real, the political system can enact proportionate representation in the electoral process, regulate the market through enactment of laws and regulations governing wages, benefits, and working conditions, implement taxation to provide support programs and decommodified services such as health and social care, child benefits, unemployment benefits, pensions, active labor policy, affordable and quality housing, agricultural, food pricing, water and sanitation regulations, and access to affordable education, among many others (39).

The extent to which they actually occur represents the empirical level and is activated at the actual level by many of the same forces working on the economic system: governing parties, working class power, unionization and collective agreement coverage.

Social conditions

Social conditions include the ability to build social and community networks to foster social engagement and participation, as well as the avoidance of racism, sexism, ableism, and ageism, and an environment open to debate and free expression (3). The development of human potential, however defined, can also be included. These manifest as a result of the organization of the economic and political systems and the manner in which they produce and distribute resources as described above.

Individual factors

While individual factors interact with political, economic, and social conditions, there is no denying that there are distinct biological characteristics such as inherited genetic conditions and gene mutations, stages of the life course, psychological dispositions such as resilience and coping strategies, and life events (40). While certainly important to the individual, the overall contribution of the individual factors of genetic and psychological characteristics to population health are rather limited since the main killers – cancers, cardiovascular, and respiratory diseases – are related to environments rather than the effects of unfolding genetic dispositions and psychological characteristics which themselves are shaped by environmental circumstances (41,42).

Our definition of health

Based on these considerations, we offer a definition of health which incorporates Kelman's (27) concepts of experiential and functional health and the critical materialist political economy analysis of how economic and political systems distribute the resources necessary for health:

> Health – as experienced by the individual (experiential) and their ability to carry out life's activities (functional) – is a product of the interaction of economic and political systems' equitable or inequitable distribution of financial

resources, political power, and social supports with the individual's unique biological and psychological dispositions and situations.

Discussion

Most definitions of health direct attention to the individual's experiential and functional health rather than the political, economic, and social conditions that shape it. As a result, inquiry into the public policies and the economic and political forces that shape how these policies distribute the social determinants of health is frequently neglected. An explicit examination of how economic and political systems shape health is even less common. We believe our definition of health addresses this neglect and will direct attention to these and additional issues discussed below.

Making the economic and political determinants of health visible

Bates *et al*. (43) argue that individualized and decontextualized definitions of health are 'removed from the social, economic, and environmental contexts in which that individual resides' (p.2). This removal advantages dominant regimes and reproduces existing systems that threaten health. We want to force health providers, health promoters, and policymakers on a day-to-day basis to face the question: How do existing societal structures and processes – both economic and political – shape health?

There is growing interest in how the capitalist economic system threatens health with its generating economic crises, declining quality and equitable distribution of the social determinants of health, and a climate crisis moving Earth towards a climate catastrophe (44,45). Our definition of health makes these broader issues difficult to ignore.

Health, functional health, and capitalism

The concern with the health effects of capitalism is not new. Fifty years ago, Kelman (27) argued that in capitalist society, where capital accumulation is the primary goal of economic and political organization, there is an inherent contradiction between functional health – the ability of the individual to contribute to the capitalist accumulation process primarily through labor – and experiential health – avoiding objectification of the self, alienation from self, others, and society, and the experience of illness. This contradiction comes about because of the constant imperative of business and industry to increase profits set into motion by two prominent processes: the expansion of markets and the reduction of costs. Indeed, Das (46) details how the processes inherent to capitalism create health threatening living and working conditions.

Consistent with our analysis, Kelman (27) pointed out how concern with individualized functional and experiential health in the absence of attempts to transform the economic and political systems causing these health problems led to an array of biomedical and psychological interventions to remedy health problems. The continuing emphasis upon biomedical and behavioral approaches to health illustrates how Kelman's observations of 50 years ago of health as defined under capitalism remain germane today (47).

Gaining the attention of clinicians, health promoters, researchers, and policymakers

We believe therefore that our definition of health will spur health promoters, researchers, and policymakers in their day-to-day work to move beyond focus on the individual and consider the social determinants of health and how economic and political systems produce and distribute them within their society. There have been many calls for this to occur; our new definition of health makes this an ongoing imperative. Experiential and functional health continue to be important, but these are now explicitly placed within their societal context.

Bircher and Kuruvilla (32) provide suggestions on how many of the concepts in our definition can be applied at the individual and population levels. Clinicians can assess the present state of patients' current exposures to various social determinants of health and identify resources that can provide assistance. They suggest 'Governments could use the Model to think through how best to provide adequate health and social interventions, and the related legal rights and entitlements' (p.382).

From our perspective our definition can help identify how economic and political systems and other societal structures and processes shape the

quality and distribution of numerous social determinants of health. Especially important would be consideration of how the power and influence of specific societal sectors such as the corporate and business sector threaten the quality and make equitable distribution of various social determinants of health difficult.

Environmental conditions

We do not place environmental conditions – including the climate crisis – in our definition, to not over complicate an already complex definition. Yet these conditions and overall planetary health are important determinants of health and are closely related to the economic and political systems we describe above. Although environmental conditions have a significant impact on health, in this article we focus on economic and political structures and processes yet do not deny that environmental issues provide a strong background context to our definition of health.

Conclusion

Definitions of health direct attention to what is important for promoting health through research, public policy, and health care services. We offer a definition of health that makes these usually invisible forces – especially how the economic and political systems distribute resources to either promote or threaten health – visible on an ongoing basis and therefore provide targets for action. These targets will include clinical activities on a day-to-day basis to meet the needs of patients, develop research agendas to illuminate the societal structures and processes that either promote or threaten health, and public policy advocacy to improve the quality and distribution of the social determinants of health. Our definition of health may also help build social and political movements to transform health threatening economic and political systems (48).

Declaration of conflicting interests

The authors have no conflicts of interest to declare.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

ORCID iDs

Stella Medvedyuk https://orcid.org/0000-0002-8810-4757
Dennis Raphael https://orcid.org/0000-0002-0724-3174

References

1. World Health Organization. Bulletin of the World Health Organization: Supplement. Geneva: WHO; 1948.
2. Teeple G. Globalization and the Decline of Social Reform: Into the Twenty-First Century. Aurora, Ontario: Garamond Press; 2000.
3. Nutbeam D, Muscat DM. Health promotion glossary 2021. Health Promot Int. 2021; 36: 1578–1598.
4. Leonardi F. The definition of health: towards new perspectives. Int J Health Serv. 2018; 48: 735–748.
5. Fuchs C. Communication and Capitalism: A Critical Theory. Westminster: University of Westminster Press; 2020.
6. Dutta M, Pandi AR, Zapata D, Mahtani R, Falnikar A, Tan N, et al. Critical health communication method as embodied practice of resistance: culturally centering structural transformation through struggle for voice. Front Commun. 2019; 4: 67.
7. Bryant T. Health Policy in Canada. Toronto: Canadian Scholars; 2016.
8. Bryant T. Implications of public policy change models for addressing income-related health inequalities. Can Public Policy. 2015; 41(Suppl 2): S10–S16.
9. Coburn D. Health and health care: a political economy perspective. In: Bryant T, Raphael D, Rioux M (eds). Staying Alive: Critical Perspectives on Health, Illness, and Health Care. 2nd ed. Toronto: Canadian Scholars' Press; 2010, pp.65–92.
10. Dutta-Bergman MJ. Theory and practice in health communication campaigns: a critical interrogation. Health Commun. 2005; 18: 103–122.
11. Lupton D. Toward the development of critical health communication praxis. Health Commun. 1994; 6: 55–67.
12. Ellingson LL. Embodied methods in critical health communication. Front Commun. 2019; 4: 73.
13. Zoller HM. Health activism: communication theory and action for social change. Commun Theory. 2005; 15: 341–364.
14. Zoller HM, Kline KN. Theoretical contributions of interpretive and critical research in health communication. Ann Int Commun Assoc. 2008; 32: 89–135.
15. Dutta MJ. The critical cultural turn in health communication: reflexivity, solidarity, and praxis. Health Commun. 2010; 25: 534–539.
16. Blaxter M. Health. New York, NY: John Wiley; 2010.
17. Teeple G. The Riddle of Human Rights. Toronto: University of Toronto Press; 2005.
18. Nobile M. The WHO definition of health: a critical reading. Med Law. 2014; 33: 33.

19. Martín-Martín A, Orduna-Malea E, Thelwall M, López-Cózar ED. Google Scholar, Web of Science, and Scopus: a systematic comparison of citations in 252 subject categories. J Informetr. 2018; 12: 1160–1177.
20. Canguilhem G. On the Normal and the Pathological. New York, NY: Springer Science & Business Media; 2012.
21. Schulkin J (ed.). Allostasis, Homeostasis, and the Costs of Physiological Adaptation. Cambridge: Cambridge University Press; 2004.
22. Sartorius N. The meanings of health and its promotion. Croat Med J. 2006; 47: 662.
23. Huber M, Knottnerus JA, Green L, Van Der Horst H, Jadad AR, Kromhout D, et al. How should we define health? BMJ. 2011; 343: d4163.
24. Card AJ. Moving beyond the WHO definition of health: a new perspective for an aging world and the emerging era of value-based care. World Med Health Policy. 2017; 9: 127–137.
25. McCartney G, Popham F, McMaster R, Cumbers A. Defining health and health inequalities. Public Health. 2019; 172: 22–30.
26. Krahn GL, Robinson A, Murray AJ, Havercamp SM, Havercamp S, Andridge R, et al. It's time to reconsider how we define health: perspective from disability and chronic condition. Disabil Health J. 2021; 14: 101129.
27. Kelman S. The social nature of the definition of health. In: Navarro V (ed.). Health and Medical Care in the U.S. New York, NY: Routledge; 2019, pp.3–20.
28. The Lancet. What is health? The ability to adapt. Lancet. 2009; 373: 781.
29. World Health Organization. Ottawa charter for health promotion. First International Conference on Health Promotion, Ottawa, Canada, 17–21 November 1986.
30. Shilton T, Sparks M, McQueen D, Lamarre MC, Jackson S; Executive committee of the International Union for Health Promotion and Education-IUHPE. Proposal for new definition of health. BMJ. 2011; 343: d5359.
31. Scott-Samuel A. Rapid response to How should we define health? BMJ. 2011; 343: d4163.
32. Bircher J, Kuruvilla S. Defining health by addressing individual, social, and environmental determinants: new opportunities for health care and public health. J Public Health Policy. 2014; 35: 363–386.
33. People's Health Movement. People's Charter for Health [Internet]. 2000 [cited 2023 August 25]. Available from: https://phmovement.org/wp-content/uploads/2018/06/phm-pch-english.pdf
34. UBC Health. Definition of health [Internet]. Vancouver; 2023 [cited 2023 August 25]. Available from: https://health.ubc.ca/what-ubc-health/definition-health
35. Lincy Institute at UNLV. What is a healthy community? Las Vegas; 2012 [cited 2023 August 25]. Available from: https://www.unlv.edu/sites/default/files/24/Health-Community-January2012.pdf
36. Sayer A. Realism and Social Science. London: Sage; 2000.
37. Esping-Andersen G. The Three Worlds of Welfare Capitalism. Princeton, NJ: Princeton University Press; 1990.
38. Kickbusch I, Clavier C, De Leeuw E (eds). Foreword: We need to build a health political science. In: Health Promotion and the Policy Process. Oxford: Oxford University Press; 2013, pp.iii–iiv.
39. Raphael D (ed.). An analysis of international experiences in tackling health inequalities. In: Raphael D (ed.). Tackling Health Inequalities: Lessons from International Experiences. Toronto: Canadian Scholars' Press; 2012, pp.229–263.
40. Whitehead M, Pennington A, Orton L, Nayak S, Petticrew M, Sowden A, et al. How could differences in 'control over destiny' lead to socio-economic inequalities in health? A synthesis of theories and pathways in the living environment. Health Place. 2016; 39: 51–61.
41. Davey-Smith GD, Ebrahim S, Lewis S, Hansell AL, Palmer LJ, Burton PR. Genetic epidemiology and public health: hope, hype, and future prospects. Lancet. 2005; 366: 1484–1498.
42. Nettleton S. Surveillance, health promotion and the formation of a risk identity. In: Sidell M, Jones L, Katz J, Peberdy A (eds). Debates and Dilemmas in Promoting Health. Birmingham: Open University Press; 1997, pp.312–324.
43. Bates BR, Marvel DL, Nieto-Sanchez C, Grijalva MJ. Painting a community-based definition of health: a culture-centered approach to listening to rural voice in Chaquizhca, Ecuador. Front Commun. 2019; 4: 37.
44. Raphael D, Bryant T. Socialism as the way forward: updating a discourse analysis of the social determinants of health. Crit Public Health. 2023; 33: 387–394.
45. Flanagan E, Raphael D. From personal responsibility to an eco-socialist state: political economy, popular discourses and the climate crisis. Hum Geogr. 2022: 19427786221138965.
46. Das RJ. Capital, capitalism and health. Crit Sociol. 2023; 49: 395–414.
47. Popay J, Whitehead M, Hunter DJ. Injustice is killing people on a large scale—but what is to be done about it? J Public Health. 2010; 32: 148–149.
48. Baum F. How can health promotion contribute to pulling humans back from the brink of disaster? Glob Health Promot. 2021; 28: 64–72.

Original Article

The specter of race in global Covid-19 responses: the future is decolonial

Madalitso Z. Phiri

Abstract: The Covid-19 pandemic reified pre-existing inequalities predicated on anti-Black racism, imperial geographical cartography, and the violent language of biomilitarism. In this reflective essay I deploy tools of historical sociology to underscore the importance of race, racism, racialization, and global responses to pandemics. I considerer the following questions. First, how can world society develop ideas and concepts for the imagination of a post-imperial global health regime? Second, can alternative futures be imagined if the monopolistic control of power, global scientific processes and knowledge regime is framed around a problematic lexicography of a Eurocentric totalizing project of being human? Lastly, if there is a scientific consensus that we need alternative futures, what kinds of knowledge is needed to bring about a post-imperial liberated order? The future of global health regime is a decolonial one predicated on a new biopolitics. I provide four paradigmatic approaches to subvert imperial global health: (i) pivoting ecocide in the imperial global health regime; (ii) abandonment of a Eurocentric conceptualization of racial hierarchy and modernity; (iii) disbanding the commodification of public health; and (iv) organizing a new world order through health reparations.

Keywords: anti-Black racism, biopolitics, pandemic, reparations, violence, race, racism, South Africa, Brazil, United States

Introduction

This reflective essay critiques declarations of equality in the rules-based liberal international order during the Covid-19 pandemic. International health experts had predicted that the Covid-19 pandemic is a respiratory disease that would inadvertently spread proportionately following what the liberal discourse frames as the 'universal right to breathe'. Mbembe's critique of the universal right to breathe during the pandemic is incisive. He observes:

> All these wars on life begin by taking away breath. Likewise, as it impedes breathing and blocks the resuscitation of human bodies and tissues, COVID-19 shares this same tendency. If war there must be, it cannot so much be against a specific virus as against everything that condemns the majority of humankind to a premature cessation of breathing, everything that fundamentally attacks the respiratory tract, everything that, in the long reign of capitalism, has constrained entire segments of the world population, entire races, to a difficult, panting breath and life of oppression (1, p. 61).

I partially agree with Mbembe (1) that taking away breath is the genesis of violence that has been unleashed throughout Euro-American colonial

South Africa-United Kingdom Bilateral Research Chair in Political Theory, University of the Witwatersrand/Centre of African Studies, University of Cambridge, Cambridge, UK.

Correspondence to: Madalitso Z. Phiri, Post Doctoral Fellow, South Africa-United Kingdom Bilateral Research Chair in Political Theory, University of the Witwatersrand/A.G. Leventis Visiting Fellow, Centre of African Studies, University of Cambridge, UK. Email: mzp20@cam.ac.uk

(This manuscript was submitted on 5 April 2023. Following blind peer review, it was accepted for publication on 17 October 2023.)

Global Health Promotion 1757-9759; Vol 31(2): 43–51; 1211828 DOI: 10.1177/17579759231211828 journals.sagepub.com/home/ghp

modernity. Yet, I depart from his observations deploying my own theoretical reading of Fanon's (25) radical sociogenics. Africa as a continent in global discourses is rendered lifeless by a Euro-American Christian Global Racial Empire that declared itself 'God of humanity' through imperial violence. Colonial modernity rendered the so-called inferior peoples of the world into a 'bastardized Other' whose ontological category exists as diseased in the biopolitics of a hierarchical Global Racial Empire. The mythical and fictitious God-like status that European colonial modernity asserts itself is through the fear of defining, describing as well as condemning the 'darker races' into hell. Long before the pandemic reached Africa, the proverbial 'dark continent', in the global colonial imaginery, had been thrown to the doldrums of death and epistemic impossibility.

This truism was not far from the reality, as the pandemic across Africa and its diaspora followed patterns that are predicated on anti-Black racism, gender hierarchies, geographical apartheid, racialized classes and state sanctioned negation of Black life. This should not be surprising, as imperial violence and problematic motis of the nation-state continues to distribute violence to those political modernity ejected as the 'bastardized Other', such as refugees, casualized workers, e-hailers, women, and LGBTQI+ people in metropole countries and across erstwhile colonized societies. Mindful of these observations, I ask the following questions. First, can the erstwhile colonized peoples develop ideas and concepts for the imagination of a post-imperial global health regime? Second, how can alternative futures be imagined if the monopolistic control of power, global scientific processes, and knowledge regime is framed around problematic ideas of a Eurocentric totalizing project of being human? Lastly, if there is a scientific consensus that we need alternative futures, what kind of knowledge is needed to bring about a post-imperial liberated order?

My aim in this reflective essay is to underscore the importance of treating race as a scepter when responding to pandemics. I achieve this by foregrounding a historical sociology of race, imperial genocide, and pandemics. Opposed to the current imperial health policy regime, I advocate for a decolonial health regime predicated on a new biopolitics from the position of the subalterns themselves. I provide four paradigmatic approaches to subverting imperial global health: (i) pivoting ecocide in global health regimes (ii) abandonment of a Eurocentric conceptualization of racial hierarchy and modernity; (iii) disbanding the commodification of public health; and (iv) organizing a new world order through health reparations.

Medical anthropology and the genesis of imperial genocide

The diabolical connection between racism, biopolitics, science, and pandemics has always been an intimate one since the onset of colonial modernity. But what exactly is *Racism* and *Colonial Modernity*, and how do these twin social artifacts manifest themselves in global scientific responses to pandemics? Race as a categorical imperative was constitutive from the onset of what the African American critical scholar, West (2), understood as the 'Age of Europe'. By Europe, we mean Edmund Husserl's description of a place that is 'not as it is understood geographically, as on a map, as if thereby the group of people who live together in this territory would define European humanity. In the spiritual sense, the English Dominions, the United States, Canada, Australia, South Africa, New Zealand, clearly belong to Europe . . . Here the title 'Europe' refers to the unity of a spiritual life, activity, creation, with all its ends, interests, and endeavors, with its products of purposeful activity, institutions, and organizations' (3).

Racism is not merely a discourse, but a practice which produces certain *knowledges* of the colonized, and, indeed, exploited, that makes the practice of domination, restructuring, and having an authority on the colonized (4). Race as a categorical principle of ordering world society emerged towards the end of the 15th century, and simultaneously created a global system that distributes violence, difference, and domination. Racism, Magubane (4) notes, is thus both a specific term, as in dehumanizing of a whole people, and a global social practice, that is, elevating Europeans and/or White people into 'lords of humanity'. Racism absolved the perpetrators of institutionalized injustices by blaming the victims. Race is the mask of class in the final analysis (4). This institutionalized articulation of racism as global apartheid provides us with a lexicography on how a world predicated on anti-Black racism has responded to pandemics.

Colonial modernity, on the other hand, refers to a totalizing global project of domination without consent that pivots Euro-American worldviews and values, predominantly organized around capitalist economic institutions, draconian laws, violence, force, and manipulation, exerting itself through patterns of obliterating the Black race across politics, society, cultural affiliations, symbol formations, and norms which influence global scientific flows. It was achieved through the institutionalization of White supremacy as a Global Racial Polity, as the late critical philosopher, Mills (5), articulated throughout his scholarship. White supremacy produced its 'bastardized Other', a 'Global Jim Crow' (6) predicated on anti-Black racism. The reproduction of White identity was further cemented through anti-Black preferential immigration policies, eugenics, and social engineering projects of whitening in settler colonial societies, such as the United States, Canada, South Africa, Brazil, Australia, and New Zealand (7).

It is a forgotten fact that, during the Enlightenment Era, armchair philosophers, such as Locke, Hume, and Kant, had made it a habit to speculate about the inferiority of Africans and Asians, which they attributed, among other things, to *biology*, climate, despotic governments and, of course, ignorance of Christian virtue (4). The Enlightenment Era consolidated and coalesced hegemonic ideas about 'race' and 'biology' that have found frequent expressions in the lexicon of biopolitics and, thereby, how the world responds to contemporary global pandemics. Europe's sadistic infatuation to prove the infantalization of the Negroid race produced sub-disciplines in the medical and biological sciences, such as phrenology, eugenics, and racial hygiene, leading to entrenched perspectives of a hierarchical humanity. These polarizing views were publicly aired in a debate between two French doctors at the peak of the pandemic when the Research and Development project of Covid-19 vaccines and trials was to be implemented. Jean-Paul Mira, head of intensive care at Cochin Hospital in Paris, suggested: 'If I can be provocative, shouldn't we be doing this study in Africa, where there are no masks, no treatments, no resuscitation?' 'A bit like as it is done elsewhere for some studies on HIV/AIDs. In prostitutes, we try things because we know that they are highly exposed and that they do not protect themselves' (8).

Contrary to what is presented as the neutrality of the liberal regime of safeguarding human life, ideas that champion Social Darwinism and eugenics never left Euro-American modernity. The Black body was historically produced as a site of scientific experiments exempted from pain and suffering. Colonial discourses have continued to organize biopolitics across the centuries – through forced sterilizations, racial hygiene, eugenics, and genocidal responses to pandemics, such as HIV/AIDS. For most people of the erstwhile colonized, the triumph of the liberal international world order in 1945 has meant living under the violence, brutality, and exclusionary practices of Euro-American fascism under the guise of safeguarding global humanity. The aesthetics of Blackness exists parallel to a global apartheid agenda under the pretext of going practices of neo-colonial's 'inclusive violences' and domination. Colonial violence is, indeed, the violence of fascism enmeshed in the contemporary Global Racial Empire.

From the doldrums of the historically produced 'bastardized Other', Black Radical Theorists have always provided counter-hegemonic ideas espoused in the 'Age of Europe' that championed medical apartheid and genocide. Ramose intimates: '[I]t is a known fact that science has classified and categorised human blood. Every human being is a potential donor or receiver of its blood group. Thus, blood is there to be shared in safeguarding the lives of one another as human beings. We are yet to find human beings with literally and empirically proven 'black' or 'blue' blood flowing in their veins and arteries' (9, p. 4). He goes on to say, 'The assumption of medical science is that whatever is medically proper for a patient with a specific illness is medically appropriate for all other human beings suffering from the same disease. If this were not so, then medical science would have no legitimate claim to science because it would go against the hallowed though questionable criterion of 'objectivity" (9). In the current dispensation of colonial modernity, however, 'the objectivity of science exempted medical science from prejudice against Africans, Negroes, or Black human beings' (9, p. 4). In the case of this group of human beings,

'medical science denied them agency and rather opted for wilful ignorance as well as prejudicial rationalisations' (9). Unsurprisingly, responses to the pandemic followed problematic ideas under the aegis of colonial modernity.

Aesthetics of Black breath during the pandemic: South Africa, Brazil, the United States

Black breath during the pandemic was constituted around what Fanon (25) coined as 'theft of air' and 'combative breathing'. Vectors of violence embedded in approaches to a racialised medical anthropology were ubiquitous across settler colonial societies, such as South Africa, Brazil, and the United States. Black aesthetics continued to be legislated under state-sanctioned violence, generating disproportional distribution of mortalities, infections as well as segregated social effects through imposed global lockdowns. While some scientists had predicted very high death rates, many African countries were hard-hit by the negative effects of hard lockdown. Precariate work became more overt especially those working in the informal sector. Disruption of global supply value chains led to food scarcity a dystopia that millions on the African continent continue to live with four years after the pandemic.

It was South Africa, on the African continent, whose health architecture is enmeshed with institutions of settler colonialism, that was the epicenter of the pandemic. I have already intimated elsewhere, that, in South Africa, Covid-19 was a pandemic of racial capitalism (10). Under the guise of 'saving all lives', severe restrictions imposed during lockdown championed the militarization of health policy as well as the abstraction of the 'social' from the ambits of responses to the pandemic. South Africa's response to the pandemic was at best paradoxical (due to a colonially informed discourse), which revealed disproportional distribution of the pandemic: 'One Virus Two Countries' (11). Black life became more disposable to the negative effects of the pandemic. Friedman suggests that most scientists in South Africa are firmly embedded in 'First World' South Africa. Some of the decisions endorsed a science that was highly contested in both the United States and the United Kingdom (11, p. 35). Yet, this medical policy elitism was championed, as South African policy elites chose one 'science' over others which might have offered an alternative to mounting case numbers and fatalities (11, p. 56). This elitist approach to health policy protected the lives that are catered for in the private tier of South Africa's segregated commodified healthcare provision. The gulf between public and private social provisioning has never been wider. Prior to the pandemic, 50% of total health expenditure was spent on 16% of the population covered by medical schemes, while the other 50% is spent on 84% of the population in the public sector (12). Friedman (11) further suggests that these scientists adopted, without much reflection at all, the view which we would expect from professionals in a country divided into two realities, and in which the national debate reflects the experiences and attitudes of the 'First World' minority, not the 'Third World' majority (p. 56). Further, the health pandemic exacerbated the social pandemic that created conditions of destitution, precariousness, and indigence. Of the approximately three million net job losses between February and April 2020, women accounted for two million, or two-thirds of the total, even though, in February, they accounted for less than half of the workforce (47%) (13).

The realities of global apartheid became more apparent when South Africa had 'identified' a new variant of the coronavirus – omicron. Harvesting knowledge from years of active research, development, and training in dealing with tuberculosis, it was a logical conclusion that South African scientists could provide a lead in this area. Instead of commending scientists for enhancing scientific collaborations that could inform the world's approaches to the pandemic, South Africa and the whole of southern Africa was subjected to travel bans imposed by Western countries. This was despite the fact that some countries on the travel ban were nowhere close to the epicenter of the pandemic, such as Malawi and Zambia. This move, however, justified the geographical racism that has been informed by colonial cartography enforced by the Mercator projection of the world. The Mercator projection of the world map continues to reproduce imperial violence and, thereby, how Africa is categorically condemned to a zone of disease, war, and indigence and not a zone of scientific collaboration and knowledge production.

Such projections of the world abstract the interrelatedness, visibility, and resilience of Black life on the African continent and across its diaspora. In Brazil, for example, vulnerable populations, such as low-income families, single mothers, the elderly, Blacks, indigenous peoples, and other minority groups, were the most affected by the pandemic (14). Before the inception of the Covid-19 pandemic, the social assistance Bolsa Familia Programme (BPF) was dubbed 'The Silent Revolution of the Global South' to alleviate poverty and inequality (15). It was estimated that the level of extreme poverty would be between 33% and 50% higher without a social assistance program such as the BPF. Coupled with the distribution of assets, such as 'affordable' public housing, education, and healthcare, the program had contributed to reducing income inequality, accounting for 12 to 21% of the recent sharp decline in Brazil's Gini co-efficient (16). Brazil, however, is a country with the largest Black diaspora with a complicated unacknowledged history of how the trajectories of health and social policy are enmeshed in fiendish discourses of *racialisation* and hierarchical social citizenship.

The Brazilian Research Network on Food and Nutrition Sovereignty and Security (*A Rede Brasileira de Pesquisa em Soberania e Segurança Alimentar e Nutricional – Rede PENSSAN*) conducted a survey to assess food security in Brazil in the context of the Covid-19 pandemic (17). The survey shows that less than half of Brazilian households (44.8%) were food secure (2021). While 55.2% of households were experiencing some level of food insecurity, 9% of households were facing hunger (severe food insecurity). Out of a total of 211.7 million Brazilians, 116.7 million were experiencing some level of food insecurity, 43.4 million did not have enough food, and 19 million were facing hunger (17). When regional inequalities are accounted for, the pandemic of hunger reifies Brazil's racial and geographical hierarchies. Households with income of up to half of a minimum monthly salary per capita faced severe food insecurity at levels 2.5 times the national average. Close to 25% of residents in the north and north-eastern households reported monthly incomes of less than quarter of a minimum monthly salary per capit, compared with 10% in the south-southeast and central west regions (17). Further to this, severe food insecurity was higher among households headed by women, or by men or women self-declared as being Black or Brown, or with fewer years of schooling. Among households where the pandemic had led to job loss or increased debt, nearly 20% were facing severe food insecurity. Households with residents who had applied for and received government emergency assistance were affected by moderate or severe food insecurity at levels three times the national average (17).

Throughout the pandemic, Jair Bolsonarro's right-wing populist politics weaponized the state, cementing a culture of scientific denialism that led to higher fatalities in states and communities that are predominantly inhabited by Black and Brown people. Such responses to the pandemic further entrenched the idea that Brazil is divided on two fronts, whereby the north and north-eastern states (such as Bahia and Pernambuco), which occupy a totalizing discourse, are condemned to the zone of 'non-being'. In contrast, southern and south-eastern states (such as São Paulo and Porto Alegre) have achieved the teleological goal of 'Brazilian modernity and civilization'. Since the inception of the Covid-19 crisis, Brazil was one of the hardest hit countries in the world accounting for close to half a million fatalities. Such elitist and divisive approaches to the pandemic also reverberated in the narrative of civilizational exceptionalism and populism that bedevilled not only Brazil but also the United States. The global paradox is that polities that promoted the myth of civilizational exceptionalism (such as the United States, United Kingdom, and Brazil) inadvertently became the epicenters of the pandemic.

In the United States, under covert political rhetoric of White nationalism, the pandemic was initially referred to as the 'China Virus', by the then-leader of the 'Free World', Donald Trump. However, Kanngieser and Samudzi highlight subtle practices of ongoing American healthcare apartheid and White supremacy under the guise of liberal progress. They accent,'[t]he disregard of immunocompromised chronically ill and disabled peoples speaks to larger ideological and material practices of disability discrimination, racism and eugenics that define disabled life as valuable only in its sacrifice' (18). Pre-existing material conditions, such as housing discrimination, environmental decay, gentrification, and commodified health provision, necessitated conditions of inequality where African Americans and First Nations were disproportionately affected

in the pandemic. First Nation communities had the highest crude Covid-19 mortality rates nationwide – about 2.8 times as high as the rate for Asians, who have the lowest crude rates (19). The Center for Disease Control notes that Indigenous American deaths were often undercounted, with the latest research suggesting the true mortality rate for this group could be around 34% higher than official reports (20). As of April 2022, 142,361 African Americans were known to have lost their lives to Covid-19. There were 1,431 new deaths reported among African Americans for the last full month of data (March 2022), which is a 74% decrease from the preceding month (5,431) (20). This reflects the responses to state-sanctioned violence that was used under the trope of promoting the social good in this untransformed settler colonial state. Contrary to the promotion of the social good, Kanngieser and Samudzi further suggest: '[i]n both the United States and United Kingdom, as in Italy, critical care consultants spoke about having to limit who would receive medical equipment such as ventilators, creating a discourse that rationalised and normalised the disposal of sick, elderly and disabled patients' (18). This cements exclusionary practices that are intrinsic to ongoing subtle racialized social determinants of health that are enmeshed in the make-up of the United States as a bastion of segregated healthcare provisioning in the world.

The tropes of exclusionary approaches were further reified in the regime of intersectional state-sanctioned violence through the Medical Industrial Complex as well as the Prison Industrial Complex in the United States. The United States incarcerates around 2.3 million people in prisons, which is the highest across all developed countries. According to the National Association for the Advancement of Colored People (NAACP) (21), Black men are incarcerated at five times the rate of White men and Black women at double the rate of White women (21). African Americans experienced 14.3% of all deaths, while they represent 12.6% of the population (21). These disproportional rates are no different from the effects of the pandemic itself. Black bodies are subjected to legislated state-sanctioned violence exemplified through a failed American social and political project. Accounting for the politics of health, '[T]here is an increased rate of chronic illness associated with incarceration that continues even after release and chronic illnesses are the leading cause of death within prisons - attributed to the extremely poor healthcare available' (18).

The Prison Industrial Complex in the United States exists as the final stage of state-legislated negation of Black life. Thus, the Covid-19 pandemic produced a negation of life on two fronts: the right to exist in a healthcare regime that renders Black life nonexistent, and citizenship rights curtailed in a polity whose political institutions are predicated on anti-Black racism and settler colonialism. At the peak of the pandemic, Kanngieser and Samudzi made poignant observations: 'The Ohio prison system alone accounts for more than 20% of the state's total novel coronavirus cases, and it is spreading rapidly – 'like wildfire' – through correctional facilities in epicentral New York and other states. But rather than de-carcerating institutions en masse, incarcerated people in New York state are sewing masks for hospitals (when most do not have their own), producing hand sanitizer in light of widespread shortages, and digging mass graves' (18).

Global infections patterns disproportionately affected groups that colonial modernity has defined as the dehumanized 'Other': Blacks, refugees, undocumented migrants, Indigenous people, and the disabled. These groups of people were the hidden faces of fatalities within the ambits of safeguarding the mythological 'better life for all'. In South Africa, argues Canham, 'before the virus became a black condition, fears of contagion had become racialised and classed' (22, p. 301). Canham further raises the paradoxical questions of Black existence under the gaze of White supremacy. He notes that, during the pandemic, the irony was, of course, that 'there was a universal consensus that the virus began in China but in the logic of racism, Africans were a convenient scapegoat' (22).

Those most loathed in society are seen as always infected. 'What does it mean to always be infected by viral plagues?' To always be death bound?' (22, p. 302). Butler's (23) concept of 'grievability' facilitates a sophisticated understanding of the ways in which frames intersect with modes of recognition and power to surface and (re)enact social arrangements that render some bodies more grievable than others. For a particular body to be recognized as dead, Butler argues, we must first have validated that body as human and living. Not all lives are validated as living, and this alerts us to the idea that mourning (the validation of lives lost) is stratified,

psycho-social, and deeply political (23). As Butler further intimates, statistical observations are insufficient to explain pandemic outcomes, 'but we can assume that one reason is that within the so-called common world the loss of Black life is simply not considered as worrisome or grievable as the loss of white life (often described simply as 'human life')' (23, p. 4). The pandemic further reified the biopolitics that inform the disposability of Black life and its bioethical limitations. Canham accents, 'If Covid-19 leads to overwhelmed lungs, how different is this from death through being submerged and drowned in the floods or in the deathly Mediterranean crossings by Africans reaching for Europe? Death is death and we are all destined to its stranglehold. But Black death has a particular logic. It is always in excess. Black people always die disproportionately more. Death always latches onto existing social fissures of inequality. In the calculus of death, health outcomes are racialised' (22, p. 303).

The regime that governs the biopolitical aesthetics of Black life is woven with the preservation of values that entrench a Global Racial Empire and inadvertently, White supremacy. In this regime, Blackness exists as an ontological category that is pathologized and diseased. There is no future of a liberal health regime and inadvertently, world society without decolonization. Hence, the Black Radical Tradition always imagined a post-imperial polity in what Du Bois understood as the 'Gift of Sight' (24) from the erstwhile colonized peoples. Decolonization, as Fanon (25) exegetically espoused, is a process of replacement of the old world order with a 'New Humanity' that is born from the position of those who have been historically wronged and ontologically produced as the colonialized and diseased 'Other'.

Conclusion: toward a decolonial health regime

There is no global social justice without epistemic justice (9, p. 13). To decolonize the global health regime requires that world society pivots intellectual archives and quitodian encounters of the erstwhile colonized whose raison d'être is to dismantle the imperial health regime. Decolonization must produce 'a New Humanity' transforming the objects of exploitation, which were under colonialism, into free humans. I reflect on what this imagined decolonial future of global health regime entails.

First, if global health justice is to be achieved through a flawed global governance architecture's ability to prosecute genocide, then the definition of genocide needs to, at minimum, include ecocide as a recognized act. Contemporary neoliberal global hierarchical racialized capitalism thrives on the divorce of human and nonhuman ecologies, which has inadvertently led world society further toward the Anthropocene epoch. Assuming causal relationship between pandemics, environmental determinants of health and humanity then we need to re-constitute the social, political, and environmental. There is currently no international crime of ecocide that applies in peacetime, only in wartime, covered by the Rome Statute (26). It was originally planned to be included in the Rome Statute and support by many states, but was removed due to objections by the United Kingdom, France, and the United States (26). The global energy complex is based on an extractive model where carbon capital and green capitalism are exploited through diabolical approaches that are championed by neoliberal ecofascists. While there is no global consensus as to complex causalities of the coronavirus, there is suspicion from countries in the Global South that just transitioning to net zero is fictious. These positions are sustained by the hypocrisies of an imperial global governance regime. Satgar suggests that the United States has been dominated by carbon capital, which is closely tied to ruling financial interests, it has failed to provide decisive leadership in the United Nations multilateral processes, from the Kyoto Protocol to the Paris Climate Agreement. Normative assumptions of capitalist growth are predicated on a system of extraction and the divorcing of the human from the nonhuman world (27). In the Global South, as Satgar intimates, the positions emboldened by imperial positions necessitated a 'catch-up carbon development', which ensured fossil fuel spigots remained open over the past 20 years to meet the needs of China, India, and other G20 countries. Billions for a just transition promised to countries that did not cause the climate crisis have not materialized (27, p. 97). Ending ecocide will start with a recovery of the idea of a Global Commons that usurps the promulgation of Euro-American fascism as 'lord of humanity'. World society should, rather, think about politics as transpolitics: ensuring workers go beyond narrow economistic demands,

feminists beyond women's oppression, and environmentalists beyond specific environmental problems (27, p. 105). The current capitalist ethos can be replaced by a democratic socialist system that values the interrelatedness and spirituality of human and nonhuman ecologies.

The second point is the abandonment of a Eurocentric totalizing idea of the 'universal man', which justifies the violence of Euro-American modernity. Du Bois made a poignant point that Black people live with a tortured two-ness or what he termed 'double consciousness' (24, pp. 128–173). Life on the other side of the veil is governed under the precepts of White supremacy; whereas the other side of the veil is lived under the fullness of Black humanity expressed through the gift of 'Second Sight'. 'Second Sight', as Rabaka has elaborated, provides Blacks with a window into the 'two worlds within and without the Veil', and it also enables them to begin the dialectical process(es) of revolutionary decolonization and human liberation by critically calling into question double consciousness (24, p. 143). This social project is occupied with a radical idea of dismantling the totalizing idea of the 'European man', so that a 'self-conscious humanhood' emerges. Decolonization starts with a change of the consciousness of the colonized, a far-reaching, and fundamental goal. The changing of the colonial structure entails that all social relations are fundamentally transformed into new, higher unity, beyond the original position, assuming the radical opposite of everything that colonialism was, its violence, its brutality, suppression, racism, and its unfreedom (28).

The third point is to disband the idea of commodification of public goods such as health. The current health regime privileges the commodification and financialization of society. The regime that governs intellectual property rights thrives on the commodification of science and medicine. Neoliberal healthcare jettisons the idea that knowledge and scientific discoveries thrive on collaboration and not its corollary, competition, and violence. Billions of people live under dystopian conditions that have been wrought by imperial health planning, eugenics, and population control. All this feeds into a capitalist and genocidal ethos that seeks to eliminate the 'Other' in parallel to a mythical liberal approach that champions the preservation of life for 'all humanity'. In contrast to a dystopian capitalistic approach of global public initiatives, the other side of the coin is that, throughout the pandemic, scientists and medical practitioners resisted this idea, 'from public-access of medical data sets to the open-source software used to visualise and model virological data to the digital communications infrastructure that has allowed scientists to collaborate freely across the globe, there is a great common of knowledge, mutual aid and solidarity that underpins and nurtures the foremost scientific endeavours of our time' (29).

Fourth, the future of the global health regime can only continue to exist if we think about healthcare/health promotion as '*worldmaking*'. Those who have historically been constructed in the world as the 'bastardized Other' also occupy the racial hierarchy as the 'Diseased Other'. The cancer of colonialism spreads its cells to their sicker cells. However, imaginaries of the global healthcare regime that is rooted in violence should be thinking of it as an emancipatory project that champions a post-imperial world order free from *domination* (30). This means conceptualizing healthcare as reparations predicated on a constructive view of justice. Conceptualizing the global health regime through the constructive view of justice removes the impetus of its normative instruments. The contemporary African philosopher Táíwò (31) opines that most theorizing about reparations treats it as a social justice project – either rooted in reconciliatory justice focused on making amends in the present or focusing on the past, emphasizing restitution for historical wrongs. Neither approach is optimal; rather, Táíwò (31) advances the case for reparations rooted in distributive justice, which he refers to as the 'constructive' view of reparations.

Declaration of conflicting interests

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author received no financial support for the research, authorship, and/or publication of this article.

ORCID iD

Madalitso Z. Phiri https://orcid.org/0000-0003-2784-7298

References

1. Mbembe A. The universal right to breathe. Crit Inq. 2021; 47: 58–62.
2. West C. Race Matters. Boston, MA: Beacon Press; 2017.
3. Gordon L. Fanon and the Crisis of European Man: An Essay on Philosophy and the Human Sciences. London: Routledge; 2020.
4. Magubane B. Social construction of race and citizenship in South Africa. In: United Nations Research Institute for Social Development (UNRISD) Conference on Racism and Public Policy, Durban, South Africa; 2001 September 3 Geneva: UNRISD, p.3.
5. Mills C. Black Rights/White Wrongs: The Critique of Racial Liberalism. Oxford: Oxford University Press; 2017.
6. Rabaka R. Return to the source: Cabral, Fanon, the dialectic of revolutionary decolonization/ revolutionary re-Africanization, and the African renaissance. J Black Stud. 2022; 53: 419–440.
7. Bhambra GK, Holmwood J. Colonialism and Modern Social Theory. Cambridge: Polity Press; 2021.
8. British Broadcasting Cooperation. Coronavirus: France racism row over doctors' Africa testing comments [Internet]. 2020 April 3 [cited 2023 November 12]. Available from: https://www.bbc.com/news/world-europe-52151722
9. Ramose MB. Towards a post-conquest South Africa: beyond the constitution of 1996. S Afr J Hum Rights. 2018; 34: 4.
10. Phiri MZ. The South African pandemic of racial capitalism. Mon Rev. 2021; 73: 36–50.
11. Friedman S. One Virus, Two Countries: What Covid-19 Tells Us About South Africa. Johannesburg: Wits University Press; 2021.
12. Department of Health. National health insurance policy: towards universal health coverage. Government Gazette 40955, 2017 June 30.
13. Casale D, Posel D. Gender and the Early Effects of the COVID-19 Crisis in the Paid and Unpaid Economies in South Africa. Pretoria: National Income Dynamics Study, Corona-virus Rapid Mobile Survey (CRAM); 2020.
14. Segatto CI, Santos FB, Bichir RM, Morandi EL. Inequalities and the COVID-19 pandemic in Brazil: analyzing un-coordinated responses in social assistance and education. Policy Soc. 2022; 41: 306–320.
15. Hanlon J, Barrientos A, Hulme D. Just Give Money to the Poor: The Development Revolution from the Global South. Sterling: Kumarian Press; 2010.
16. Paiva LH, Falcao T, Bartholo L. From Bolsa Familia to Brasil sem miseira: a summary of Brazil's recent journey towards overcoming extreme poverty. In: Campello T, Neri MC (eds). Bolsa Familia Program: A Decade of Social Inclusion in Brazil: Executive Summary. Brasilia: Ipea; 2014, pp.15–17.
17. Rede PENSSAN. II VIGISAN National Survey of Food Insecurity in the Context of the Covid-19 Pandemic in Brazil. Brasilia: Rede PENSSAN; 2021, p.8.
18. Kanngieser AM, Samudzi Z. Thank you for your sacrifice: how the rush for hydroxychloroquine exemplifies the need for anti-racism and disability justice in the valuation of pandemic life [Internet]. Society and Space. 2021 April 19 [cited 2023 November 12]. Available from: https://www.societyandspace.org/articles/thank-you-for-your-sacrifice-how-the-rush-for-hydroxychloroquine-exemplifies-the-need-for-anti-racism-and-disability-justice-in-the-valuation-of-pandemic-life
19. Gawthrop E. The color of Coronavirus: Covid-19 deaths by race and ethnicity in the U.S. [Internet]. 2022 May 10 [cited 2023 November 12]. Available from: https://www.apmresearchlab.org/covid/deaths-by-race-05-09-2022
20. Center for Disease Control and Prevention (CDC). Distribution of COVID-19 deaths and populations, by jurisdiction, age, and race and Hispanic origin [Internet]. 2023 March 6 [cited 2023 November 13]. Available from: https://data.cdc.gov/NCHS/Distribution-of-COVID-19-Deaths-and-Populations-by/jwta-jxbg
21. NAACP. Criminal Justice Factsheet [Internet]. 2023 [cited 2023 November 13]. Available from: https://naacp.org/resources/criminal-justice-fact-sheet
22. Canham H. Black death and mourning as pandemic. J Black Stud. 2021; 52: 296–309.
23. Butler J. What World Is This?: A Pandemic Phenomenology. New York, NY: Columbia University Press; 2022.
24. Rabaka R. Against Epistemic Apartheid: W.E.B. du Bois and the Disciplinary Decadence of Sociology. Lanham: Rowman & Littlefield Publishers; 2010.
25. Fanon F. The Wretched of the Earth. London: Penguin; 1963.
26. Eichler LJ. Ecocide is genocide: decolonizing the definition of genocide. Genocide Stud Prev. 2020; 14: 104–121.
27. Satgar V. End ecocidal capitalism or exterminate life on planet earth: a South African contribution to ecosocialist strategy. Mon Rev. 2022; 74: 94–106.
28. Reddy T. South Africa, Settler Colonialism and the Failure of Liberal Democracy. London: Zed Books; 2015.
29. Eloff A. Bread and vaccines [Internet]. New Frame. 2021 January 8 [cited 2023 November 13]. Available from: https://libcom.org/article/bread-and-vaccines
30. Getachew A. Worldmaking After Empire: The Rise and Fall of Self-Determination. Princeton, NJ: Princeton University Press; 2019.
31. Táíwò O. Reconsidering Reparations. Oxford: Oxford University Press; 2022.

Original Article

Decolonial framework for applying reflexivity and positionality in global health research

Thirusha Naidu[1], Gareth Gingell[2] and Zareen Zaidi[3]

Abstract: Contemporary research practices link to colonial and imperialist knowledge creation and production and may promote harmful perspectives on marginalized and oppressed groups. We present a framework for a decolonial approach to research in global health and health promotion applicable across research settings. This framework is aimed at anticipating and alleviating potentially harmful practices inherent in dominant research methods. The framework focuses from a macro- and micro-level perspective on three critical dyads: 'context' and 'accountability'; 'researcher identity' and 'positionality'; and 'procedural ethics' and 'ethics in practice' considerations. We present guidance for how to consider reflexivity and positionality as they apply in this framework in global health and health promotion research practice.

Keywords: community-based research, participatory research, education (including health education), equity, social justice

Introduction

> *From the vantage point of the colonized, the term 'research' is inextricably linked to European imperialism and colonialism. The ways in which scientific research is implicated, in the worst excesses of colonialism, remains a powerful remembered history for many of the world's colonized peoples* (1).

An emerging initiative within global health and health promotion research questions Euro-America imperialism and coloniality within the field (1–3). Deeply entrenched discriminatory practices exist because coloniality is intertwined with dominant models of research, which dislocate and silence epistemic diversity (4). Researchers are trained to believe and reproduce assumptions that the social and material world is structured and functions based on Euro-American epistemic dominance (5–7). Globally, researchers adopt methods and approaches based on colonial knowledge systems in lieu of situated or contextual knowledges (8–10). These assumptions may ignore or deny the humanity of research participants and disregard their ability agency in their own lives and contexts (11). Knowledge production emanating from this approach to research is complicit with the oppressive practices of sorting, labeling, and controlling the lives of everyday people. Oppressive research practices position people inaccurately as these practices use external lenses for research purposes that serve to create evidence for externally developed research questions and hypotheses.

1. University of KwaZulu-Natal, Durban, South Africa.
2. The University of Texas at Austin, USA.
3. George Washington University Medical Faculty Associates, Washington, USA.

Correspondence to: Thirusha Naidu, University of KwaZulu-Natal, Rm 3013rd flr George Campbell Building, 719 Umbilo Road, Congella, Durban, 4001, South Africa. Email: naidut10@ukzn.ac.za

(This manuscript was submitted on 8 November 2023. Following blind peer review, it was accepted for publication on 21 February 2024.)

Global Health Promotion 1757-9759; Vol 31(2): 52–58; 1238016 DOI: 10.1177/17579759241238016 journals.sagepub.com/home/ghp

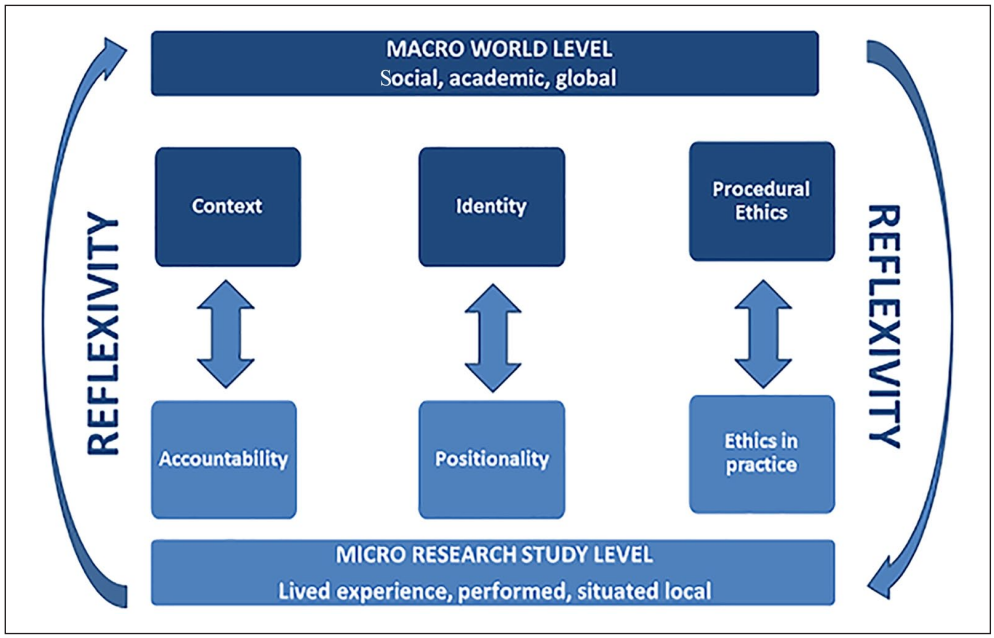

Figure 1. Decolonial research framework.

Decoloniality encompasses theory and debate around sociohistorical, geopolitical, and economic perspectives on gender, race, and heteropaternalism (heterosexual, male, paternalistic ways of thinking, viewing, acting, and controlling contexts, identities, and relationships) (12,13). Decolonial perspectives see the long-lasting effects of colonial power; the 'coloniality of power', expressed through oppression, as intersectional, multidimensional, multisystemic, institutional, historical, and self-perpetuating (13).

In research projects that aim for contextually reflexive research practice, researcher identity and positionality, ethical considerations and researcher accountability are critical components for iterative interrogation (14). This decolonial framework aims to offer global health and health promotion research ways to examine epistemic positioning, and research methodology to promote decolonial research praxis (Figure 1).

This decolonial framework for approaching research comprises macro- and micro-level elements that influence the research process. At the macro-level are three elements: context, identity, and procedural ethics. At the research/micro-level, three elements (accountability, positionality, ethics-in-practice) are important. Throughout the research process researchers use reflexive questioning to orient and position themselves towards participants and contextual perspectives. Reflexive questioning may occur within teams (dialogical reflexivity) or at an individual level (reflexivity) (15).

Author positionality

TN is a is a cis-gendered, displaced woman of color, of ethnic minority background, and a clinical psychologist and researcher practicing in a public health setting in South Africa. ZZ is a cis-gender, straight, woman of color, first-generation immigrant in the US of an ethnic minority background, whose research focuses on the intersection of critical race theory, educational power dynamics, and social justice. GG's experiences as a biracial (Black and White), gay, cis-gendered man in the Southern United States shape his focus as a medical education researcher.

Macro-level: the high-level vantage point framework

The *macro-level* in the framework addresses context, identity, and ethical approval. These are the broader environments in which research is conducted

(i.e. contexts); how people view themselves in these contexts (e.g. do they view themselves as part of the Global South *vs*. Global North; developing country *vs*. developed, identifying with a racial, gender, sexual, ethnic, linguistic, group); and how this identification impacts the ethical considerations Global North university review boards required of researchers.

Micro-level: the study/project-level framework

The micro-level is the study or fieldwork level, and comprises accountability, positionality, and ethics-in-context. This refers to the daily variability and activity of the project, including how researchers account for various activities and outcomes as they report to relevant stakeholders (e.g. funders, participants, etc.), the researchers' positionality, and what identity elements may shift in the research process (e.g. physician, principal investigator (PI), thesis advisor, community advocate, etc.), and ethics in practice (e.g. what decisions are made in the course of the project which conform to or contravene procedural ethics and how these are negotiated or managed).

The next section explains how elements of the framework may be used together.

Context and accountability

Context is the broader social and political milieu, and the sociohistorical context of colonialism in the world. At this level, researchers may describe local contexts in detail, including how they impact and intersect with each other. This may be as large as global regions and countries (e.g. members of the Global South interacting with the Global North), or as narrow as a single community of health workers in a clinic. Context may refer to the political environment at the time when the research was conducted (e.g. dictatorship, democracy) or social environmental events that influence the everyday research context (e.g. war, natural disaster). In considering the context, researchers must note the dynamic cultural practices that shape that time and community space, and describe how those practices shape and intersect with the research process in that context. Questions for reflection include:

How would I describe the physical location of the research?

How does the contemporary and historical social and political milieu impact on the study?

What other rules, laws, and conventions are operational in this context that might be pertinent to and/or impact the study?

Accountability refers to researchers' obligations to the various stakeholders in the research process, such as the research participants, the funding body, and the researcher's employing organization (16). Accountability takes many forms, including member checking as an imperative rather than an optional addendum. Reciprocity is an ethical requirement holding researchers accountable to reflexively engage with emergent data regardless of the level of community engagement in other aspects of the research (5). In dominant contexts, accountability to power (funding institutions, North in North–South collaborations) may overshadow accountability to participants. As such, researchers may ask: what are the implications of prioritizing funders over participants and communities in accountability checks? How does accountability to structures and systems over participants and communities affect/inform the research and its outcomes? Here it is important to consider community intellectual property rights and access to and publication of cultural and personal information, for example, using community or traditional folklore, art or music to illustrate research findings without proper permission and possibly compensation or presenting a patient's artwork or journal writing without acknowledgment. Participatory forms of knowledge include knowledge developed and gained in collaboration with participants. Community members and leaders should understand and agree to a research engagement that is mutually beneficial and in ways that make sense from their perspectives. Community rights, interests, and cultural governance must be central to accountability.

Identity and positionality

Identity refers to social constructed and externally conferred identities which then dictate expectations of roles and behaviors of researchers (8). Decolonial

theory poses that one of the major projects of colonialism was to categorize and define identity relative to White male colonizers so that the colonizers' identity would form the dominant norm and stand as a referent through which the world is understood and constructed (10,14,17). These can range from professional identity to racial, gender, or sexual identity, and are important to consider in view of structural power controls, both subtly and overtly, on what constitutes legitimate identities, and how they should be performed. Identities cannot be accounted for as single categories, such as gender, race, sexuality, socio-economic status; rather they are multidimensional and complex categories which are impacted by overlapping matrices of oppression. As a result, the default identity became self-referential – that of the colonizer, the White, male, heterosexual, cis-gender. Thus, researchers should reflect on their personal identity as well as the research team's identity. The following questions might be useful to explore identity in the broader research context: what are the socially-constructed and externally conferred identities that might be salient in this study? How do these socially constructed identities and externally conferred identities differ and/or impact on how participants view themselves? What is the composition of my research team and how might that influence their own and participants' identity perspectives? Does the team have representation from the community?

Positionality refers to the concept that the social–historical–political location of a researcher influences their orientations (i.e. the idea that researchers are not separate from the social processes they study). It also influences the importance given to, the extent of belief in, and their understanding of the concept of positionality (8,11,12,18). Positionality here refers to the 'stance or positioning of researchers in relation to the social and political context of the study, the community, the organization or the participant group. (19)' This designation has roots in the traditions of action-based and critical research in the sense of researchers' views and interaction with the study participants. Researchers' positionality, including the personal and philosophical perspectives (e.g. worldview), influences the assumptions, research design, and methods of a study. The components of research design, methods, and worldview are interconnected and therefore influenced by the positionality of the researcher. Researchers' active interrogation of their own positionality is critical as the primary investigators' perspectives influence and shape all aspects of the study design, data collection and interpretation, including where, why, and how data is written up and presented. Positionality consciously or unconsciously shifts depending on whether we are training field workers, talking to a senior, or presenting proposals to funders. How we assert or hold back on different aspects of our identity depends on with whom we interact and for what purpose, and must be made explicit. Questions researchers could consider asking themselves are: what are my beliefs about race culture and education in society and how do those beliefs impact my choice of research question, methods, and analysis? What are some racialized experiences that I have had that shaped my research decisions? What is the impact of my identity as a researcher in the global context? What power and privileges does my own identity afford me in this particular research work?

Positionality and identity example

In a collaborative study in which a research project was funded in the Global North but located in the Global South, all the PIs barring one were White, male English speakers. The junior researchers, fieldworkers, and graduate students were all women of color from the Global South. The PIs controlled the research process and funding while those researchers in the Global South handled the administration and fieldwork under their direction. The PIs did not intentionally silence or oppress junior members; however, they may in fact have silenced themselves, believing their opinions were not worthy of consideration. In situations where asymmetrical power dynamics are at play, some questions pertinent to this study could include: what effects can unequal identity dynamics have on the research process? Are these dynamics likely to impact how the process is conducted, how it is designed, how meetings are conducted and controlled, what research questions take priority, how data is interpreted, et cetera? What advantages can we offer to the junior researchers in this study to mitigate some of the skewed power dynamics?

Procedural ethics and ethics in practice

Procedural ethics are the processes outlined and governed by academic conventions (20). In a process dominated by procedural ethics, researchers seek prior

ethical approval for research through institutional review boards (IRBs). An IRB located in a previously colonizing country might provide ethical oversight for a study conducted in a country where people continue to live with the effects of colonization (21,22); this is procedural ethics being informed and enforced by dominant power structures. However, in some countries practices have moved on considerably, for example, Australia, where Indigenous ethics cooperatives such as the Aboriginal Health Research Ethics Committee (AHREC), established in the 1980s, is a formally registered ethics forum where anyone wishing to conduct research matters with or about Aboriginal or Torres Strait Island People's priorities must consult this committee for approval. There are other contexts where no formal ethics committees exist. Then it is crucial for researchers to employ contextual reflexivity and consult within their teams, with participants and with relevant community stakeholders about how they will maintain ethical and respectful practice in the research process (15).

Ethics in practice are the everyday, situational, and unanticipated ethical issues that occur when doing research with others (11). A decolonial reading of ethics in research in modern institutions would see procedural ethics as essentially colonial in origin. For example, the notion that IRBs typically hold a zero-point perspective on confidentiality and informed consent in ethics; these standards are based on individual decision making and personal autonomy created and propagated for colonializers' purposes. These may be contrary to ethical, social, and moral practice in contexts where community and family consultation and group interdependence are important. Essentially the procedures and processes of IRBs are situated within a Euro-American Western epistemology and therefore do not and cannot morally be applied to all groups of people in all contexts and all parts of the world (1,3,22).

IRB approval should be obtained from the institutions of all international researchers. Researchers may want to ask themselves the following questions: if the research is being conducted in a Global South context, does the local institution have a formalized IRB? Is the concept of IRB approval considered foreign in the country of research? What tools will be used to ensure ethical research conduct? Am I making assumptions about ethics that are not aligned with the lived reality of the participants, researchers, or community in the study setting? Are there additional steps that I must take to ensure respectful relationships with stakeholders in the research project that are not specified by the IRB? Specifications need to be extended so that it is clear that additional steps are necessary when IRB specifications counter local community and contextual ethics. Some communities have begun established community-based ethics foundations and cooperatives to elevate contextually resonant ethical practices. Where these foundations do not yet exist because community ethics are considered embodied knowledge or communities have not yet deployed conscious agency to counterbalance externally introduced ethics systems, researchers must constantly reflect on whether IRB rules are consistent or in conflict with community ethics, in collaboration with research teams and community members.

In line with the iterative practices in qualitative research, researchers must question and challenge IRB decisions or imperatives that counter local and contextual conventions, norms, and accepted ways of engaging. Some communities may have begun established community-based ethics foundations and cooperatives to elevate contextually resonant ethical practices. Where these foundations do not yet exist because community ethics are considered embodied knowledge or communities have not yet deployed conscious agency to counterbalance externally introduced ethics systems, researchers must constantly reflect, in collaboration with research teams and community members, on whether IRB rules are consistent or in conflict with community ethics.

'Global health research ethics should be premised not upon passive accordance with existing guidelines on ethical conduct, but on tactile modes of knowing that rely upon being engaged with, and responsive to, research participants (23, p.29)'. We suggest that researchers must be accountable first to the ethics and expectations of local communities before IRBs. Often IRB knowledge of communities and contexts that researchers work in, especially when those are novel and foreign contexts, comes from those researchers themselves. Researchers in the field must engage iteratively and reflectively with community and contextual ethics in relation to IRB requirements (14).

Procedural ethics versus ethics in practice example

In a Global North–South collaboration exploring the lived experience of home-based caregivers, the Global North-based IRB approved financial compensation for participants being interviewed in the study. However, cultural convention in the local community expected that the researcher (seen as the host) provide a meal at the meeting. If the IRB specification was strictly followed, word would quickly spread around the community and participants would not turn up for the meeting once they realized that they would not receive a meal to sustain them on the long journey home. The ethics-in-practice decision made by researchers was to offer participants a meal, which was respectful of local expectation, and to overlook IRB specifications made by a committee located miles away or in a different country.

Discussion

Researchers in global health promotion have a responsibility to be disruptive, to look critically at the kind of research we do, and how we implement and situate our research within the broader world. This is the basis of generating new knowledge and perspectives in the context of global social justice in research practice. This framework aims to scaffold efforts at reflexive positioning at both the macro- and micro-level research contexts by using a decolonial lens to meaningfully disrupt entrenched hegemonic discrimination.

Whilst there are frameworks and interventions that address Equity, Diversity and Inclusion (EDI), cultural safety, and social accountability in Global Health research, our framework departs from these in some fundamental ways; we take a decolonial perspective which challenges the structural basis on which knowledge that underpins research is predicated. Conventional approaches hold tacit assumptions that have the sanction to include others in structures and institutions from which the researchers themselves draw power. This includes the assumption that researchers should create safety for others within the precepts of how safety is defined by power structures and to be accountable to structures from which they gain their legitimacy or credibility. In contrast, our decolonial approach encourages researchers to question where power in these structures originates and whether they have the right to control inclusion, govern accountability rules and determine what safety is for people from diverse cultures in diverse contexts.

The framework will not apply to all research projects in the same way. Some elements will be dominant or foregrounded, while others will not be directly relevant. Counterintuitively, the framework may be most applicable when a research project does not address race, equity, social justice, or other obvious forms of discrimination. In projects that are not considered socially controversial, issues of discrimination tend to be veiled and most salient. For example, in a study investigating how to teach residents about assessing cardiac patients, researchers need to ask themselves about the assumptions they make as they construct research questions, how the larger context might influence data, and who benefits from their research.

This framework represents a methodological contribution through which researchers may begin to look more critically at epistemological and ontological assumptions. It offers ways to access unconscious attitudes underpinned by (colonized) ways of seeing and doing research. Given that coloniality in research implies the perpetuation of research methods and approaches that emanate from colonially founded bases of knowledge, we propose that questioning these methods, guided by this framework, will challenge coloniality in research. The framework offers the opportunity to step back and notice and acknowledge embodied and taken for granted research practices, and to consider that what may be true for us as researchers may not apply in the same way to the people with whom we teach, study, and work.

This framework may align in part with EDI concepts, attitudes and recommendations; however, we pose that EDI is peculiar to North American literature on antiracism and discrimination in research. Therefore, the literature relates to 'equity, diversity, and inclusion' within existing systems based on Global North colonially based epistemologies. We question approaches that aim to change actions within existing systems and structures by specifically adopting an approach based in Decolonial theory. We take a position that interrogates and dismantles

existing systems and structures from the perspective that their basis in Global North ideology rejects against those who do not fit the norm of the zero-point White male perspective.

For those of us who come from marginalized, oppressed and neglected groups, contexts, locations, and identities, this framework can alert us to how we may have been co-opted or colluded into participating in oppressive work. It may also alert us to our unquestioning acceptance of the universality of ontological and epistemological notions inherited from a single dominant colonial mindset. The framework may provide means to acknowledge, reflect on, and constantly adjust our embodied presence in a research situation.

Declaration of conflicting interests

The authors have no conflicts of interest to declare.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

ORCID iD

Thirusha Naidu https://orcid.org/0000-0002-8154-790X

References

1. Tuhiwai-Smith L. Decolonizing Methodologies: Research and Indigenous Peoples. London: Zed Books; 1999.
2. Naidu T. Modern medicine is a colonial artifact: Introducing decoloniality to medical education research. Acad Med. 2021; 96: S9–S12.
3. Paton M, Naidu T, Wyatt TR, Oni O, Lorello GR, Najeeb U, et al. Dismantling the master's house: new ways of knowing for equity and social justice in health professions education. Adv Health Sci Educ Theory Pract. 2020; 25: 1107–1126.
4. Grosfuguel R. Decolonizing Western Universalisms: Decolonial Pluri-versalism from Aime Cesaire to the Zapatistas. In: Paraskeva JM (ed.). Towards a Just Curriculum Theory The Epistemicide. New York, NY: Routledge; 2018, pp.147–164.
5. Naidu T, Prose N. Re-envisioning member checking and communicating results as accountability practice in qualitative research: A South African community-based organization example. Forum Qual Sozialforschung / Forum Qual Soc Res. 2018; 19: 3153
6. Barlo S, Boyd WE, Hughes M, Wilson S, Pelizzon A. Yarning as protected space: relational accountability in research. AlterNative Int J Indig Peoples. 2021; 17: 40–48.
7. Jacobson D, Mustafa N. Social identity map: a reflexivity tool for practicing explicit positionality in critical qualitative research. Int J Qual Methods. 2019; 18: 1609406919870075.
8. Grosfoguel R, Hernández R, Velásquez ER. Decolonising the Western University. Interventions in Philosophies of Education from Within and Without. London: Lexington; 2016.
9. Fanon F. Black Skin, White Masks. New York, NY: Grove Press; 1952.
10. Silva JM, Fernández JS, Nguyen A. "And now we resist": three testimonios on the importance of decoloniality within psychology. J Soc Issues. 2022; 78: 388–412.
11. Shaw I. Ethics and the practice of qualitative research. Qual Soc Work. 2008; 7: 400–414.
12. Mignolo WD. The Darker Side of Western Modernity: Global Futures and Decolonial Options. Durham, NC: Duke University Press; 2011.
13. Quijano A. Coloniality of power, eurocentrism, and Latin American. Int Sociol. 2000; 15: 215–232.
14. Naidu T, Sliep Y. Contextual reflexivity: Towards contextually relevant research with South African HIV/AIDS home-based care volunteers. Int J Qual Methods. 2011; 10: 431–443.
15. Jamie K, Rathbone AP. Using theory and reflexivity to preserve methodological rigour of data collection in qualitative research. Res Methods Med Health Sci. 2022; 3: 11–21.
16. Given LM. Accountability the SAGE Encyclopedia of Qualitative Research Methods. Thousand Oaks, CA: Sage; 2008.
17. Maldonado-Torres N. On the coloniality of being. Cult Stud. 2007; 21: 240–270.
18. Kassan A, Nutter S, Green AR, Arthur N, Russell-Mayhew S, Sesma-Vasquez M. Capturing the shadow and light of researcher positionality: a picture-prompted poly-ethnography. Int J Qual Methods. 2020; 19: 1609406920977325.
19. Rowe WE. Positionality. In: Coghlan D, Brydon-Miller M (eds). The SAGE Encyclopedia of Action Research. Vols 1–2. London: Sage; 2014, pp.628–628.
20. Guillemin M, Gillam L. Ethics, reflexivity, and "ethically important moments" in research. Qual Inq. 2004; 10: 261–180.
21. Pollock K. Procedure versus process: ethical paradigms and the conduct of qualitative research. BMC Med Ethics. 2012; 13: 25.
22. Hunt MR, Godard B. Beyond procedural ethics: foregrounding questions of justice in global health research ethics training for students. Glob Public Health. 2013; 8: 713–724.
23. D'souza NA, Guzder J, Hickling F, Groleau D. The ethics of relationality in implementation and evaluation research in global health: reflections from the Dream-A-World program in Kingston, Jamaica. BMC Med Ethics. 2018; 19: 50.

Determinación social de la obesidad, la diabetes y la hipertensión arterial desde las narrativas de mujeres de una comunidad indígena en el sur de Morelos, México

María Ángeles Villanueva Borbolla[1], Agustín Pernia[2] y Marisol Campos Rivera[3]

Resumen :
Objetivo : comprender los procesos críticos (PC) de determinación social de la obesidad, la diabetes y la hipertensión (ODH) en una comunidad nahua de México.
Metodología : estudio cualitativo de registros de un taller de fotovoz, donde las participantes fotografiaron su entorno y analizaron las causas y posibles soluciones a la ODH. Para analizar los PC de la ODH utilizamos como método la investigación narrativa y, como referente teórico, la epidemiología crítica.
Resultados : la ODH se reproduce social e históricamente a través de PC destructivos vinculados con las relaciones de producción global y de género. Estas determinan modos de vida deteriorantes que limitan la atención a la salud, comprometen la salud mental, producen contaminación y diferenciación de uso de espacios, y reducen oportunidades para alimentarse nutritivamente y realizar actividad física. Todo ello se expresa como ODH y problemas de salud mental. Los PC protectores ante estas expresiones incluyen la atención estatal, las oportunidades de trabajo, y la promoción de dispositivos culturales y comunitarios.
Conclusiones : nuestros resultados aportan a la discusión global sobre cómo las condiciones históricas de vida son parte de la determinación social de la ODH. Comprender los PC y sus expresiones locales puede orientarnos hacia la descolonización de la forma de pensar y hacer promoción de la salud.

Palabras clave : determinación social, obesidad, diabetes, hipertensión arterial, investigación cualitativa, participación comunitaria, pueblos indígenas

1. Instituto Nacional de Salud Pública, Cuernavaca, México.
2. Universidad Autónoma Metropolitana, División de Ciencias Biológicas y de la Salud, Coyoacán, Ciudad de México, México.
3. Universidad Autónoma del Estado de Quintana Roo, Quintana Roo, México.

Correspondencia a: Agustín Pernia, Universidad Autónoma Metropolitana, División de Ciencias Biológicas y de la Salud. Calzada del Hueso 1100, Coyoacán, Ciudad de México, 04960, México. Email: pernia.agustin@gmail.com

(Este manuscrito fue presentado el 17 de mayo del 2023. Tras revisión por pares, fue aceptado para la publicación el 5 de octubre del 2023.)

Global Health Promotion 1757-9759; Vol 31(2): 59–69; 1211232 DOI: 10.1177/17579759231211232 journals.sagepub.com/home/ghp

Introducción

Las condiciones socioeconómicas, educativas y sanitarias desventajosas que viven las poblaciones indígenas las convierten en un grupo vulnerable frente a enfermedades como la obesidad, la diabetes y la hipertensión (ODH) (1). Particularmente en México, la obesidad en dicha población se incrementó de 28.6 % a 34.6 % entre el 2012 y el 2018 (2).

Tradicionalmente para el estudio de la ODH se ha utilizado la epidemiología basada en factores de riesgo. Sin embargo, esta se limita al plano empírico de la realidad observando exclusivamente relaciones causales. En contraposición, la epidemiología crítica, que surge de la Medicina Social Latinoamericana, sostiene que estas condiciones de salud-enfermedad están socialmente determinadas por lógicas estructurales que organizan la sociedad. Esto incluye el plano generativo de la realidad donde ocurren la génesis y la reproducción de procesos de salud-enfermedad. Así, entiende que el capitalismo (3), la organización patriarcal (4) y la colonización de los pueblos indígenas (5) determinan prácticas de cuidado y posibilidades de obtener empleo y condiciones de vida dignos. Dichas lógicas operan a partir de procesos críticos (PC) que son nodos clave en la determinación-protección de la salud-enfermedad y resultan útiles para proponer estrategias de promoción de la salud situadas y locales (3).

Particularmente en pueblos indígenas, la ODH resulta de la articulación de procesos históricos, sociales y biológicos. Los estudios refieren que el aumento de estas y de los consumos de sustancias y alcohol, está determinado socialmente por procesos originados en las lógicas que estructuran las sociedades: colonización, urbanización, contaminación y transformación de los modos de vida (5,6).

Por lo tanto, es necesario adoptar enfoques críticos y comprehensivos para estudiar la salud-enfermedad en dichos pueblos, que reconozcan su concepción integral de la salud y relación con el entorno y la comunidad (7,8). Esto permite incorporar a la trama causal de padecimientos otras dimensiones como las emociones (9), distinguiéndose del enfoque biomédico.

Proponer estrategias para enfrentar dichas problemáticas de salud-enfermedad debe considerar su historia, cultura y modos de vida (1). En este sentido, la descolonización en promoción de la salud amplía la reflexión hacia la inclusión de conocimientos tradicionales para su fortalecimiento (8). Para lograrlo, se recomienda impulsar espacios de reflexión crítica y metodologías participativas (10). Esto apoya la comprensión de los fenómenos desde quienes los viven y brinda respuestas desde la organización comunitaria. Además, es necesario incorporar perspectivas que visibilicen aspectos estructurales y de género implícitos en los procesos de participación (11).

Por lo anterior, nuestro objetivo es comprender los PC de determinación social de la ODH en una comunidad de origen nahua, desde las narrativas de mujeres que participaron en talleres de fotovoz. Esto para recuperar críticamente los saberes locales que aporten al diseño de iniciativas de promoción de la salud.

Métodos

Contextualización

La comunidad de origen nahua se encuentra al sur poniente del estado de Morelos, México. En el 2010 tenía aproximadamente 21 000 habitantes y pertenecía a uno de los municipios con mayor pobreza de Morelos (12). Más de la mitad de su población no tenía seguridad social y el analfabetismo alcanzaba al 13 % de las personas de 15 años o más (13). Desde hace varias décadas, el comercio y la oferta de servicios desplazaron a la agricultura como principal actividad económica.

Metodología

Estudio cualitativo de investigación narrativa (14) de los registros de un taller de fotovoz durante el 2010. El enfoque cualitativo profundiza en la complejidad de lo singular (3) desde la experiencia de quienes participan en el estudio. Adicionalmente, la investigación narrativa sustenta un proceso de construcción de un relato de la vida social a partir del diálogo de distintas voces y referentes teóricos, situándolo en un contexto histórico (14).

Fotovoz es una herramienta de investigación-acción-participativa que utiliza fotografías tomadas por las personas para reflejar sus necesidades, promover el diálogo y fomentar la acción (15). El taller mencionado formó parte de un diagnóstico para construir un plan de salud comunitario y se desarrolló en 13 sesiones con 21 participantes mujeres distribuidas en cuatro grupos, quienes

tomaron fotografías de su entorno sobre los temas que identificaron como causas de ODH. Cada una eligió de 1 a 3 fotografías por tema y con estas realizaron colectivamente esquemas explicativos. De estos últimos, eligieron la fotografía más representativa para realizar el ejercicio de VENCER (interpretación del acrónimo de "SHOWED"), que implica llevar la discusión desde un nivel concreto y personal hacia el análisis social y acción organizada (15). Con ello, cada grupo realizó una fotohistoria de ODH en su comunidad y sus posibles soluciones. Grabamos y registramos las sesiones bajo consentimiento informado, en el cual las participantes aprobaron el uso del material generado para futuras publicaciones. El estudio fue aprobado por el Comité de Ética en Investigación del Instituto Nacional de Salud Pública.

Nuestro análisis consistió en la reinterpretación de las narrativas de las participantes plasmadas en los materiales visuales y escritos producidos en el taller. Utilizamos como herramienta interpretativa la investigación narrativa y como marco teórico la epidemiología crítica.

La epidemiología crítica entiende que la salud se encuentra determinada socialmente por el movimiento entre los PC ubicados en los dominios singular, particular y general de la realidad. El singular comprende las respuestas y explicaciones que las personas otorgan a la salud-enfermedad según su subjetividad, recursos y estilos de vida. Lo anterior se desenvuelve en el dominio particular, en el seno de los modos de vida propios del grupo social. A su vez, el particular se mueve dentro del general, en el sistema de distribución de poder correspondiente a la producción y a la propiedad (3).

Los dominios se relacionan jerárquicamente mediante dos movimientos simultáneos y opuestos: subsunción y autonomía relativa. La subsunción va en el sentido general-particular-singular e implica la reproducción de la organización social hegemónica de distribución de poder. La autonomía relativa explica la capacidad de incidencia en la dirección singular-particular-general para generar otras formas de organización. Los PC adquieren una proyección destructiva si provocan deterioro en la calidad de vida y una proyección protectora si contribuyen favorablemente a su desarrollo (3).

Metodológicamente, reinterpretamos las narrativas de las participantes a partir de la investigación narrativa (14). Esta distingue cuatro momentos analíticos:

1. Generación y registro: ordenamos la información contenida en registros escritos, de audio e imágenes producidos durante los talleres.
2. Nivel textual: sistematizamos la información a través de una matriz-resumen de cada grupo.
3. Nivel contextual: identificamos en las matrices-resumen los procesos que las participantes narraron sobre las causas y posibles acciones sobre la ODH en su contexto. Basamos la codificación abierta en las dimensiones de la epidemiología crítica, utilizando las siguientes categorías: lógicas de producción, consumo y Estado, y condiciones geo-ecológicas para el dominio general; patrones de trabajo y consumo, cosmovisión, formas organizativas y relaciones ecológicas para el dominio particular; y estilos de vida familiares e individuales para el dominio singular.
4. Nivel metatextual: Analizamos y reestructuramos las narrativas en tres etapas. Primero, revisamos los fragmentos codificados de la narrativa en cada grupo de participantes y los organizamos dentro de las categorías descritas, resultando una matriz de datos analizados para cada grupo. Segundo, conjuntamos los datos en una matriz general. En este momento, identificamos los PC y sus movimientos de subsunción y autonomía relativa. Tercero, reconfiguramos las narrativas sintetizándolas en cada categoría.

Resultados

Las participantes tenían entre 25 y 55 años. La mayoría estudió primaria o secundaria, vivía en pareja, tenían hijos/as y su ocupación principal era el trabajo en el hogar.

Para presentar los resultados, seguimos la lógica del ejercicio VENCER, es decir, de lo concreto a la explicación y acción. Comenzamos identificando las expresiones más visibles narradas por las participantes hasta desentrañar los PC destructivos determinantes de la organización social. Finalmente, visibilizamos los PC protectores ante la problemática de la ODH en la comunidad. En el texto indicamos en letra cursiva los PC.

La Figura 1 muestra los PC en los diferentes dominios, así como sus movimientos. En la Tabla 1 incluimos citas textuales de las reflexiones y fotohistorias creadas.

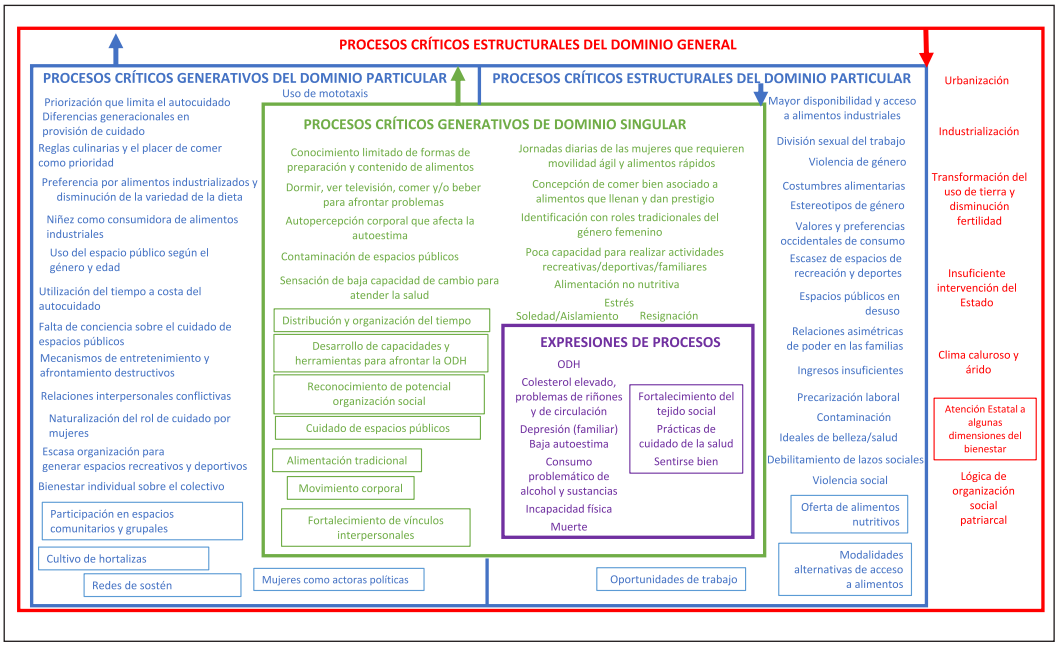

Figura 1. Relaciones jerárquicas, de reproducción y generación de la determinación social en una comunidad indígena en Morelos, México.

Fuente: Elaboración propia (2023).
Descripción de figura: Cada cuadrado representa un dominio. Así, del centro de la figura hacia afuera, encontramos: primero, expresiones de salud-enfermedad; segundo, procesos generativos del dominio singular; tercero, procesos del dominio particular, del lado izquierdo están los generativos, y del lado derecho los estructurales; cuarto, procesos estructurales del dominio general. Los procesos protectores se distinguen de los destructivos al estar dentro de un recuadro. Para indicar los movimientos, utilizamos flechas. Cuando estas señalan hacia el centro de la figura, indican subsunción, y cuando señalan hacia afuera significan autonomía relativa.

¿Qué es lo que Vemos?: expresiones de procesos destructivos

Las participantes identificaron la *ODH* como expresiones destructivas prevalentes. La explicación sobre la génesis de dichas expresiones no se limitó a una *alimentación no nutritiva*. La salud mental y *las relaciones interpersonales conflictivas* se consideraron centrales en la *ODH*, así como el *consumo problemático de alcohol y sustancias*. Esto afecta la vida emocional y la economía familiar.

Se identificó que la *baja autoestima* afecta el cuidado de la salud individual y comunitaria. Adicionalmente, la *depresión* se experimenta individual y familiarmente. Esta puede originarse por el rechazo hacia las personas con *obesidad* y la *sensación de soledad* ante un problema. Asimismo, se vincula con el *estrés* derivado de *relaciones interpersonales conflictivas*, situaciones económicas adversas y la falta de reconocimiento del trabajo del hogar. Finalmente, se relaciona con la *diabetes* y la *muerte*.

Explicando qué y cómo suceden los PC destructivos cotidianamente: movimientos singulares y particulares

Limitaciones para la atención y cuidado de la salud

La *priorización y utilización del tiempo se realizan a costa del autocuidado*. Las familias con situaciones económicas adversas priorizan sus gastos. Ello limita realizar actividades familiares, la inversión en la atención a la salud y el acceso a alimentos.

El cuidado personal sucede de manera diferencial para las mujeres. Su triple carga de trabajo (del hogar, de cuidado y remunerado) disminuye el

Tabla 1. Fragmentos de las fotohistorias y citas de las reflexiones de las participantes de los cuatro grupos del taller de fotovoz en una comunidad indígena en Morelos, México, durante el 2010.

Nivel explicativo de acuerdo con el VENCER	*Fragmento o cita*
¿Qué es lo que Vemos?: expresiones de procesos destructivos	"Había una señora con sobrepeso que siempre se sentía mal y se deprimía mucho por su condición física y sus enfermedades . . . ella padecía diabetes, presión alta y ya empezaba a tener problemas en la vista; siempre se le veía triste y se agotaba pronto, un día una vecina la invitó a hacer ejercicio, pero ella no aceptó, pensaba dentro de sí misma que si iba solo haría el ridículo vestida con ropa deportiva pero la vecina siguió insistiendo . . .un día se animó a ir, pero no le gustó porque quedó exhausta y adolorida en el cuerpo y pensó que le estaba haciendo daño. . ." (fotohistoria colectiva del grupo 2)
Explicando qué y cómo suceden los procesos críticos destructivos en la vida cotidiana: dinámicas y movimientos a nivel singular y particular	"La ODH son consecuencia de (. . .) los malos hábitos de alimentación, el comer en horarios no establecidos, así como por un descuido al ser madres y no tener tiempo para preparar alimentos sanos." (relato de una participante del grupo 3)" "Yo soy la única mujer, salirme de la casa de mi esposo es como irles a dar problemas a mis hermanos y mis papás (. . .) Mi esposo es de los que no dice nada, él nunca ha dicho vámonos o hagamos nuestra casa para apartarnos (. . .)" (relato de una participante del grupo 1) "A veces estamos nerviosos y comemos y comemos (. . .) porque yo soy una de esas que a cada rato come y come, cuando estoy nerviosa (. . .)" (relato de una participante del grupo 4) "(. . .) anteriormente pus éramos más activas, ahorita con lo de las benditas mototaxis que nos ayudan a no caminar (. . .)" (relato de una participante del grupo 1) ". . . ahora los jóvenes prefieren pasarse sus tiempos libres en los cyber sentados frente a la computadora y no nada más por una hora, a veces te haces adicto a eso (. . .) pudiendo estar en el campo deportivo, no sé, jugando" (relato de una participante del grupo 2) ". . . hay canchas vacías, porque no hay seguridad para los niños, por eso hay padres que no van con sus hijos (. . .) hay muchas cosas por las que uno no usa las canchas, no las cuidamos" (relato de una participante del grupo 2) "[En la foto vemos] una señora planchando. . . ella es una de esas personas que no hacen ejercicio, dice que prefiere hacer su quehacer que andar en la calle. [. . .]" (relato de una participante del grupo 2) ". . . recordé que cuando era yo niña también me gustaba jugar fútbol fuera de casa en un callejón [con] varios vecinos para formar equipos. . . [A] mi mamá no le gustaba que yo estuviera fuera de casa (. . .) decía que yo corría riesgo (. . .) por los borrachos que estaban en la cancha y los muchachos que se drogaban. Ahora que he crecido me doy cuenta que mi mamá tenía un poco de razón (. . .), pero también a mí me afectó mucho porque me alejé de los deportes" (relato de una participante del grupo 2) "(. . .) conocí a una señora que le da a su bebé Coca en el biberón y al preguntarle por qué dice que su hijo no es burro para que le dé agua" (relato de una participante del grupo 2) "Vivimos en un pueblo y nuestra forma de comer se basa en las costumbres de aquí, es lo que vemos en nuestra comunidad, nos enseñan y es una cadena de muchos años" (relato de una participante del grupo 2). "(. . .) Hay muchas tienditas, los niños desde temprano, desde las 8am con la Coca ya está en la mano (. . .) Gente que no hace de comer, no almuerza, pero sí come gansitos y refrescos" (relato de una participante del grupo 1) "mi suegra luego decía - "ay, por qué no le das de comer, parece que tú trabajas, para eso mijo trabaja (. . .) luego dice -tu hijo está gordito porque está sano, come, su papá trabaja no está de huevón, (. . .) [El niño] está bonito o qué ¿lo quieres todo flaco, como a esos niños que andan desnutridos?" (relato de una participante del grupo 1)

(Continued)

Tabla 1. (Continued)

Nivel explicativo de acuerdo con el VENCER	*Fragmento o cita*
Causas: la determinación estructural general y particular	"el refresco, tomábamos anteriormente de a poquito, pero ellos como tienen dinero, ellos se pueden comprar una Coca cada uno. Eso es personalmente lo que yo asociaba anteriormente. El poder de tener dinero te puedes alimentar como tú quieres." (relato de una participante del grupo 1) "(. . .) la falta de productividad en el campo ocasiona estrés en cada familia y en todo el pueblo." (relato de una participante del grupo 2) "(. . .) Anteriormente había patios grandes y se juntaban los primos a jugar, ahora todo son espacios pequeños." (relato de una participante del grupo 1) "(. . .) últimamente se está utilizando mucha química en lo que cosechan." (relato de una participante del grupo 1)
Posibles respuestas y fortalezas: procesos protectores de la salud colectiva	"(. . .) porque el pueblo tiene muchos recursos (. . .) Vas al campo y no tienes dinero, está la verdolaga, le digo que está el huauzontle" (relato de facilitadora originaria de la localidad, del grupo 1) "Pequeñas hortalizas; tenemos tierra y pa ayudarnos económicamente." (relato de una participante del grupo 1) "(. . .) por carros vienen a vender fruta de la estación bien barata pero no consumimos." (relato de una participante del grupo 1) "(. . .) invitar a la gente (. . .) a caminar, contar nuestra experiencia, animarlos a hacer ejercicios (. . .) pedir apoyo al delegado para que nos apoye con más talleres, más deportes y andar en un grupo de danza, como el chinelo, es un buen deporte (. . .)" (relato de una participante del grupo 2) "Aprendimos a escuchar, a entendernos entre nosotras y pues más que nada platicar nuestras experiencias, y olvidarnos un poco de todo lo demás." (relato de una participante del grupo 1) "(. . .) nosotros podemos ayudar. . . realizando campañas sobre los temas, talleres, carteles. . . poniéndolo en práctica todo lo que se está aprendiendo y ayudar a la familia o a las personas que todavía no lo quieran hacer (. . .)" (relato de una participante del grupo 3)

Fuente: Elaboración propia (2023).

tiempo disponible para sí mismas. Se *naturaliza* que asuman el *rol de cuidado* familiar y las actividades de reproducción sin recibir reconocimiento ni remuneración.

Problemas y mecanismos de afrontamiento que comprometen la salud mental

En la comunidad, se acostumbra que cuando las parejas jóvenes deciden vivir juntas, la mujer se muda a la casa familiar del varón. Frecuentemente, la suegra es una figura de poder en su hogar, estableciendo normas sobre cuidado y alimentación. Ello puede generar conflictos entre mujeres y, ante esta situación, los varones normalmente no intervienen. Esto origina *estrés*, que, con la percepción de falta de apoyo, contribuye a que las mujeres jóvenes desarrollen sensaciones de *soledad* y *resignación*.

Por otra parte, la *autopercepción corporal afecta la autoestima*. El acceso a los servicios de salud se da de manera tardía por la percepción de *no poder generar cambios oportunos para atender su salud*.

En algunos casos, *dormir, ver televisión, comer y/o beber* constituyen refugios durante el tiempo libre y mecanismos para evadir y sobrellevar las emociones, el *estrés* y los conflictos. Estas *formas de entretenimiento y afrontamiento generan sedentarismo, aislamiento y consumos problemáticos* de alcohol, sustancias y alimentos.

Actividad física insuficiente

Las emociones y sensaciones como la *soledad*, *resignación*, *autopercepción corporal* y fatiga por angustia o exceso de trabajo generan que las personas sean menos activas físicamente y permanezcan en sus hogares. La sensación de dolor y agotamiento después del ejercicio produce su rechazo.

Además, el *uso de mototaxis* para trasladarse es compatible con las *jornadas diarias de las mujeres*. Estas requieren movilidad ágil para cumplir con sus actividades y protegerse del *clima caluroso*.

Por último, la *organización para generar espacios recreativos y deportivos es poca y aislada*. Ante la *escasez de espacios seguros y adecuados*, las personas optan por *entretenimientos sedentarios*.

Contaminación y uso diferenciado de los espacios públicos

La *poca conciencia del cuidado de dichos espacios*, el manejo inadecuado de la basura y la poca limpieza de las calles generan *contaminación*. Esto desincentiva la *capacidad de realizar actividades deportivas, recreativas y familiares*. La *baja autoestima* dificulta mantener limpio el espacio común.

Existe un *uso diferenciado del espacio público según el género y la edad*. El significado de "andar en la calle" difiere si se es joven o mujer. En el primer caso, sobre todo varones, se vincula con el consumo de sustancias y alcohol. La *identificación con roles y prácticas tradicionales asociadas al género femenino* desincentiva la práctica de ejercicio y el *uso de espacios públicos* con dicho fin al concebirse como un descuido del hogar. Dejar este espacio genera en ellas sentimientos de desconfianza y vergüenza. Además, las mujeres deben pedir autorización a sus esposos y suegras para salir. Específicamente, a las niñas no se les permite jugar fuera de casa por temor a que sufran violencia sexual.

Alimentación no nutritiva

Se prefiere el *consumo de alimentos industrializados* y hay *disminución de la variedad de la dieta*. Por restricciones económicas, las familias compran alimentos básicos que quitan el hambre y llenan.

La *concepción de comer bien está asociada a alimentos llenadores y de prestigio*. Los alimentos industrializados y altos en grasas e hidratos de carbono simples sacian el hambre, son considerados sabrosos, optimizan los tiempos disponibles, y diferencian el consumo humano del animal.

A largo plazo, estos procesos instalan *costumbres alimentarias* no cuestionadas y reproducidas en la comunidad. Algunas *reglas culinarias dominan*; por ejemplo, el refresco acompaña el almuerzo y repara del trabajo extenuante, y *el placer como prioridad al comer*.

La *niñez es considerada consumidora privilegiada de alimentos industrializados*, ya que las personas adultas fomentan su consumo por su prestigio y por el *conocimiento limitado de formas de preparación* y *contenido de alimentos*. Además, existen *diferencias generacionales en torno a la forma de proveer cuidado a la niñez*; las mujeres mayores consideran que comer mucho y sin restricciones garantiza salud y fortaleza.

Causas: la determinación estructural general y particular

Relaciones de producción globales expresadas en lo local

En la comunidad, la lógica de producción, en la que predominaba la agricultura, se transformó hacia la *industrialización*. El trabajo campesino es poco remunerado. A esto se suma el *clima árido*, la *disminución de la fertilidad de la tierra* y la *transformación de su uso* para actividades no agrícolas. Esto hace que la generación de recursos para la subsistencia dependa de las oportunidades de empleo en el tercer sector o de la comercialización de productos industriales en la localidad.

Lo anterior favorece la *disponibilidad y el acceso* a alimentos industrializados, comparativamente con los frescos. Las narrativas expresaron *ingresos insuficientes* para comprar frutas y verduras, sin embargo, esta restricción no opera sobre los industrializados. Esto pareciera indicar una progresiva adopción de *valores y preferencias occidentales de consumo*.

Además, existe un contexto de *precarización laboral*, en el cual los empleos ofrecen bajos salarios y menos prestaciones. La pluriactividad es la respuesta para obtener recursos para sobrevivir, y con ello se reduce el tiempo disponible.

La *urbanización* se ha incrementado en la comunidad. El patio y los espacios al aire libre en las casas se redujeron, disminuyendo la posibilidad de juego activo para las niñeces y de socialización familiar. Asimismo, se refiere una *escasez de espacios para la convivencia y recreación*, como también la *contaminación* de las calles, donde abundan puestos,

mototaxis y basura. Las canchas y *espacios públicos* tienen poco mantenimiento y son inseguros, por lo que se encuentran *abandonados y se utilizan poco*.

Como respuesta a lo anterior, y a una percepción del incremento en la *violencia social*, las personas toman como medida de protección quedarse en casa. Asimismo, se produce *debilitamiento de los lazos sociales*, que se hace visible a través de actitudes de desconfianza y rechazo entre habitantes, y de falta de comunicación familiar.

Finalmente, la acción e *inversión del Estado ante estas problemáticas resultaba insuficiente* para las participantes. Estas expresaron la falta de programas y políticas que permitieran la conservación de espacios públicos, garantizaran la seguridad de sus usuarios/as e impulsaran eventos culturales y deportivos. Por otro lado, refirieron que no existían iniciativas que fomentaran la agricultura local, manejo de residuos sólidos, recolección de basura y limpieza de los cuerpos de agua, así como la atención y prevención de problemas de salud mental. En su opinión, los/as funcionarios/as públicos/as que gozan de representatividad política en la comunidad, con frecuencia no desarrollan su programa de gobierno como lo espera la población.

Organización de las relaciones de género

La *división sexual del trabajo* entre varones y mujeres organiza las tareas cotidianas de la comunidad, donde ellas ocupan una posición desventajosa en términos económicos, participativos, de reconocimiento y de carga laboral.

La *violencia de género* se manifiesta hacia las mujeres como control social, violencia sexual y exigencia de apegarse a los *ideales de belleza* y sumisión. En cuanto a dichos ideales, notamos contradicciones. Por un lado, las personas en la localidad aprecian un cuerpo grande como símbolo de riqueza y buen estado de salud. Por otro, este mismo tipo de cuerpo se caracteriza como enfermedad, generando burlas, apodos y vergüenza.

Los *estereotipos de género* afectan a hombres y mujeres. Si ellas llevan a cabo las tareas reproductivas podrán ser respetadas; mientras que la "virilidad" de ellos se limita a su rol de proveedor e inexpresión de sus emociones. Dichos estereotipos se reproducen al interior de las familias, generando *relaciones asimétricas de poder*. Según las participantes, algo que distingue a la comunidad es que las actividades y decisiones de las jóvenes quedan supeditadas a las expectativas y permisos que otorguen su pareja varón y la suegra.

Posibles respuestas y fortalezas: procesos protectores de la salud colectiva

Se incluyen tanto procesos existentes, como aquellos que necesitan generarse y fortalecerse. En el dominio general, ubicaron la *atención estatal hacia algunas dimensiones del bienestar* tal como la provisión de ingresos mediante programas sociales y atención primaria de salud. También, la creación de *oportunidades de trabajo* remunerado favorece el bienestar familiar.

Como protectores frente a la *alimentación no nutritiva*, destacan en los dominios particular-singular: las *modalidades alternativas de acceso a alimentos* locales; la *oferta de alimentos ricos en nutrimentos y fibra*; las *prácticas alimentarias tradicionales* como el uso de hierbas comestibles silvestres y el *cultivo de hortalizas*. Para hacer frente al sedentarismo, el *movimiento corporal*, a través del juego, baile y caminata, favorece la salud. Estas prácticas se relacionaron con la espiritualidad y reivindicación cultural.

En la comunidad existen muestras de solidaridad y apoyo. La *participación en los espacios comunitarios y grupales* permite intercambiar experiencias. Asimismo, constituyen mecanismos para solicitar apoyo a las autoridades locales, brindar contención ante problemas y ofrecer compañía para realizar actividades recreativas y deportivas. El *fortalecimiento del tejido social* se favorecería al *reforzar los vínculos interpersonales*, desarrollar capacidades de comunicación basadas en el diálogo y sostener relaciones recíprocas y colaborativas.

Durante el taller, el *reconocimiento del potencial de la organización social* permitió generar mayor sensibilidad y agencia sobre la ODH. Las participantes se asumieron como *actoras políticas y agentes de cambio*, al expresar su papel como parte de *redes de sostén*.

Estos procesos protectores permitirían a las personas generar *prácticas de cuidado de la salud* y *sentirse bien*. Esta última expresión se asoció al optimismo, la alegría, la felicidad con la familia y a una niñez sana y feliz.

Discusión

Con el análisis propuesto, dilucidamos los PC involucrados en la determinación social de la ODH en una comunidad nahua. Estos se encuentran determinados por las relaciones de producción global expresadas en lo local y las de género que estructuran su organización social.

En las relaciones de producción, identificamos que la lógica de organización capitalista a nivel global transformó el modo de vida local: de estar vinculado con la actividad y ciclo agrícola hacia uno dependiente del modelo de producción industrial. Se ha documentado que esto genera cambios en las relaciones entre las comunidades y su territorio, lo que a su vez afecta los procesos de salud-enfermedad (16).

En la comunidad identificamos como efectos de dichas transformaciones: la alimentación no nutritiva, la contaminación ambiental, la disminución de la fertilidad del suelo y la precarización laboral. En Latinoamérica algunos estudios muestran cómo la desvinculación entre comunidad-territorio introdujo alimentos industriales en las comunidades (4), cambió las formas de trabajo y redujo los espacios para el cultivo (16). Otros más, identificaron la marginación social (17), el estrés crónico y la contaminación ambiental (18) como procesos involucrados en la obesidad.

También encontramos que, a través de la lógica de consumo capitalista, se instalaron símbolos asociados a la alimentación. Además de optimizar los tiempos disponibles, los alimentos industrializados significan prestigio económico-social. Por esto, adquirirlos para las niñeces representa proporcionarles una mejor calidad de vida. Esto mismo se encontró en otras comunidades en México (19).

Refiriéndonos a las relaciones de género, Lemke y Delormier (1) explican su participación en la determinación de la malnutrición mediante dos tipos de violencia. Una es la estructural, manifestándose en la asimetría de poder e inequidades en las oportunidades de vida. La segunda es la cultural, que legitima la anterior mediante prácticas, tradiciones e instituciones culturales (1).

De acuerdo con las narrativas, la ODH obedece a ambos tipos. Por un lado, la división sexual del trabajo y la identificación con los roles y estereotipos de género limita a las mujeres en términos económicos, productivos y de reconocimiento, y les genera una triple carga de trabajo. Por el otro, estos procesos son legitimados en la familia, ejerciendo un control social sobre las mujeres. Lo anterior desincentiva que utilicen los espacios públicos para hacer ejercicio. Esto mismo fue reportado en otro estudio con población chontal en México (4).

El carácter participativo de la investigación permitió reconocer procesos protectores aún presentes en la comunidad y que necesitan potenciarse. Entre estos identificamos la solidaridad, los dispositivos culturales (danza, alimentación tradicional y muestras de apoyo), la participación en espacios comunitarios, la organización social y el fortalecimiento del tejido social. Mediante estos procesos, y en concordancia con la cosmovisión de los pueblos indígenas, el cuidado de la salud se asume como acto colectivo y no individual.

La descolonización en la promoción de la salud implica poner en práctica metodologías que incluyan diversos conocimientos en la solución de problemas, reconociendo sus aportes específicos (8). En nuestro caso, la herramienta fotovoz revaloriza el conocimiento local de las participantes sobre la forma de organización y distribución del poder en la comunidad. Asimismo, utilizando la epidemiología crítica, comprendimos las dinámicas entre procesos, alejándonos de una noción de causalidad estática y unilateral. Este enfoque, lejos de atribuir el proceso de salud-enfermedad a factores de riesgo, cuestiona las lógicas hegemónicas que generan inequidad. Lo anterior permite desnaturalizar la realidad como un escenario dado y, por lo tanto, transformarla (3). Así se pueden diseñar estrategias de promoción de la salud y abordaje de ODH que sean científicamente sólidas, dialoguen con otras cosmovisiones (8) y respeten la diversidad cultural (5).

No obstante, el conocimiento local y tradicional también es minado por nociones que resultan de la inserción en las relaciones de producción global y de género. Coincidimos con Lemke y Delormier (1) sobre no romantizar las sociedades indígenas que también pueden perpetuar la injusticia. En nuestro estudio, la interiorización del discurso que responsabiliza únicamente al individuo de su salud y la naturalización de la organización social patriarcal estuvieron presentes en las narrativas. Esto último se reflejó también en que solo asistieron mujeres al taller de fotovoz. A pesar de que realizamos una convocatoria específica para hombres, no representó un interés para ellos.

Por lo anterior, practicar una promoción de la salud descolonizadora (8) requiere crear espacios para problematizar dicha interiorización. También, demanda recuperar recursos existentes (10), experiencias locales y conocimientos tradicionales que plantean formas distintas de entender la realidad. Incorporarlas a la comprensión crítica del proceso epidemiológico permite encontrar claves para generar otras formas de organizar la sociedad y, de esta manera, promover la salud (7).

Una limitación de utilizar las narrativas del taller de fotovoz, es que este no se planeó para identificar procesos determinantes de la ODH. Subsanamos lo anterior a partir del análisis metatextual. Otra limitación es que no se incluye en la narrativa la perspectiva de los hombres de la comunidad.

Reconocemos también que las condiciones locales pudieron haber cambiado desde la realización del taller. Sin embargo, sostenemos que los procesos determinantes de la ODH para los pueblos indígenas en México persisten. La evidencia da cuenta de la continuidad del rezago socioeconómico (20). Adicionalmente, dos hitos evidenciaron y profundizaron las desigualdades sociales: el sismo del 2017 en Morelos (21) y la pandemia de la COVID-19. Con respecto a este último, el acceso a los alimentos se redujo debido al aumento de sus precios y a la pérdida de fuentes de ingreso. Además, se cancelaron proyectos productivos dirigidos a dichas comunidades (22).

Por otro lado, desde el 2020 se realizaron transformaciones en los servicios de salud en México, pero los pueblos indígenas continúan enfrentándose a condiciones estructurales de discriminación y exclusión que impactan negativamente en el uso de servicios (20). Esto advierte que, incluso cambiando los modelos de atención y financiamiento de los servicios de salud, dichos pueblos viven formas específicas e históricas de dominación y subordinación en diferentes ámbitos de desarrollo de la vida social que deberían considerarse en los programas y políticas de salud.

Nuestros resultados aportan a la discusión global sobre cómo las condiciones de vida son parte de la red causal de ODH. Si bien los PC estructurales descritos pueden ser generalizables a varias comunidades, los desenlaces particulares y singulares deben ser analizados en cada caso. La metodología de fotovoz y la epidemiología crítica constituyen herramientas efectivas para ello. Además, permiten el diálogo entre diferentes sistemas de conocimientos y pueden orientarnos hacia la descolonización de la forma de pensar y hacer promoción de la salud.

Agradecimientos

A las diseñadoras, facilitadoras y participantes de los talleres que apostaron por reflexionar y actuar colectivamente para crear mundos distintos.

Declaración de conflicto de intereses

Ningún conflicto declarado.

Financiación

Financiado por Fondos Mixtos Conacyt - Morelos -MOR-2009-CO2-120654.

ORCID iDs

María Ángeles Villanueva Borbolla https://orcid.org/0000-0002-7657-1729

Agustín Pernia https://orcid.org/0000-0001-5901-5379

Marisol Campos Rivera https://orcid.org/0000-0002-0866-9337

Referencias

1. Lemke S, Delormier T. Indigenous Peoples' food systems, nutrition, and gender: conceptual and methodological considerations. Matern Child Nutr. 2017; 13(S3): e12499.
2. Shamah-Levy T, Campos-Nonato I, Cuevas-Nasu L, Hernández-Barrera L, Morales-Ruán M, Rivera-Dommarco J, et al. Sobrepeso y obesidad en población mexicana en condición de vulnerabilidad. Resultados de la Ensanut 100k. Salud Publica Mex. 2019; 61: 852–865.
3. Breilh J. Epidemiología crítica. Ciencia emancipadora e interculturalidad. Buenos Aires: Lugar Editorial; 2003.
4. Cruz Sánchez M, Tuñon Pablos E, Villaseñor Farías M, Álvarez Gordillo G, Nigh Nielsen R. Desigualdades de género en sobrepeso y obesidad entre indígenas Chontales de Tabasco, México. Poblac Salud Mesoam. 2012; 9: 1–22.
5. Stanley LR, Swaim RC, Kaholokula JK, Kelly KJ, Belcourt A, Allen J. The imperative for research to promote health equity in indigenous communities. Prev Sci. 2020; 21(Suppl 1): 13–21.
6. Gracey M, King M. Indigenous health part 1: determinants and disease patterns. Lancet. 2009; 374: 65–75.
7. IUHPE World Conference on Health Promotion. Waiora – Indigenous Peoples' Statement for Planetary Health and Sustainable Development [Internet]. Rotorua, Aotearoa New Zealand: IUHPE World Conference on Health Promotion; 2019 [citado el 10

de noviembre del 2023]. Disponible en: https://www.iuhpe.org/images/CONFERENCES/world/2019/Indigenous_People_statement_es.pdf
8. Sánchez-Pimienta CE. Sobre el cuestionamiento de los supuestos coloniales en la promoción de la salud. Glob Health Promot. 2023; 30: 83–86.
9. Frank S, Durden T. Two approaches, one problem: cultural constructions of type II diabetes in an indigenous community in Yucatán, Mexico. Soc Sci Med. 2017; 172: 64–71.
10. Villanueva-Borbolla MA, Cervantes-Ortega E, Campos-Rivera M. Análisis de la capacidad de respuesta comunitaria para desarrollar iniciativas de promoción de la salud. Glob Health Promot. 2020; 27: 187–197.
11. López-Bolaños L, Campos-Rivera M, Villanueva-Borbolla M. Compromiso y participación comunitaria en salud: aprendizajes desde la sistematización de experiencias sociales. Salud Publica de Mex. 2018; 60: 192–201.
12. Consejo Nacional de Evaluación de la Política de Desarrollo Social (CONEVAL). Pobreza municipal 2010. Morelos [Internet]. México: CONEVAL; 2010 [citado el 2 de septiembre del 2022]. Disponible en: https://www.coneval.org.mx/coordinacion/entidades/Morelos/Paginas/pob_municipal.aspx
13. CONEVAL. Rezago Social 2010. Morelos [Internet]. México: CONEVAL; 2010 [citado el 2 de septiembre del 2022]. Disponible en: https://www.coneval.org.mx/coordinacion/entidades/Morelos/Paginas/rezago_social.aspx
14. Arias Cardona AM, Alvarado Salgado SV. Investigación narrativa: apuesta metodológica para la construcción social de conocimientos científicos. Rev CES Psicol. 2015; 8: 171–181.
15. Wang C, Morrel-Samuels S, Hutchison P, Bell L, Pestronk R. Flint photovoice: community building among youths, adults and policymakers. Am J Public Health. 2004; 94: 911–913.
16. Hirsch S, Alonso V. La emergencia de la diabetes en una comunidad tapiete de Salta: género, etnicidad y relaciones con el sistema de salud. Salud Colect. 2020; 16: e2760.
17. Vázquez-Durán M, Jiménez-Corona M, Moreno-Altamirano L, Graue-Hernández E, Guarneros N, Jiménez-Corona L, et al. Social determinants for overweight and obesity in a highly marginalized population from Comitán, Chiapas, Mexico. Salud Pública Mex. 2020; 62: 477–486.
18. Ford ND, Patel SA, Narayan KM. Obesity in low- and middle-income countries: burden, drivers, and emerging challenges. Annu Rev Public Health. 2017; 38: 145–164.
19. Théodore FL, Bonvecchio A, Lozada Tequeanes AL, Alvarado R, García-Guerra A, Villanueva Borbolla MA, et al. Challenges around child-feeding practices with 'Comida Chatarra': a qualitative study to understand the role of sociocultural factors in caregiver feeding decisions. Nutrients. 2023; 15: 1317.
20. Pelcastre-Villafuerte BE, Avila-Burgos L, Meneses-Navarro S, Cerecer-Ortiz N, Montañez-Hernández JC. Use of outpatient health services by Mexicans aged 15 years and older, according to ethnicity. *Int J Environ Res Public Health*. 2023; 20: 3048.
21. Ortiz RM, Reséndiz RF, Ortiz CMJ, Martínez RM, Ortiz CM, Bazán CAG. El sismo del 19 de septiembre. ¿Cómo enfrentamos la crisis en Morelos, México?. Cad Metróp. 2018; 20: 325–345.
22. Aura Investigación Estratégica, Centro de Capacitación en Ecología y Salud Para Campesinos y Defensoría del Derecho a La Salud (CCESC), Tlachinollan Centro de Derechos Humanos de La Montaña, Centro de Derechos Humanos Fray Bartolomé de Las Casas, Centro de Derechos Indígenas (CEDIAC), Consultoría Técnica Comunitaria (CONTEC), et al. Los pueblos y comunidades indígenas frente al Covid-19 en México [Internet]. 2020 [citado el 10 de noviembre del 2023]. Disponible en: https://www.ohchr.org/Documents/HRBodies/SP/COVID/NGOs/Centro_de_Derechos_Humanos_de_la_Montaña_Tlachinollan.pdf

Género, infodemia y desinformación en salud. Revisión de alcance global, vacíos de conocimiento y recomendaciones

Daniela Luz Moyano[1,2], María Silveria Agulló-Tomás[2,3] y Vanessa Zorrilla-Muñoz[2,4]

Resumen

Objetivo: explorar el estado de la literatura científica sobre los aspectos de infodemia y desinformación en salud vinculados al género y a la interseccionalidad, detectar vacíos de conocimiento y brindar recomendaciones.

Métodos: revisión de alcance global, con la detección de vacíos de conocimiento y recomendaciones. Se buscó en ocho bases de datos: MEDLINE (Pubmed), Anthropological Index Online, Studies on Women & Gender Abstracts, LILACS, Scielo, Global Index Medicus, Web of Science, Google académico y se hizo una búsqueda manual en Google de documentos de los últimos 10 años, sin restricciones de idioma y geográficas. Se realizó un análisis de contenido de los estudios incluidos.

Resultados: 855 registros fueron identificados y 21 cumplieron con los criterios de inclusión. Predominan los estudios que tuvieron como primer autor/a una mujer (13/21), aunque en la autoría global se destacaron los hombres (10/21). El modelo binario fue el enfoque principal (16/21). La mayoría (18/21) se publicaron a partir del 2020. Se abordaron principalmente temas relacionados con la COVID-19 y la salud sexual y reproductiva (antes de la pandemia), y en menor medida la salud mental. Se identificaron interacciones entre diferencias de sexo/género en la desinformación/infodemia en salud especialmente en mujeres, colectivos de género diverso, personas mayores y población de bajo nivel socioeducativo.

Conclusiones: existen brechas de conocimiento en el tema explorado, con escaso número de estudios, y limitaciones de alcances y del enfoque de género y/o feminista (más allá del binario). No obstante, los resultados tentativos constatan la presencia de inequidades de género e interseccionalidad en la desinformación en salud.

Palabras clave: infodemia, desinformación, género, COVID-19, revisión sistemática

1. Departamento de Ciencias de la Salud, Universidad Nacional de La Matanza, San Justo, Buenos Aires, Argentina.
2. Instituto Universitario de Estudios de Género, Universidad Carlos III de Madrid, Getafe, Madrid, España.
3. Departamento de Análisis Social, Universidad Carlos III de Madrid, Getafe, Madrid, España.
4. Instituto de Bioingeniería, Universidad Miguel Hernández de Elche, Comunidad Valenciana, España.

Correspondencia a: Daniela Luz Moyano, Departamento de Ciencias de la Salud, Universidad Nacional de La Matanza, Florencio Varela, San Justo, 1903, Buenos Aires, Argentina. Email: moyanodaniela12@gmail.com

(Este manuscrito fue presentado el 10 de julio del 2023. Tras revisión por pares, fue aceptado para la publicación el 4 de noviembre del 2023.)

Global Health Promotion 1757-9759; Vol 31(2): 70–79; 1216945 DOI: 10.1177/17579759231216945 journals.sagepub.com/home/ghp

Introducción

El enfoque de género en la comunicación en salud es necesario para que las intervenciones sean efectivas y ayuden a eliminar las brechas (1), buscando cubrir las necesidades desde la intersección (2) promoviendo la aceptabilidad de las recomendaciones (3,4).

En algunos países de América Latina y el Caribe y, en España, se ha demostrado la escasa perspectiva de género en las iniciativas de comunicación durante la pandemia de la COVID-19 (5,6), así como de otros determinantes sociales tales como etnia y discapacidad (6) y desde un enfoque interseccional y antiedadista (7).

La invisibilización del género también se documentó en las políticas de salud implementadas durante la emergencia y se han generado múltiples efectos negativos en la vida de las mujeres y colectivos de género diversos (8).

La comunicación en salud tiene un papel clave en el comportamiento y en la creación de actitudes en diferentes audiencias (9,10).

Sin embargo, durante la pandemia se ha generado una explosión global de información, lo que se conoce como infodemia. Esta desinformación surge habitualmente de una presencia de información inexacta, datos falsos o engañosos que se transmiten a través de redes sociales y que, gran parte, están basados en teorías de conspiración (11) cuyo impacto negativo resulta mayor en grupos vulnerables (12), como personas mayores, mujeres, colectivos LGBTQ+, minorías y población con vulnerabilidad socioeducativa. En este contexto se puede plantear la presencia de un enfoque de interseccionalidad (13,14), que reconoce los efectos combinados de las diferentes categorías sociales.

Antes de la pandemia, ya se había reportado cómo el género –en especial el ser mujer– afecta el acceso a la información y las formas en que responden a la enfermedad (1) siendo susceptibles a la desinformación especialmente en contextos de crisis (12).

La desinformación puede resultar dañina para la salud individual y pública (15). Las noticias denominadas 'fake news' son un problema complejo y sin resolver (16) y los errores de comunicación tanto desde los gobiernos (6,17) como a través de diferentes medios y entidades (18,19) fueron evidenciados en diferentes continentes, dando lugar a problemas bioéticos y movimientos negacionistas.

En este trabajo se indagaron los siguientes objetivos: explorar el estado actual de la literatura científica sobre aspectos de la infodemia y desinformación en salud vinculados al género y a la interseccionalidad antes y después de la pandemia causada por la COVID-19, detectar algunos de los vacíos de conocimiento y brindar recomendaciones.

Materiales y métodos

Diseño

Estudio en dos etapas: 1) revisión de alcance (*scoping review* en inglés) (20,21), que permitió una aproximación global a un cuerpo de literatura científica desde un enfoque de género e interseccionalidad (8,13,14,22) en temas de desinformación e infodemia en salud (11); 2) detección de vacíos de conocimiento y generación de recomendaciones.

Las etapas llevadas a cabo durante la revisión (21) fueron: definición de la pregunta (enfoque amplio), identificación (búsqueda en diferentes fuentes) y selección de estudios relevantes, extracción de información y resumen de los resultados (enfoque narrativo e identificación de brechas).

A continuación, se definen las principales dimensiones de análisis exploradas de manera específica, buscando indagar en sus vinculaciones.

Definiciones y enfoques

- Contexto de la literatura científica: geografía (país), temporalidad (año de publicación y de análisis, momento –antes o durante la pandemia de la COVID-19–), diseño, objetivo, sexo de la primera y resto de autorías (categorías: hombre o mujer; imputación a partir de prefijos, pronombres, nombres, bibliografías o imágenes en línea o redes profesionales).
- Enfoque analítico de género desde la interseccionalidad (8,13,14,22). La intersección de diferentes categorías sociales (raza, clase, género, edad y discapacidades) generan un aumento de la vulnerabilidad y dan como resultado un estatus social, económico y cultural desigual. A partir del análisis global del contenido de los documentos, se incluyó el enfoque de género predominante utilizado en los textos. Categorías: Binario (cuando hacía referencia a femenino/masculino, mujer/hombre, niña/niño,

madre/padre, chicas/chicos, mujer, mujer embarazada, o gestante) y Diverso (refiriendo a lesbiana, gay, bisexual, transgénero, travesti, intersex, queer u otras identidades LGBTQ+).
- Enfoque analítico de infodemia y desinformación en temas de salud. La infodemia se refiere a una explosión de información (sobreinformación) en un periodo corto, dando lugar a la desinformación donde aparecen rumores basados en información falsa con el propósito deliberado de engañar (11). A partir del análisis global del contenido se determinó el enfoque predominante. Categorías: infodemia/desinformación, ambas, y otras emergentes relacionadas con ellas.

Criterios de selección

Criterios de inclusión: se incluyeron todos los documentos que respondían a los criterios de interés desde un proceso "post hoc" y de familiarización con la literatura científica de la última década, sin restricciones de idioma, geográfica, o de diseños (revisiones sistemáticas y narrativas, estudios experimentales, longitudinales, descriptivos, ensayos, cualitativos, resúmenes de políticas, y documentos técnicos), que abordaron de manera central el género junto a la infodemia o desinformación en temas de la salud (en objetivos, título o resultados principales).

Criterios de exclusión: textos que abordaron información (sin incluir desinformación/infodemia) en: brecha digital, digitalización, alfabetización en salud, aceptabilidad de las vacunas, necesidades de información, estrategias de diseminación, roles de las redes sociales, ciberactivismo, y estilo de comunicación y cuando en análisis la variable género/sexo fue de ajuste (sin reportar datos estratificados). No se consideraron los textos en preprint, resúmenes de congresos o ponencias, información en sitios web o estudios de protocolo.

Estrategias de búsqueda

Se utilizó un marco temporal de los últimos 10 años (2013–2023). La búsqueda se realizó mediante estrategias en bases de datos en línea provenientes de diferentes áreas disciplinares: MEDLINE (Pubmed), Anthropological Index Online, Studies on Women & Gender Abstracts, Scielo, Global Index Medicus (GIM que incluye los índices regionales: AIM, IMEMR, IMSEAR, WPRO, con una búsqueda independiente en la base LILACS), Web of Science, Google académico y búsqueda manual en Google. Las búsquedas se llevaron a cabo desde el 17 de marzo hasta el 9 de mayo del 2023 (Archivo complementario 1: estrategias de búsqueda).

Se generaron y probaron diferentes estrategias amplias y sensibles diseñadas para cada base de datos a partir de términos en inglés, portugués y español. Se eliminaron los duplicados encontrados en las diferentes bases.

La primera selección fue a través de la evaluación de títulos y resúmenes, luego los seleccionados fueron analizados en texto completo y se revisaron todas las referencias (tanto en incluidos como excluidos).

Si no se pudo acceder a un texto completo potencialmente relevante, se intentó contactar al autor/a. Las citas se gestionaron con EndNote 20.

Extracción de datos y análisis

Se implementó un proceso de extracción de información y un análisis de contenido cualitativo (23) en los documentos incluidos.

La sistematización de la información se llevó a cabo en una planilla de datos en línea. Para mejorar la validez y mitigar posibles sesgos de información, los datos recolectados fueron revisados al menos dos veces, tres revisoras independientes (DLM, MSAT y VZM) evaluaron la relevancia de los documentos a incluir (incluyendo un mecanismo de consenso) y una muestra de estudios excluidos durante la etapa inicial se revisó a texto completo. La síntesis de resultados se realizó de manera narrativa.

Consideraciones éticas

Se llevó a cabo una revisión de la literatura científica a partir de documentos disponibles y accesibles, no en personas ni en datos personales, por lo que se encuentra exento de una evaluación ética.

Resultados

Características generales. De los 855 registros identificados por las estrategias de búsqueda y 17 por búsqueda manual, 36 documentos fueron

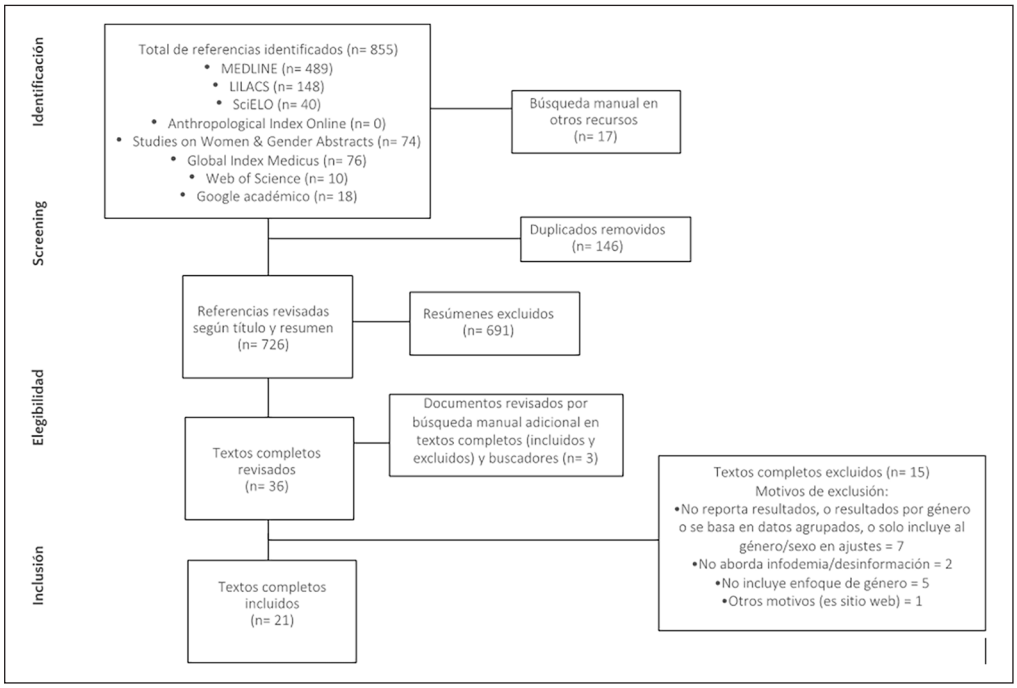

Figura 1. Flujograma de la revisión de alcance.

revisados a texto completo, y 21 cumplieron con los criterios de inclusión (6,24–43) (Figura 1), 14 estaban en inglés, 5 en español y 2 en portugués.

Los estudios incluidos cubrieron en sus análisis al menos un país de la región europea ($n = 1$), de las Américas ($n = 9$, 4 de América Latina y el Caribe y 5 de América del Norte), África ($n = 3$) y Asia ($n = 5$). No se encontró ninguno proveniente de Oceanía, tres tuvieron un alcance de más de un continente o general (Archivo complementario 2: Tabla de resumen de los estudios incluidos).

Los estudios se basaron principalmente en diseños cuantitativos a partir de encuestas, y en menor medida cualitativos, y revisiones; uno de cohorte y un ensayo. La mayoría (18/21) se publicaron a partir del 2020 (durante la pandemia de la COVID-19). Más de la mitad tuvo como primer autor/a una persona del género mujer (13/21). Sin embargo, en 10/21 trabajos dentro de la autoría global predominaron los hombres.

El modelo binario fue el enfoque principal (16/21); y el foco estuvo en la categoría de desinformación. Se encontraron otras categorías emergentes como: creencias conspirativas, fatalismo religioso, mitos y percepciones erróneas, nociones preconcebidas, intenciones o indecisión de vacunación o tratamiento, percepciones sobre infodemia, actitudes negativas, exposición a información, narrativas mediáticas, consulta de información y creencias inexactas.

Los grupos de interés abordados en los trabajos fueron especialmente mujeres y personas adultas y pocos en personas mayores, también algunos refirieron a embarazadas, estudiantes y otras minorías de sexo y género.

La mayoría abordó temáticas relacionadas con la prevención de la COVID-19 y la vacunación (9/21), la salud sexual y reproductiva (SSyR), incluyendo aborto, enfermedades de transmisión sexual (ETS) y otros aspectos de la salud (9/21), y en menor medida la salud mental (3/21).

Vinculaciones entre el género, desde el enfoque de interseccionalidad, y la infodemia/desinformación en salud

A continuación, se presentan los resultados organizados según los diferentes tópicos de salud abordados en los estudios incluidos que consistieron en: prevención de la COVID-19 y vacunación, salud mental, SSyR y otros aspectos de la salud.

Los trabajos enfocados en la COVID-19 fueron predominantes. En cuanto a la vacunación, el estudio de Gao *et al.* (29) en Pakistán mostró que las creencias de conspiración conllevan más dudas sobre las vacunas entre las mujeres, siendo ellas más vulnerables a la infodemia y a la influencia de las creencias conspirativas.

Otro estudio (39) en África Subsahariana demostró que la creencia de que la COVID-19 está diseñada para reducir la población mundial estuvo asociada al género femenino (OR 1.54, IC 95 % 1.17-2.02; $p = 0.002$), mientras que no se encontró dicha asociación en el grupo masculino.

Gelgel *et al.* (34) reportaron diferencias entre los géneros sobre la información errónea, indicando que más mujeres que hombres es probable que difundan esta información. Sin embargo, en la misma investigación se indicó que cuando se ofrece información incorrecta sobre la COVID-19, tanto hombres como mujeres reaccionan casi igual.

Pedraza Bucio (37) postuló cómo en medio de la infodemia que acompaña la crisis, las noticias falsas no solo se distribuyen por las plataformas digitales sino que se extienden a través de la comunicación personal.

Otro estudio realizado en los 47 países de América Latina y el Caribe (6) mostró que en 35 países (74.5%) hubo al menos un producto con información errónea y en 13 (27.7%) no se encontró ningún producto que abordara la prevención de la infodemia. En este mismo contexto, solo en 4 países se incluyó productos con enfoque de género.

Los estudios sobre salud mental se llevaron a cabo durante la pandemia. En un trabajo en Canadá (38), los análisis mostraron que para los hombres, el Trastorno de Ansiedad Generalizada moderadoo severo, se asoció con una exposición frecuente a noticias falsas (OR entre 3.14 y 6.55; $p < 0.01$) en las diferentes categorías de frecuencia, y para las mujeres fue de un OR 1.88 ($p = 0.009$) en la categoría de varias veces al día.

Dos estudios (35,42) abordaron el grupo de personas mayores y mostraron que la exposición a la información se relacionó con repercusiones en la salud mental, siendo el grupo femenino más susceptible a los efectos de la infodemia (42).

La investigación de Kitamura *et al.* (35) en personas de más de 60 años de Brasil, indicó que los signos y síntomas de cambios psicopatológicos estuvieron presentes en el 3.8% de las mujeres y en el 5.9% de los hombres, asociados a un menor nivel educativo, a una disminución de los ingresos pospandemia y a que las personas mayores se sintieron afectadas por las noticias sobre la COVID-19 en redes sociales.

La revisión de Delgado *et al.* (42) sobre las repercusiones de la infodemia en la salud mental de personas adultas y mayores durante la pandemia de la COVID-19, identificó que la ansiedad está muy presente en contexto de infodemia y que las mujeres y adultos jóvenes fueron los más afectados.

Otra parte importante de los documentos abordó la desinformación relacionada con la SSyR, y todos fueron realizados antes de la pandemia. Los subtemas se basaron en prevención de las ETS, como el Virus de Papiloma Humano (VPH) y el virus de la Inmunodeficiencia Humana (VIH) (28,31,33). En dos estudios se indagó sobre el aborto (32,43).

El estudio de Jaiswal *et al.* (33) en minorías sexuales reportó la presencia de desinformación, y que compartieron información incorrecta con elementos correctos sobre el VIH y las ETS, lo que sugiere que algunos mensajes de salud pública han sido efectivos, pero el VPH no se ha abordado lo suficiente.

Grov *et al.* (28) en su análisis en minorías sexuales de Estados Unidos sobre anuncios en redes sociales sobre la preexposición a la profilaxis del VIH, mostraron que las personas negras, latinas y/o multirraciales tenían más probabilidades de verse afectadas negativamente por los anuncios, con percepciones de que estos anuncios les hacían pensar que la profilaxis preexposición no era segura.

El estudio de Patev y Hood (43) sobre el aborto indicó la presencia de información errónea sobre este tema y de creencias inexactas, concluyendo que ampliar el conocimiento puede ser un primer paso para comprender mejor este fenómeno.

Otro estudio (32) en mujeres en Estados Unidos que se presentaron para una visita de información sobre el aborto en cuatro centros de planificación familiar, postuló que la información inexacta se asoció con una disminución en el conocimiento de las mujeres sobre esta temática, violando los principios aceptados del consentimiento informado.

Andrade-Rivas y Romero (31) a partir de datos representativos de Colombia, reportaron que las mujeres colombianas más jóvenes, ricas y con mayor nivel de estudios tienen más probabilidades de apoyar a sus hijos homosexuales y aprobar los derechos de las parejas del mismo sexo, mientras que

las mujeres con conceptos erróneos respecto al VIH y a la homosexualidad son menos propensas.

El estudio de Blanc *et al.* (24), a partir del análisis de mensajes de texto de un programa en Nigeria que permite a jóvenes hacer preguntas sobre SSyR, mostró que éstas transmiten confusión, desinformación y urgencia.

En cuanto a la población gestante, la publicación de Ennab *et al.* (26) expresó las preocupaciones de las mujeres embarazadas sobre la seguridad de las vacunas y las dudas sobre los efectos a largo plazo en este grupo, amplificadas por la desinformación que parecen jugar un papel primordial en la tasas de aceptación.

Se encontraron estudios que abordaron otros temas como la infección alimentaria por trematodos hepáticos en Tailandia (25), mostrando una asociación entre la desinformación y la masculinidad en cuanto al abordaje y prevención. Otra investigación en minorías de género, discutió sobre desinformación y acceso a servicios de salud (27).

Solo un antecedente (36) enunció la violencia de género y la desinformación en diarios impresos durante la pandemia en Ecuador, mostrando cómo estos canales se caracterizaron por una reducción de información, con el uso de estereotipos.

Detección de vacíos de conocimiento. A partir de la revisión se pudieron identificar diferentes brechas de conocimiento por la escasa bibliografía científica disponible en la temática, como también específicas en cuanto a los grupos vulnerables abordados. Se encontró una ausencia de trabajos en niños, niñas y adolescentes y en grupos minoritarios, indígenas o personas con discapacidades. Se detectaron escasos antecedentes en colectivos de la diversidad sexual y de género, en poblaciones de diferentes etnias y razas e incluso, en personas mayores.

También se visualizaron lagunas en los temas de salud explorados (casi todos los estudios se enfocaban en la COVID-19 y antes de la pandemia a la SSyR).

Se generaron recomendaciones generales sociopolíticas a partir del análisis de documentos (6,24–43) organizadas en 3 niveles de acción (Archivo complementario 2: recomendaciones).

Discusión

Principales resultados

La pandemia causada por la COVID-19 hasta el 10 de mayo del 2023 no solo ha dejado más de 765 millones de casos confirmados y cerca de 7 millones de muertes en todo el mundo (44), sino que la infodemia y la desinformación sobre la nueva enfermedad también se han convertido es un desafío y una amenaza a nivel global (18,45). Tal como se muestra en los resultados de este análisis, existieron importantes desigualdades de género desde el enfoque de interseccionalidad, prestando especial atención a los colectivos vulnerables.

Comparación de los hallazgos con estudios previos

Los estudios incluidos fueron generados principalmente en el contexto de la pandemia de la COVID-19 y se contextualizan en un escenario en el que el enfoque de género y la interseccionalidad no se han considerado en la mayor parte de las medidas sociosanitarias impulsadas durante la pandemia a nivel global como se ha constatado en una revisión previa (8).

A todo esto, se une el hecho de que el problema de la desinformación y el uso de información falsa se vuelve especialmente importante en ciertos contextos (46), en especial en las crisis sanitarias, humanitarias, bélicas o en los desastres naturales.

A pesar de las brechas de conocimientos encontradas (solo 21 artículos a nivel global respondieron a los criterios de inclusión), en este trabajo se mostró la existencia de intersecciones entre las inequidades de género y la desinformación que podrían haberse profundizado especialmente durante la pandemia de la COVID-19 pero que ya se habían documentado previamente en otros temas de salud como la SSyR, presentándose en diferentes grupos vulnerables como mujeres y colectivos de diversidad provenientes de las regiones de África, Asia y América (24,28,31–33,43).

Durante la pandemia se ha indicado cómo las estrategias para enfrentarla, así como las formas y los canales de comunicación elegidos para difundirlas, no respondieron a las necesidades por sexo/género, clase y etnia (47), ni de edad (7). Los documentos encontrados durante este periodo mostraron la presencia de desinformación, información falsa y de creencias conspirativas sobre el virus y la vacunación que afecta mayoritariamente a las mujeres (29,34,37,39). Posiblemente, aparecen más en un contexto de emergencia con políticas de salud y protección ciegas al género (8) reforzadas por políticas de comunicación no inclusivas y con errores (6).

En esta revisión, y como lo han constatado estudios previos en el campo del género y políticas de salud (8,48), se destacan de manera central las limitaciones propias de la bibliografía disponible en cuanto a su alcance analítico, desde un enfoque predominantemente binario; siendo necesario recopilar datos interseccionales (49).

Si bien en este trabajo no se ha profundizado sobre enfoques conceptuales de los estudios primarios más allá de las categorías binaria/diversa presentes en los documentos, pudieron existir limitaciones en la profundización de estas categorías y en la distinción entre los conceptos de orientación sexual, identidad y la expresión de género.

También se identificaron brechas en los temas de salud abordados, enfocados en los efectos inmediatos de la infodemia sobre el nuevo coronavirus y antes de la pandemia en el campo de la Salud Sexual y Reproductiva relacionados con el género. Se visualizaron vacíos en otras áreas centrales en el campo explorado necesarias de ser consideradas para la recuperación y que están íntimamente relacionadas con los determinantes sociales de la salud, como por ejemplo, implicaciones en los medios de subsistencia, envejecimiento poblacional y edadismo, inseguridad alimentaria, crisis climática, endeudamiento y aumento de la pobreza, como la ausencia de bibliografía en algunos grupos prioritarios desde la interseccionalidad como la raza, la etnia y la discapacidad. Ideas relacionadas, aunque no específicas a la desinformación sobre las limitaciones de la literatura científica desde una perspectiva feminista fueron reportadas previamente en el trabajo de Agarwal (50).

En esta revisión no se ha evaluado la calidad de los estudios incluidos. Sin embargo, se ha podido visualizar que existen escasos estudios cualitativos, diseños longitudinales (para capturar variaciones de la desinformación en el tiempo) y de métodos mixtos.

En este sentido, una revisión previa destacó que se necesitan estudios longitudinales para comprender cómo la infodemia afecta, por ejemplo, a la salud mental a largo plazo (42), en grupos de mujeres y personas mayores.

Como se mostró en esta revisión, y al igual que en la antes mencionada, entre las consecuencias más negativas de la desinformación se encuentran el impacto en la salud mental y el rechazo a las vacunas (51).

A pesar de las limitaciones de los documentos, los hallazgos muestran la presencia de desinformación vinculada a inequidades de género que se presentan junto a otros determinantes interseccionales, como diversidad sexual, edad, raza, nivel educativo y estatus socio-económico. Por todo ello, las estrategias de comunicación tienen un papel importante en la conversación interseccional (52).

Fortalezas y limitaciones

Las principales fortalezas de este estudio consisten en el abordaje integral del género interseccional en la desinformación en salud y la detección de brechas que puede servir tanto para las políticas, estrategias, acciones comunitarias y generación de conocimiento, como de interés para diferentes sectores y partes involucradas.

El propósito de este trabajo no fue comparar sistemáticamente los estudios ni realizar una síntesis cuantitativa, sino describir el estado del arte sobre el tema.

También pudo existir información que no fue capturada por las estrategias de búsquedas limitadas a tres idiomas (aunque el idioma no fue criterio de exclusión) y, durante la etapa de selección inicial, por cuestiones de factibilidad, solo una revisora tamizó todas las referencias.

Otra limitación en los datos fue la imputación del género/sexo de la autoría a partir de información en línea y no autopercepción de las propias personas.

Como se ha indicado, se tomaron medidas para minimizar los sesgos de información aunque no podemos descartar el sesgo de publicación relacionado con un mayor caudal de datos científicos generado durante la pandemia de la COVID-19.

La originalidad de este trabajo se sustenta desde diferentes aspectos, por un lado, que la búsqueda de documentos publicados en la última década permitió comparar diferentes escenarios en cuanto a las características principales de bibliografía científica para poder detectar vacíos de conocimiento del tema. Abordar el trabajo desde un enfoque de género e interseccionalidad permitió un análisis amplio de diferentes dimensiones y categorías relevantes relacionadas con el género en la desinformación en salud que puede servir de base para futuras investigaciones sobre preguntas específicas y trasladarlas a otras áreas y enfoques. Las recomendaciones generadas tienen un amplio potencial, pudiendo ser reproducibles, aunque previamente adaptadas a los contextos de crisis presentes y futuros.

Conclusiones

Se concluye que es necesario generar más investigación en el campo explorado con el reto de reducir la brecha actual de conocimiento. La evidencia disponible está alertando sobre la presencia de inequidades en especial en mujeres, colectivos de diversidad de género y otros grupos vulnerables como personas mayores y de bajos niveles socioeducativos vinculados a la infodemia, noticias falsas y la desinformación en salud.

Agradecimientos

Al Instituto Universitario de Estudios de Género, Universidad Carlos III de Madrid, por la acogida y el apoyo institucional a Daniela Luz Moyano, a través del programa de estancias internacionales de investigación para el desarrollo de este estudio y al Programa I+D ENCAGEn-CM (H2019/HUM-5698, 2019-2023), en el que también se enmarca parte del desarrollo de este trabajo.

Contribuciones de autoría

DLM diseñó el estudio. DLM diseñó la estrategia de búsqueda y realizó las búsquedas. DLM, MSAT y VZM revisaron la pertinencia de los textos completos de los artículos relevantes. La interpretación inicial de los datos fue realizada por DLM. Los datos y las referencias seleccionadas fueron revisados por DLM, MSAT y VZM. La redacción del borrador original fue realizada por DLM. La aportación y consulta de algunas referencias y la revisión del manuscrito, por DLM, MSAT y VZM. Todas las autoras aprobaron la versión final del manuscrito.

Declaración de conflictos de interéses

Ningún conflicto declarado.

Financiación

Ninguna financiación declarada.

ORCID iD

Daniela Luz Moyano https://orcid.org/0000-0003-2728-9708

Material complementario

Este artículo tiene material complementario disponible en línea.

Referencias

1. Liuccio M. Gender, health, and communication. J Commun Healthc. 2015; 8: 5–6.
2. Couto MT, Oliveira ED, Separavich MAA, Luiz OdC. La perspectiva feminista de la interseccionalidad en el campo de la salud pública: revisión narrativa de las producciones teórico-metodológicas. Salud Colect. 2019; 15: e1994.
3. Reddy BV, Gupta A. Importance of effective communication during COVID-19 infodemic. J Family Med Prim Care. 2020; 9: 3793–3796.
4. Afolabi MO, Folayan MO, Munung NS, Yukubu A, Ndow G, Iegede A, et al. Lessons from the Ebola epidemics and their applications for COVID-19 pandemic response in sub-Saharan Africa. Dev World Bioeth. 2021; 21: 25–30.
5. Villegas-Tripiana I, Villalba-Díaz A, López-Villegas A. Análisis de la información sobre COVID-19 en sitios web de organizaciones públicas sanitarias. Rev Esp Comun Salud. 2020; (Suppl 1): 235–242.
6. Moyano D, Mendivil LL. Productos comunicacionales para la prevención de la COVID-19 promovidos por los gobiernos de América Latina y el Caribe. Rev Panam Salud Publica. 2021; 45: e111.
7. Fernández-Mayoralas G, Schettini R, Sánchez-Román M, Rojo-Pérez F, Agulló-Tomás MS, Forjaz MJ. El papel del género en el buen envejecer. Una revisión sistemática desde la perspectiva científica. Revista Prisma Social. 2018; 21: 149–176.
8. Moyano DL, Martínez ML, Martínez LL. Gender and social protection and health policies promoted during the COVID-19 pandemic: global scoping review and future challenges. J Glob Health. 2022; 12: 05056.
9. Sharma P, Gupta S, Kushwaha P, Shekhawat K. Impact of mass media on quality of life during COVID-19 pandemic among Indian population. Int J Sci Healthc Res. 2020; 5: 260–267.
10. Dhanashree, Garg H, Chauhan A, Bhatia M, Sethi G, Chauhan G. Role of mass media and it's impact on general public during coronavirus disease 2019 pandemic in North India: an online assessment. Indian J Med Sci. 2021; 73: 21–25.
11. Organización Panamericana de la Salud. Entender la infodemia y la desinformación en la lucha contra el COVID-19 [Internet]. Washington, DC: Organización Panamericana de la Salud; 2020 [citado el 26 de agosto del 2023]. Disponible en: https://iris.paho.org/bitstream/handle/10665.2/52053/Factsheet-Infodemic_spa.pdf
12. Flor LS, Friedman J, Spencer CN, Cagney J, Arrieta A, Herbert ME, et al. Quantifying the effects of the COVID-19 pandemic on gender equality on health, social, and economic indicators: a comprehensive review of data from March, 2020, to September, 2021. Lancet. 2022; 399: 2381–2397.
13. Bilge S. Recent feminist outlooks on intersectionality. Diogenes. 2010; 57: 58–72.
14. Crenshaw K. Mapping the margins: intersectionality, identity, and violence against women of color. Stanford Law Rev. 1991; 43: 1241–1300.
15. Office of the Surgeon General (OSG). Confronting Health Misinformation: The U.S. Surgeon General's Advisory on Building a Healthy Information

Environment [Internet]. Washington, DC: US Department of Health and Human Services; 2021 [citado el 11 de mayo del 2023]. Disponible en: https://pubmed.ncbi.nlm.nih.gov/34283416/
16. Aïmeur E, Amri S, Brassard G. Fake news, disinformation and misinformation in social media: a review. Soc Netw Anal Min. 2023; 13: 30.
17. Seytre B. Erroneous communication messages on COVID-19 in Africa. Am J Trop Med Hyg. 2020; 103: 587–589.
18. Caceres MMF, Sosa JP, Lawrence JA, Sestacovschi C, Tidd-Johnson A, Rasool MHU, et al. The impact of misinformation on the COVID-19 pandemic. AIMS Public Health. 2022; 9: 262–277.
19. Rathore FA, Farooq F. Information overload and infodemic in the COVID-19 pandemic. J Pak Med Assoc. 2020; 70(Suppl 3): S162–S165.
20. Pham MT, Rajić A, Greig JD, Sargeant JM, Papadopoulos A, McEwen SA. A scoping review of scoping reviews: advancing the approach and enhancing the consistency. Res Synth Methods. 2014; 5: 371–385.
21. Arksey H, O'Malley L. Scoping studies: towards a methodological framework. Int J Soc Res Methodol. 2005; 8: 19–32.
22. Mukhopadhyay C, Blumenfield T, Harper S, Gondek A. Gender and sexuality. In: Brown N, McIlweaith T, Tubelle de Gonzalez L (eds). Perspectives: An Open Invitation to Cultur- al Anthropology. 2nd ed. Arlington, VA: Society for Anthropology in Community Colleges; 2020: 282–335.
23. Altheide D. Reflections: ethnographic content analysis. Qual Sociol. 1987; 10: 65–77.
24. Blanc AK, Glazer K, Ofomata-Aderemi U, Akinfaderin-Agarau F. Myths and misinformation: an analysis of textmessages sent to a sexual and reproductive health Q&A service in Nigeria. Stud Fam Plann. 2016; 47: 39–53.
25. Wang YC, Grundy-Warr C, Namsanor J, Kenney-Lazar M, Tang CJY, Goh LYW, et al. Masculinity and misinformation: social dynamics of liver fluke infection risk in Thailand. Parasitol Int. 2021; 84: 102382.
26. Ennab F, Babar MS, Khan AR, Mittal RJ, Nawaz FA, Essar MY, et al. Implications of social media misinformation on COVID-19 vaccine confidence among pregnant women in Africa. Clin Epidemiol Glob Health. 2022; 14: 100981.
27. Argyriou K. Queerentena y desinformación sobre minorías de género: Efectos en accesibilidad a servicios. Dilemata. 2022; 38: 177–192.
28. Grov C, Westmoreland DA, D'Angelo AB, Johnson J, Nash D, Daskalakis DC. Together 5000 team. Marketing of Tenofovir Disoproxil Fumarate (TDF) lawsuits and social media misinformation campaigns' impact on PrEP uptake among gender and sexual minority individuals. AIDS Behav. 2021; 25: 1396–1404.
29. Gao J, Raza SH, Yousaf M, Shah AA, Hussain I, Malik A. How does digital media search for COVID-19 influence vaccine hesitancy? Exploring the trade-off between google trends, infodemics, conspiracy beliefs and religious fatalism. Vaccines (Basel). 2023; 11: 114.
30. Marimuthu Y, Singh M, Garg S, Nagappa B, Engtipi K. COVID 19-related infodemic and its effects during COVID-19 outbreak among medical students in North India. Int J Biomed Public Health. 2020; 3: 90–94.
31. Andrade-Rivas F, Romero M. Misinformation about HIV and negative attitudes toward homosexuality and same-sex couples' rights: the case of Colombia. Int J Public Opin Res. 2017; 29: 426–448.
32. Berglas NF, Gould H, Turok DK, Sanders JN, Perrucci AC, Roberts SC. State-mandated (mis)information and women's endorsement of common abortion myths. Womens Health Issues. 2017; 27: 129–135.
33. Jaiswal J, LoSchiavo C, Maiolatesi A, Kapadia F, Halkitis PN. Misinformation, gendered perceptions, and low healthcare provider communication around HPV and the HPV vaccine among young sexual minority men in New York City: the P18 cohort study. J Community Health. 2020; 45: 702–711.
34. Gelgel NMRA, Ranteallo IC. The COVID-19 infodemic: women and digital (Health) literacy. J Soc Polit Sci. 2022; 5: 70–78.
35. Kitamura ES, Cavalcante RB, Castro EABD, Leite ICG. Infodemia de covid-19 em idosos com acesso a mídias digitais: fatores associados a alterações psicopatológicas. Rev bras geriatr gerontol. 2022; 25: e220016.
36. Herrera F. COVID y violencia de género en la cuarentena: Análisis de la prensa ecuatoriana. #PerDebate. 2020; 4: 18–45.
37. Bucio CIP. La brecha digital de género como vértice de las desigualdades de las mujeres en el contexto de la pandemia por Covid-19. Logos. 2021; 136: 9–22. Disponible en: https://doi.org/10.26457/lrf.v136i136.2873
38. Lin SL. Generalized anxiety disorder during COVID-19 in Canada: gender-specific association of COVID-19 misinformation exposure, precarious employment, and health behavior change. J Affect Disord. 2022; 302: 280–292.
39. Osuagwu UL, Miner CA, Bhattarai D, Mashige KP, Oloruntoba R, Abu EK, et al. Misinformation about COVID-19 in Sub-Saharan Africa: evidence from a cross-sectional survey. Health Secur. 2021; 19: 44–56.
40. Hou F, Bi F, Jiao R, Luo D, Song K. Gender differences of depression and anxiety among social media users during the COVID-19 outbreak in China: a cross-sectional study. BMC Public Health. 2020; 20: 1648.
41. Vaca Trigo I, Valenzuela ME. Digitalización de las mujeres en América Latina y el Caribe: acción urgente para una recuperación transformadora y con igualdad, Documentos de Proyectos (LC/TS.2022/79) [Internet]. Santiago; 2022 [citado el 11 de mayo del 2023]. Disponible en: https://www.cepal.org/es/publicaciones/47940-digitalizacion-mujeres-america-latina-caribe-accion-urgente-recuperacion
42. Delgado CE, Silva EA, Castro EAB, Carbogim FC, Püschel VAA, Cavalcante RB. COVID-19 infodemic and adult and elderly mental health: a scoping review. Rev Esc Enferm USP. 2021; 55: e20210170.

43. Patev AJ, Hood KB. Towards a better understanding of abortion misinformation in the USA: a review of the literature. Cult Health Sex. 2021; 23: 285–300.
44. World Health Organization. WHO. Coronavirus (COVID-19) Dashboard [Internet]. 2023 [citado el 10 de abril del 2023]. Disponible en: https://covid19.who.int
45. Roozenbeek J, Schneider CR, Dryhurst S, Kerr J, Freeman ALJ, Recchia G, et al. Susceptibility to misinformation about COVID-19 around the world. R Soc Open Sci. 2020; 7: 201199.
46. Fetzer JH. Disinformation: the use of false information. Minds Mach (Dordr). 2004; 14: 231–240.
47. Pan American Health Organization. Gendered Health Analysis: COVID-19 in the Americas [Internet]. Washington, DC; 2021 [citado el 11 de mayo del 2023]. Disponible en: https://iris.paho.org/handle/10665.2/55432
48. Williams A, Lyeo JS, Geffros S, Mouriopoulos A. The integration of sex and gender considerations in health policymaking: a scoping review. Int J Equity Health. 2021; 20: 69.
49. van Daalen KR, Bajnoczki C, Chowdhury M, Dada S, Khorsand P, Socha A, et al. Symptoms of a broken system: the gender gaps in COVID-19 decision-making. BMJ Glob Health. 2020; 5: e003549.
50. Agarwal B. Imperatives of recognising the complexities: gendered impacts and responses to COVID-19 in India. Econ Polit (Bologna). 2022; 39: 31–53.
51. Borges do Nascimento IJ, Pizarro AB, Almeida JM, Azzopardi-Muscat N, Gonçalves MA, Björklund M, et al. Infodemics and health misinformation: a systematic review of reviews. Bull World Health Organ. 2022; 100: 544–561.
52. UN Women. Beyond gender: the invisible stereotypes [Internet]. 2018 [citado el 11 de mayo del 2023]. Disponible en: https://www.unstereotypealliance.org/-/media/files/un%20women/unsta/resources/unstereotype%20alliance%20beyond%20gender%20report.pdf?la=en

De la epidemiología de la actividad física a la epidemiología crítica de las prácticas corporales: una propuesta desde Latinoamérica

Heitor Martins Pasquim[1], Rodrigo Soto Lagos[2], Phillipe Augusto Ferreira Rodrigues[3] y Priscilla de Cesaro Antunes[4]

Resumen: Este ensayo tiene como objetivo analizar la epidemiología de la actividad física como un campo práctico y epistemológico en disputa, a partir del marco teórico de la epidemiología crítica internacional. Desde este punto de vista científico, la epidemiología de la actividad física está marcada radicalmente por el colonialismo epistemológico-sanitario. Esta marca se expresa en el alejamiento teórico-práctico del pensamiento epidemiológico crítico formulado en el sur global, produciendo una dependencia regional artificial y una profunda frustración en quienes quieren generar transformaciones en las formas de vivir en la contemporaneidad. Se sugiere que una epidemiología crítica de las prácticas corporales es posible y necesaria. Es decir, la epidemiología desarrollada en los países de América Latina y del Caribe puede comprender dialécticamente la determinación, distribución y reproducción social del fenómeno de las prácticas corporales, desde que retome sus formulaciones críticas y la ciencia intercultural.

Palabras clave: determinación social de la salud, epidemiología social, prácticas corporales, América Latina

"Como siempre: lo urgente no deja tiempo para lo importante"

(Mafalda, personaje creado por Quino)

Introducción

La epidemiología es potencialmente una herramienta de monitoreo, de sensibilización en salud y de planificación de acciones públicas destinadas a la defensa de la salud y a la vida de la población, pero existen diversas visiones que construyen prácticas y conceptos distintos. Por eso, es fundamental deconstruir obstáculos infértiles entre las corrientes de pensamiento epidemiológico, comprendiendo la contribución de las diferentes tradiciones de la epidemiología.

Este ensayo tiene como objetivo analizar la epidemiología de la actividad física (AF) como un campo práctico y epistemológico en disputa, a partir del marco teórico de la epidemiología crítica internacional (1). El manuscrito está dividido en dos partes. La primera presenta la salud internacional como un marco teórico-conceptual; y la segunda

1. Universidade Federal de São Paulo, Santos, São Paulo, Brasil.
2. Faculty of Administration and Economics. University of Santiago of Chile (USACH), Chile.
3. Centro Universitário Uniabeu, Belford Roxo, Río de Janeiro, Brasil.
4. Universidade Federal de Goiás, Goiania, Goiás, Brasil.

Correspondencia a: Heitor Martins Pasquim, Universidade Federal de São Paulo, R. Silva Jardim, 136 - Vila Matias, Santos, São Paulo 11015-020, Brasil. Email: pasquim@unifesp.br

(Este manuscrito fue presentado el 14 de mayo del 2023. Tras revisión por pares, fue aceptado para la publicación el 12 de febrero del 2024.)

Correction (May 2024): The affiliation for Rodrigo Soto Lagos has been updated from Universidad Andrés Bello to University of Santiago of Chile (USACH).

Global Health Promotion 1757-9759; Vol 31(2): 80–85; 1236462 DOI: 10.1177/17579759241236462 journals.sagepub.com/home/ghp

discute la epidemiología de la AF en América Latina y el Caribe como un campo radicalmente marcado por el colonialismo epistemológico-sanitario.

Luego de lo anterior, finalizamos con algunas ideas en dirección a una epidemiología crítica de las prácticas corporales, con el interés de contribuir con quien comparte el deseo de defender la salud pública y la vida. Resaltamos, todavía, que nuestro texto no pretende hacer una propuesta de aplicación práctica o propuesta explícita en investigación, sin embargo ejemplificamos algunas publicaciones en este sentido y destacamos las líneas temáticas para el seguimiento de trayectoria en el marco de la visión epidemiológica que se desea promover.

Desarrollo del tema

Epidemiología crítica internacional

A lo largo de la evolución histórica del pensamiento en salud, la epidemiología aparece como un saber y una práctica instrumental que proporciona legitimidad al saber científico y a la intervención en el ámbito de la salud pública. Sin embargo, no existe un solo pensamiento epidemiológico, sino diferentes tradiciones.

La idea principal de la salud internacional (1) es que, después de siglos de dominación colonial, los países del norte global presentaron y financiaron una serie de iniciativas internacionales, basadas en su propia agenda política, económica y de salud, creando el colonialismo sanitario como desarrollo epistemológico de la dominación territorial.

Algunas acciones de anticooperación (2) fueron realizadas en interferencias globales asimétricas y de inducción de políticas a nivel panamericano y global. Estas materializaron la expansión del proyecto capitalista a otros campos del pensamiento y práctica, inclusive la epidemiología. El poder de esa hegemonía marginalizó el pensamiento epidemiológico crítico formulado en América Latina y el Caribe, produciendo una mayor aproximación con la epidemiología lineal eurocéntrica y norteamericana.

Este alejamiento teórico-práctico del pensamiento epidemiológico latinoamericano y caribeño es tratado en este texto como una expresión del colonialismo epistemológico-sanitario. En este caso, la crítica a las diferentes caras del colonialismo tiene como finalidad fortalecer un proceso decolonial (3), pero no como una autoafirmación tropicalista de superioridad, sino para la apreciación de una ciencia intercultural (4) y una refundación del pensamiento en salud, que toma como referencia la soberanía regional sanitaria (5). Se sostiene que el colonialismo epistemológico no es una condición singular de algunos países, sino la condición particular en América Latina y el Caribe en su conjunto, porque las naciones de estas regiones pasaron de estar bajo las hegemonías española, portuguesa, inglesa, francesa y holandesa a integrar la influencia política y económica de Estados Unidos.

Para reflexionar sobre el colonialismo sanitario es importante reconocer que el pensamiento moderno en salud está cruzado por un idealismo biológico y positivista. Ese idealismo intenta explicar los fenómenos sociales con métodos desarrollados para describir hechos y eventos naturales, por eso su lógica es causal. Como efecto de lo señalado, la causalidad sería la única forma de pensar en salud, desestimando, por lo tanto, la pluralidad de abordajes teóricos (4).

En este sentido, algunos autores (4,6), indican que nuestra forma de entender la salud ha sido instrumentalizada con un conjunto de metodologías causales que se proponen describir el comportamiento activo por medio de estados de salud-enfermedad sin contexto, sin territorio y sin sociedad. Desde esto, la epidemiología con vocación positivista asumiría como pilar interpretativo la noción abstracta de lugar y tiempo.

En relación con lo señalado, los mismos autores destacan que la idea de lugar en la epidemiología positivista no introduce a la población en espacio social y el tiempo está casi siempre aislado de un proceso histórico, proponiendo solamente una delimitación burocrática (4,6).

A partir de lo expuesto, se puede señalar que el progreso en esta epidemiología no ha sido acompañado por un fortalecimiento equitativo de la salud o una mayor conciencia sobre la determinación social de los procesos de salud-enfermedad. Para explicar tal incoherencia existe una posición conservadora que dice que el perfil epidemiológico distinto de los países del sur en relación con los del norte global deriva de una etapa anterior al desarrollo y no de una característica fundamental del avance capitalista en la periferia del sistema. De esta forma, cuando esa falsa idea de etapas continuas y lineales de desenvolvimiento es aceptada, se naturaliza una supuesta inferioridad latinoamericana y caribeña con respecto a los países de capitalismo central.

Desde el punto de vista internacional, el desarrollo fue una justificación plausible y suficiente para una serie de intervenciones del norte global y, al mismo tiempo, aceptación, subordinación y sumisión de países del sur (7). En nombre del desarrollo global, es posible identificar interferencias económicas, acciones militares, políticas autoritarias con instrumentos e indicadores deshumanizados para superar un falso retraso. Más allá de la profunda devastación ambiental y social, en este caso se niegan las raíces históricas y culturales a cambio de una modernización y descoordinación regional, que imita los dichos países desarrollados.

Es importante mostrar que este proceso de colonización del pensamiento en salud no ocurrió solo por persuasión, sino también por la fuerza. El pasado reciente de América Latina y del Caribe está marcado por dictaduras militares que protagonizaron persecuciones contra los practicantes de la medicina social y estudiosos de la salud colectiva por medio de jubilación forzada, desempleo, prisión, tortura, exilio y muerte (8). De hecho, el colonialismo no es un proceso aleatorio, sino un proyecto de sociedad.

En otro sentido, el pensamiento latinoamericano y caribeño propone que la epidemiología puede responder a las necesidades sociales de salud de esta región, desde que capte la complejidad de las dimensiones del fenómeno salud-enfermedad-cuidado en la totalidad social. El eje de este pensamiento crítico es la realidad histórico-social, como objeto a ser descrito, comprendido y transformado.

La corriente latinoamericana de la salud colectiva, a partir de una interpretación dialéctica, entiende que la salud-enfermedad es un fenómeno social, marcado por el metabolismo sociedad-naturaleza en un movimiento entre la determinación y la autonomía relativa. Desde esta perspectiva, no se puede negar que el sujeto tiene un papel fundamental en el proceso salud-enfermedad ni tampoco se le puede asignar el poder de establecer la salud de la forma que mejor le parezca (4,9).

De este modo, la salud es considerada uno de los elementos de la vida social y por lo tanto, para el trabajo de investigación de las dimensiones particulares o singulares de la salud, es requisito no perder de vista sus conexiones con las esferas más generales. Después de todo, el perfil salud-enfermedad es la síntesis del conjunto de mediaciones que operan en una sociedad concreta y, en este sentido, se sabe que algunas formas de trabajar y vivir la vida son más nocivas que otras.

Es importante resaltar que el pensamiento crítico en salud no desconecta la salud de la subjetividad y de la producción de cultura. En este sentido, la salud latinoamericana y caribeña tienen manifestaciones locales y otros protagonismos, como la *Pachamama* (espacio cósmico de la Madre Tierra), la *Chakana* (heurística/ taxonomía del espacio y relaciones), el *Sumak Kawsay* (modo de vida conocido como *buen vivir*) y el *Vivir Sabroso* (filosofía de la vida de comunidades negras en el litoral pacífico colombiano). Ese pensamiento social en salud puede incluir ideas revolucionarias de pensadores que inspiraron la lucha anticolonial en el siglo XVIII; puede adoptar contribuciones de Europa del siglo XIX, como las formulaciones del Movimiento Operario Italiano; y de la Medicina Social, como las contribuciones del francés Jules Guérin y del alemán Rudolf Virchow.

De la epidemiología sobre la AF a la epidemiología crítica de las prácticas corporales

La epidemiología tradicional ha identificado múltiples relaciones y tipologías para la práctica de AF en subgrupos sociodemográficos. Por ello, es importante resaltar que las actuales recomendaciones en cantidad de AF propuestas por organismos internacionales tales como la Organización Mundial de la Salud (OMS) fueron desarrolladas por medio de una robusta base de evidencias científicas basadas en la epidemiología y que se convirtieron en prácticas, evaluaciones y demostraciones de impacto, teniendo fuerte poder para inducir políticas públicas en diversos países.

De esta manera, algunos autores (10) señalan que el debate hegemónico sobre la promoción de AF ha negado el proceso dialéctico de determinación entre el individuo, la sociedad y la historia. Desde el punto de vista de la salud, esto ha transformado el sentido de la AF en múltiples relaciones lineales de causa y efecto, ignorando la cultura presente en el territorio latinoamericano y caribeño (aspecto antropológico) y las inequidades sociales que comprometen la formulación de acciones y políticas universales (aspecto sociológico).

Seguido a lo anterior, es posible describir la expansión del pensamiento epidemiológico hegemónico de la AF, como un proceso que fue potenciado por la creación de instituciones de investigaciones e incentivo a través de respuestas

técnicas, financieras y filantrópicas. Por ejemplo, la fundación de *Harvard Fatigue Laboratory*, en 1927, y del *American College of Sports Medicine* en 1954, así como los financiamientos del *Center for Disease Control and Prevention*, con apoyo de la OMS y del proyecto *Guide for Useful Interventions for Activity in Brazil and Latin America*, que desde el 2005 proporcionan la base de una gama de estudios en América Latina en el campo de la AF (11).

A partir de ellos, los estudios sobre la aptitud física y sobre la erradicación del sedentarismo para el enfrentamiento comportamental de las enfermedades crónicas no transmisibles ganan la agenda pública, los intereses de políticos y enormes recursos económicos, lo que a su vez favorece distorsiones.

Se destacan iniciativas de carácter presuntamente filantrópico como aquellas que prometen contribuir para la construcción de hábitos de vida saludables y que intentan conectarse a discursos científicos, como el programa internacional de Responsabilidad Social Corporativa del Grupo Ferrero (*Kinder Joy of moving*), que cuenta con intervenciones propuestas a partir de la alimentación y promoción de la AF en América Latina. El impacto de ese filantrocapitalismo en la salud global ya fue extensamente mapeado por establecer una cooperación desigual, a partir de eso se configura la captura de la agenda de países por los intereses de grandes conglomerados económicos (12).

Por lo tanto, es necesario reflexionar sobre el objeto que se quiere promover. No se cuestiona la asociación positiva entre el bajo nivel de AF/ comportamiento sedentario y el riesgo para enfermedades. Este ensayo hace parte del llamado de algunos autores (13,14) a convocar la atención respecto del hecho de que la asociación estadística ha instalado un sentido de urgencia y comprensión universal independientemente de un diagnóstico situacional que incluya el contexto de las personas. Esto ha movilizado discursos descontextualizados y moralistas sobre la AF, en los cuales las personas deben cumplir la misma cantidad de minutos, lo que, a su vez, genera problemas invisibles y soluciones locales falsas (15).

En este caso, se pueden movilizar algunos ejemplos ilustrativos. Como los discursos periodísticos sobre la pereza como explicación de la inactividad física y la culpa como promotora del compromiso con la salud: "¿Tu hijo es sedentario? ¡Es tu culpa!" (16). Un estudio reciente destacó el gran énfasis en el enfoque prescriptivo-recomendativo de las guías de AF en todo el continente americano, dejando de lado importantes cuestiones contextuales, ambientales y de vigilancia (17). Otro ejemplo emblemático es el caso de anticooperación que involucró a "Agita São Paulo". El famoso programa brasileño de promoción de la AF fue denunciado por presuntamente estar involucrado en relaciones no transparentes con corporaciones norteamericanas, que financiaban estudios en América Latina. En ese momento había evidencias que apuntaban a la industria de las bebidas gaseosas como una de las responsables del crecimiento de la obesidad en el mundo. La solución que estas corporaciones encontraron fue reforzar que los obesos eran perezosos y así impulsaron campañas para cambiar hábitos individuales de AF, que no vinculaban evidencias sobre el consumo y otras condiciones de vida (18).

Cabe aquí la crítica a lógica de los dominios de la AF (en el tiempo libre, en el transporte, en el trabajo, y en el hogar), un pilar de la epidemiología convencional. A pesar de que haya posibilitado el entendimiento de algunas injusticias (19), ella se muestra en ocasiones sin compromiso con el contexto de la vida real de las personas, defendiendo una inversión ciega en los dominios de forma indiferenciada (20).

Por esta razón, diversos investigadores (21) apuntan la necesidad de delimitación de otro objeto. Las prácticas corporales son acciones contextualizadas que movilizan la corporeidad y que intencionalmente buscan promover la salud. Entendidas como actividad humana, no se limitan a su disfrute, asesoramiento y difusión, sino que constituyen parte de estrategias de cuidado de la salud y educación continua, mejora de las condiciones de los espacios públicos y de fortalecimiento de la participación comunitaria. Este concepto favorece una comprensión de sentidos y significados asociados a la producción de cultura, derecho a la salud y al reconocimiento del cuerpo, superando el concepto reduccionista y conservador, que está limitado al acto mecánico y físico, alineado a la idea de estado de salud como negación de enfermedades.

Reconociendo el aporte de las ciencias sociales y humanas en el campo de la AF, algunos estudios hechos en países suramericanos llegaron a abordar el tema a partir de métodos combinados y diferentes instrumentos (22), pero con frecuencia produjeron una subsunción de los datos al positivismo. Mucho más escasas son las investigaciones que tomaron algún paradigma de la epidemiología del sur global para ocuparse sobre el fenómeno, como los estudios de Ballesteros y Freidin (23) y Matiello Júnior *et al.* (24). Esas publicaciones criticaron el abordaje

positivista del pensamiento epidemiológico clásico y el paradigma de los factores de riesgo, asumiendo la epidemiología crítica como marco teórico.

Se entiende por lo tanto, a partir de la salud internacional, que es necesario superar el colonialismo epistemológico de la epidemiología convencional de la AF, con vocación descriptiva y empirista, en el sentido de una epidemiología crítica de las prácticas corporales. Este cambio permitiría comprender la determinación, la distribución y la reproducción social de las prácticas corporales en los diferentes grupos sociales, para formular y apoyar la implementación de acciones, de políticas y de programas en salud con vista a la transformación de la realidad.

Sería posible ensayar aquí algunos fundamentos para esa epidemiología crítica, como valorar las prácticas colectivas y creativas, así como entender que el acceso a programas públicos que ofrecen prácticas corporales debe ser defendido como un derecho social, lo que enfatiza potencialidades de fortalecimiento en los procesos de determinación-mediación de la salud. Otro presupuesto sería la necesidad de cuestionamiento del modo liberal de vivir, en especial en la periferia del sistema capitalista, y sus desdoblamientos en el cuerpo y en la salud-enfermedad-cuidado, potencializando una conciencia sanitaria colectiva. Esas son diferencias importantes para una epidemiología crítica de las prácticas corporales que pretende siempre invertir en lo que presenta un horizonte transformador y lo que hace sentido para la comunidad o para los grupos sociales.

El método científico, que favorece la epidemiología crítica de las prácticas corporales, ultrapasa la simple descripción empírico-analítica de un comportamiento o factor, para construir respuestas auténticas a las necesidades sociales de salud. No obstante, el objetivo de este ensayo no es determinar un nuevo paradigma epidemiológico ni describir un manual para investigaciones. Se entiende que los paradigmas alternativos a los convencionales ya existen, como la etnoepidemiología de Almeida-Filho (25), la epidemiología sociocultural de Menéndez (26), y la epidemiología crítica de Jaime Breilh (5), por mencionar algunos.

Desde un punto de vista crítico, urge, por lo tanto, recuperar el pensamiento epidemiológico formulado en los países de América Latina y del Caribe, y proponer aproximaciones con el campo de las prácticas corporales en la salud.

Conclusiones

El discurso de guerra contra el sedentarismo que reproduce a la repetición inferencias con números sobre los beneficios de comportamientos individuales, compone viejas estrategias de gobierno y colonización, que, actualizadas, se expresan como una biologización de la salud.

Desde el punto de vista del campo de la salud internacional, la epidemiología de la AF está radicalmente marcada por el colonialismo epistemológico-sanitario, produciendo una dependencia regional artificial y una frustración en quien pretende generar transformaciones en las formas de vivir.

En este sentido, el pensamiento crítico se distingue de la epidemiología convencional sobre la AF y exige, a su vez, una ampliación conceptual que reposicione las categorías científicas a partir del diálogo con las ciencias humanas y sociales.

Se sugiere que una Epidemiología Crítica de las Prácticas Corporales es posible y necesaria. El pensamiento social en salud, desarrollado en los países de América Latina y del Caribe, puede comprender dialécticamente la determinación, la distribución y la reproducción social del fenómeno de las prácticas corporales, desde que retome sus formulaciones críticas y la ciencia intercultural.

Esa epidemiología tiene la potencia de ser hoy una fuente de instrumentalización importante para analizar e intervenir sobre las necesidades de salud de América Latina y del Caribe.

Declaración de conflicto de intereses

Ningún conflicto declarado.

Financiación

Ninguna financiación declarada.

ORCID iDs

Heitor Martins Pasquim https://orcid.org/0000-0002-4994-7399
Rodrigo Soto Lagos https://orcid.org/0000-0002-3564-8419
Phillipe Augusto Ferreira Rodrigues https://orcid.org/0000-0003-3722-4385
Priscilla de Cesaro Antunes https://orcid.org/0000-0003-2739-193X

Referencias

1. Basile G. Repensar y descolonizar la teoría y políticas sobre sistemas de salud en Latinoamérica y Caribe. En:

Cuadernos del Pensamiento Crítico Latinoamericano, n°73. Buenos Aires: CLACSO; 2020.
2. Bosch DL. Anticooperación: Interferencias Norte-Sur: los problemas del Sur Global no se resuelven con más ayuda internacional. Icaria editorial; 2009.
3. Quijano A. Colonialidad del poder, eurocentrismo y América Latina. Buenos Aires: CLACSO; 2005.
4. Breilh J. Critical epidemiology and the people's health. New York, NY: Oxford University Press; 2020.
5. Basile G. Refundación de los sistemas de salud en Latinoamérica y el Caribe: apuntes para repensar y descolonizar las teorías y políticas. FLACSO República Dominicana: IDEP Salud; 2021.
6. Rojas LI. Geografía y salud: temas y perspectivas en América Latina. Cad Saúde Pública. 1998; 14: 701–711.
7. Acosta A. O Bem Viver: uma oportunidade para imaginar outros mundos. São Paulo: Autonomia Literária, Elefante; 2016.
8. Waitzkin H, Iriart C, Estrada A, Lamadrid S. Social medicine in Latin America: productivity and dangers facing the major national groups. Lancet. 2001; 358: 315–323.
9. Souza DO. O caráter ontológico da determinação social da saúde. Serv Soc Soc. 2020; 137: 174–191.
10. Bagrichevsky M, Estevão A. O imperativo da epidemiologia dos fatores de risco em face das desigualdades sociais: agenciamentos discursivos sobre o sedentarismo. Rev Ciênc Soc. 2012; 37: 89–102.
11. Pratt M, Brownson R, Ramos LR, Malta DC, Hallal P, Reis R, et al. Projeto Guia: um modelo para compreender e promover a atividade física no Brasil e na América Latina. En: Brasil. Avaliação de Efetividade de Programas de Atividade Física no Brasil. Brasília: Ministério da Saúde; 2013, pp.23–34.
12. Back C, Nascimento B. Filantrocapitalismo e saúde global: o neoliberalismo da vida e da morte. Mural Internacional. 2020; 11: e48766.
13. Soto-Lagos R. Deporte, Prácticas Corporales, vida saludable y buen vivir: Un Análisis crítico para una nueva praxis. J Latin Am Socio-cult Stud Sport. 2018; 9: 29–44.
14. Palma A, Araújo MFS, Rodrigues PAF. Pesquisa em atividade física e saúde: a urgência de uma epistemologia decolonial. Rev Bras Ciênc Esporte. 2023; 45: e20230053.
15. Soto-Lagos R. Bioética en el uso del deporte en políticas públicas promotoras de salud: bioethics related to the use of sports in public health promoting policies. Rev Salud Pública. 2018; 20: 641–645.
16. Parente C. Seu filho é sedentário? A culpa é sua! [Internet]. 2017 Abril [consultado el 10 de agosto del 2023]. Disponible en: https://ge.globo.com/eu-atleta/saude/noticia/seu-filho-e-sedentario-a-culpa-e-sua.ghtml
17. Guerra PH, Garcia LMT, Ribeiro EHC, Maretti ALR, Andrade DR, Florindo AA. Identificação e análise das diretrizes nacionais de atividade física nas Américas. Ciênc Saúde Colet. 2021; 26: 2961–2968.
18. O Joio e O Trigo. Transparente nos EUA, Coca-Cola adota segredo sobre relação com pesquisadores no Brasil [Internet]. 2018 Febrero [consultado el 10 de agosto del 2023]. Disponible en: https://actbr.org.br/post/transparente-nos-eua-cocacola-adota-segredo-sobre-relacao-com-pesquisadores-no-brasil/17154/
19. Cruz DKA, Silva KS, Lopes MVV, Parreira FR, Pasquim HM. Iniquidades socioeconômicas associadas aos diferentes domínios da atividade física: resultados da Pesquisa Nacional de Saúde 2019. Epidemiol Serv Saúde. 2022; 31(n spe1): e2021398.
20. Loch MR, Augusto NA, Souza BLS, Rufino JV, Carvalho FFB. Associação entre domínios da atividade física e sintomas depressivos em adultos brasileiros: todo movimento conta? Cad Saúde Pública. 2024;40(3):e00095723
21. Manske GS. Práticas Corporais como conceito? Movimento. 2022; 28: e28001.
22. Silva DR, Barboza LL, Baldew S, Anza-Ramirez C, Ramírez-Vélez R, Schuch FB, et al. Measurement of physical activity and sedentary behavior in national health surveys, South America. Rev Panam Salud Publica. 2022; 46: e7.
23. Ballesteros MS, Freidin B. Desigualdades sociales en la realización de distintas modalidades de actividad física en Argentina. Revistas Educ Fís Cienc. 2019; 21: e067.
24. Matiello Júnior E, Gonçalves A, Martinez JFN. Superando riscos na atividade física relacionada à saúde. Movimento. 2008; 14: 39–61.
25. Almeida-Filho N. Hacia una etnoepidemiología (Esbozo de un nuevo paradigma epidemiológico). Rev Esc Salud Pública. 1992; 3: 33–40.
26. Menéndez EL. Epidemiología sociocultural: propuestas y posibilidades. Reg y Soc. 2008; 20(n. spe2): 5–50.

Abstracts

Social determination of obesity, diabetes and high blood pressure from the narratives of women from an indigenous community in the south of Morelos, Mexico

María Ángeles Villanueva Borbolla, Agustín Pernia, and Marisol Campos Rivera

Objective: To understand the critical processes (CP) of social determination of obesity, diabetes and hypertension (ODH) in a Nahua community in Mexico.
Methodology: This is a qualitative study of records from a photo-voice workshop, where participants photographed their surroundings and analyzed the causes and possible solutions to ODH. To analyze the CP of the ODH, we used narrative research as a method and, as a theoretical reference, critical epidemiology.
Results: ODH is socially and historically reproduced through destructive CPs linked to global production and gender relations. These cause harmful lifestyles that limit health care, compromise mental health, produce pollution and differentiation in the use of spaces, and reduce opportunities for healthy eating and physical activity. All of this is expressed as ODH and mental health problems. The protective CPs against these expressions include state attention, job opportunities, and the promotion of cultural and community mechanisms.
Conclusions: Our results contribute to the global discussion about how historical living conditions are part of the social determination of ODH. Understanding CPs and their local expressions can guide us towards decolonizing the way of thinking and doing health promotion.

Keywords: social determination, obesity, diabetes, high blood pressure, qualitative research, community participation, indigenous peoples.

Gender, 'infodemia', and misinformation in health: global scope review, knowledge gaps, and recommendations

Daniela Luz Moyano, María Silveria Agulló-Tomás, and Vanessa Zorrilla-Muñoz

Objective: To explore the state of scientific literature on the aspects of 'infodemia' and disinformation in health linked to gender and intersectionality, to detect knowledge gaps and offer recommendations.
Methods: A global scope review was completed, with the detection of knowledge gaps and recommendations. We searched eight databases: MEDLINE (Pubmed), Anthropological Index Online, Studies on Women & Gender Abstracts, LILACS, Scielo, Global Index Medicus, Web of Science, and Google Scholar. Also, we carried out a manual search on Google for documents from the last 10 years, without language or geographic restrictions. We performed a content analysis of the included studies.
Results: We identified 855 records, of which 21 met the inclusion criteria. Studies that had a woman as first author predominated (13/21), although in overall authorship, men stood out (10/21). The binary model was the main focus (16/21). The majority (18/21) were published from 2020 onwards. The main topics addressed were those related to COVID-19 and sexual and reproductive health (before the pandemic), and to a lesser extent mental health. Interactions were identified between sex/gender differences in health disinformation/infodemia, especially in women, gender-diverse groups, older people, and populations with low socio-educational levels.
Conclusions: Knowledge gaps exist in the topic explored, with a small number of studies, and limitations of scope and gender and/or feminist focus (beyond the binary). Nevertheless, the tentative results confirm the presence of gender inequalities and intersectionality in health misinformation.

Keywords: infodemia, infodemic, misinformation, gender, COVID-19, systematic review

Global Health Promotion 1757-9759; Vol 31(2): 86–87; 1252379 DOI: 10.1177/17579759241252379 journals.sagepub.com/home/ghp

From the epidemiology of physical activity to the critical epidemiology of body practices: a proposal from Latin America

Heitor Martins Pasquim, Rodrigo Soto Lagos, Phillipe Augusto Ferreira Rodrigues and Priscilla de Cesaro Antunes

This essay aims to analyze the epidemiology of physical activity as a practical and epistemological field in dispute, based on the theoretical framework of international critical epidemiology. From this scientific point of view, the epidemiology of physical activity is radically marked by epistemological–health colonialism. This brand is expressed in the theoretical–practical distance from critical epidemiological thinking formulated in the global south, producing an artificial regional dependency and deep frustration in those who want to generate transformations in contemporary ways of living. It is suggested that a critical epidemiology of body practices is possible and necessary. In other words, the epidemiology developed in the countries of Latin America and the Caribbean can dialectically understand the determination, distribution and social reproduction of the phenomenon of bodily practices, since it resumes its critical formulations and intercultural science.

Keywords: social determination of health, social epidemiology, body practices, Latin America

Résumés

Relier les déterminants commerciaux de la santé autochtone et les héritages de la colonisation : une analyse critique

Daniel Eisenkraft Klein et Amy Shawanda

Jusqu'à présent, peu d'efforts ont été réalisés pour examiner les liens étroits qui existent entre la colonisation et les déterminants commerciaux de la santé autochtone. Il s'agit là d'une lacune importante, que cet article se propose d'aborder. Nous proposons d'examiner de quelle manière quatre pertes de traditions découlant du colonialisme sont étroitement liées avec quatre déterminants commerciaux de la santé autochtone : 1) la perte des régimes alimentaires traditionnels et l'industrie alimentaire ultra-transformée ; 2) la perte des cérémonies traditionnelles et l'industrie du tabac ; 3) la perte des connaissances traditionnelles et l'industrie du lait maternisé ; et 4) la perte des réseaux de soutien traditionnels et l'industrie de l'alcool. En nous appuyant sur les efforts des populations autochtones pour décoloniser les espaces et affirmer leur contrôle sur leur propre vie, nous soutenons que le fait d'analyser les mécanismes par lesquels les activités industrielles rejoignent les héritages coloniaux permettra d'avoir une compréhension plus large des disparités en matière de santé autochtone.

Mots clés : tabac, santé autochtone, déterminants de la santé, équité/justice sociale, allaitement maternel, sécurité alimentaire, alcool

Les grands-mères – une ressource culturelle pour la santé et le bien-être des femmes et des enfants à travers le cycle de la vie

Judi Aubel

Les grands-mères sont présentes dans toutes les sociétés. Il existe des preuves empiriques étendues du rôle des grands-mères dans la promotion de la santé et la guérison, en particulier dans le monde majoritaire non occidental, où les aînés sont à la fois très respectés et chargés de transmettre leurs connaissances aux jeunes générations. Cependant, en raison de visions eurocentristes et réductionnistes de la famille et de la communauté, une attention limitée a été portée au rôle des grands-mères dans les recherches approfondies antérieures sur les problématiques de santé maternelle, infantile et adolescente à travers l'Afrique, l'Asie, l'Amérique latine et le Moyen-Orient, et dans les sociétés autochtones d'Amérique du Nord, d'Australie et de Nouvelle-Zélande. Le présent article aborde cette lacune et soutient la nécessité de décoloniser la promotion de la santé dans le monde non occidental en développant des visions du monde, des rôles et des valeurs qui ne soient pas occidentaux. Sur la base d'un ensemble éclectique de données publiées et issues de la littérature grise, cet examen présente de nombreux éléments attestant de l'implication des grands-mères tout au long du cycle de vie des femmes et des enfants, et des rôles fondamentaux similaires qu'elles jouent à travers les cultures. Même s'il arrive dans certains cas que les grands-mères aient une influence négative, dans la plupart des cas, leur implication et leur soutien envers les jeunes femmes et les enfants est bénéfique de par leur rôle à la fois de conseils et de soins. Pour de futures recherches et interventions abordant la santé maternelle, infantile et adolescente, les conclusions de cet examen plaident fortement en faveur de : l'adoption d'un cadre de référence des systèmes familiaux pour identifier les rôles et l'influence à la fois sexospécifiques et générationnels ; et l'inclusion des grands-mères dans les programmes de promotion de la santé communautaires abordant les différentes phases du cycle de vie des femmes et des enfants.

Mots clés : systèmes familiaux, grands-mères, culture, contexte socio-culturel, santé infantile, santé maternelle, normes sociales, santé des adolescents

Global Health Promotion 1757-9759; Vol 31(2): 88–91; 1252381 DOI: 10.1177/17579759241252381 journals.sagepub.com/home/ghp

Définir la santé à travers une perspective d'économie politique matérialiste critique

Stella Medvedyuk et Dennis Raphael

Il est reconnu depuis l'Antiquité que l'organisation d'une société et la manière dont elle distribue ses ressources sont les premiers déterminants de la santé. Pourtant, la plupart des définitions de la santé fournies par la littérature académique et la littérature pratique se contentent de considérer l'expérience et les capacités fonctionnelles des individus en matière de santé, et négligent les structures et les processus des sociétés dans lesquelles s'inscrivent ces individus. Nous nous sommes basés sur les développements des littératures portant sur la communication en santé critique et l'économie politique matérialiste critique de la santé pour fournir une définition de la santé mettant en avant le rôle joué par les systèmes économiques et politiques dans les distributions équitables ou non équitables des ressources nécessaires à la santé. Dans la mesure où ces distributions interagissent avec les situations et les dispositions biologiques et psychologiques particulières des individus pour générer la santé, il est important d'identifier leurs sources et les moyens de les rendre plus équitables. Les êtres humains interprètent la société et s'interprètent eux-mêmes ainsi que les autres au travers de la communication, c'est pourquoi il est essentiel de disposer d'une définition concise de la santé qui mette en avant ces caractéristiques sociétales et les rôles qu'elles jouent au quotidien pour promouvoir ou compromettre la santé.

Mots clés: définition de la santé, économie politique, communication en santé critique, analyse critique

Le spectre de la race dans les réponses mondiales à la Covid-19 : l'avenir est décolonial

Madalitso Z. Phiri

La pandémie de Covid-19 a réifié les inégalités préexistantes qui reposaient sur le racisme anti-Noir, la cartographie géographique impériale, et le langage violent du biomilitarisme. Dans cet essai réflexif, je déploie des outils de sociologie historique pour souligner l'importance de la race, du racisme, de la racialisation, et des réponses mondiales aux pandémies. Je considère les questions suivantes. Premièrement, comment la société mondiale peut-elle développer des idées et des concepts pour imaginer un régime mondial post-impérial de la santé ? Deuxièmement, peut-on imaginer des futurs alternatifs si le contrôle monopolistique du pouvoir, des processus scientifiques mondiaux et du régime des connaissances est structuré autour d'une lexicographie problématique découlant d'un projet eurocentrique totalisant de ce qui constitue être un humain ? Enfin, s'il existe un consensus scientifique selon lequel nous avons besoin de futurs alternatifs, de quels types de connaissances avons-nous besoin pour amener un ordre post-impérial libéré ? Le futur du régime mondial de la santé est un futur décolonial reposant sur une nouvelle biopolitique. Je propose quatre approches paradigmatiques pour subvertir la santé mondiale impériale : (i) modifier la notion d'écocide dans le régime mondial impérial de la santé ; (ii) abandonner une conceptualisation eurocentrique de hiérarchie raciale et de modernité ; (iii) démanteler la réification de la santé publique ; et (iv) organiser un nouvel ordre mondial par le biais de réparations en matière de santé.

Mots clés: racisme anti-Noir, biopolitique, pandémie, réparations, violence, race, racisme, Afrique du Sud, Brésil, États-Unis

Un cadre de référence décolonial pour l'application de la réflexivité et de la positionnalité dans la recherche en santé mondiale

Thirusha Naidu, Gareth Gingell et Zareen Zaidi

Les pratiques de recherche contemporaines sont liées à la création et à la production de connaissances coloniales et impérialistes, et peuvent favoriser des perspectives néfastes pour les groupes marginalisés et oppressés. Nous présentons un cadre de référence pour une approche décoloniale de la recherche en santé mondiale et en promotion de la santé, applicable à travers les milieux de recherche. Ce cadre de référence vise à anticiper et à atténuer les pratiques potentiellement néfastes qui sont inhérentes aux méthodes de recherche dominantes. Le cadre de référence est axé d'après une perspective de niveau macro et micro sur trois dyades essentielles : « contexte » et « responsabilité » ; « identité du chercheur » et « positionnalité » ; et considérations en « éthique procédurale » et « éthique dans la pratique ». Nous présentons des conseils sur la manière de considérer la réflexivité et la positionnalité telles qu'elles s'appliquent dans ce cadre de référence dans la pratique de recherche en santé mondiale et en promotion de la santé.
Mots clés : recherche communautaire, recherche participative, éducation (y compris éducation pour la santé), équité, justice sociale

Le déterminisme social de l'obésité, du diabète et de l'hypertension artérielle perçu à partir des récits de femmes d'une communauté autochtone dans le sud de Morelos, au Mexique

María Ángeles Villanueva Borbolla, Agustín Pernia et Marisol Campos Rivera

Objectif : Comprendre les processus critiques (PC) du déterminisme social de l'obésité, du diabète et de l'hypertension (ODH) dans une communauté nahua au Mexique.
Méthodologie : Étude qualitative des enregistrements d'un atelier de photo-voix, où les participantes ont photographié leur environnement et analysé les causes de l'ODH et ses solutions possibles. Pour analyser les PC de l'ODH, nous avons utilisé comme méthode la recherche narrative et, comme référence théorique, l'épidémiologie critique.
Résultats : L'ODH se reproduit socialement et historiquement à travers des PC destructeurs liés aux rapports de production globale et de genre. Ils entraînent des modes de vie délétères qui limitent les soins de santé, compromettent la santé mentale, entraînent une pollution et une différenciation de l'utilisation des espaces, et réduisent les possibilités de bien se nourrir et de faire de l'activité physique. Tout cela se traduit en ODH et problèmes de santé mentale. Les PC protecteurs face à ces expressions incluent les soins de santé publics, les possibilités d'emploi, et la promotion des dispositifs culturels et communautaires.
Conclusions : Nos résultats alimentent la discussion mondiale sur la façon dont les conditions historiques de vie font partie du déterminisme social de l'ODH. Comprendre les PC et leurs expressions locales peut nous orienter vers la décolonisation de la pensée et faire la promotion de la santé.
Mots clés : déterminisme social, obésité, diabète, hypertension artérielle, recherche qualitative, participation communautaire, peuples autochtones.

Genre, infodémie et désinformation en santé. Revue de portée globale, lacunes dans les connaissances et recommandations

Daniela Luz Moyano, María Silveria Agulló-Tomás et Vanessa Zorrilla-Muñoz

Objectif : Explorer l'état de la littérature scientifique sur les aspects de l'infodémie et de la désinformation en matière de santé liés au genre et à l'intersectionnalité, identifier les lacunes dans les connaissances et fournir des recommandations.
Méthodes : Revue de littérature de portée globale, avec la détection des lacunes dans les connaissances et recommandations. Ces éléments ont été recherchés dans huit bases de données: MEDLINE (Pubmed), Anthropological Index Online, Studies on Women & Gender Abstracts, LILACS, Scielo, Global Index Medicus, Web of Science, Google académique et une recherche manuelle sur Google des documents des 10 dernières années, sans restrictions linguistiques ni géographiques a été réalisée de même qu'une analyse du contenu des études incluses.
Résultats : 855 documents ont été identifiés et 21 ont satisfait aux critères d'inclusion. La majorité des études ont été réalisées par une femme comme premier/ère auteur/e (13/21), alors que si l'on prend l'ensemble des auteurs ce sont les hommes qui prédominent (10/21). C'est le modèle binaire qui a été choisi comme approche principale (16/21). La plupart de ces documents (18/21) ont été publiés à partir de 2020. Les thèmes abordés concernaient principalement la COVID-19 et la santé sexuelle et reproductive (avant la pandémie), et dans une moindre mesure la santé mentale. On a pu déceler des interactions entre les différences entre les sexes/genres dans la désinformation/l'infodémie en matière de santé, en particulier chez les femmes, les groupes de genre divers, les personnes âgées et les populations ayant un faible niveau socio-éducatif.
Conclusions : Il existe des failles dans les connaissances sur le sujet exploré, avec peu d'études, et des limites de portée et d'approche par le genre et/ou féministe (au-delà du binaire). Cependant, les résultats préliminaires constatent la présence d'inégalités de genre et d'intersectionnalité dans la désinformation sanitaire.
Mots clés: infodémie, désinformation, genre, COVID-19, revue systématique

De l'épidémiologie de l'activité physique à l'épidémiologie critique des pratiques corporelles : une proposition émanant d'Amérique latine

Heitor Martins Pasquim, Rodrigo Soto Lagos, Phillipe Augusto Ferreira Rodrigues et Priscilla de Cesaro Antunes

Cet essai a pour but d'analyser l'épidémiologie de l'activité physique comme un champ pratique et épistémologique en conflit, sur la base du cadre théorique international de l'épidémiologie critique. De ce point de vue scientifique, l'épidémiologie de l'activité physique est marquée de manière radicale par le colonialisme épistémologique et sanitaire. Cette marque s'exprime au niveau de la distance théorique et pratique de la pensée épidémiologique critique formulée dans les pays du Sud, ce qui donne lieu à une dépendance régionale artificielle et à une profonde frustration chez ceux qui veulent générer des changements dans les modes de vie contemporains. Nous suggérons qu'une épidémiologie critique des pratiques corporelles est possible et nécessaire. En d'autres termes, l'épidémiologie développée dans les pays d'Amérique latine et des Caraïbes peut comprendre de manière dialectique la détermination, la distribution et la reproduction sociale du phénomène des pratiques corporelles, puisqu'elle reprend leurs formulations critiques ainsi que la science interculturelle.
Mots clés : détermination sociale de la santé, épidémiologie sociale, pratiques corporelles, Amérique latine

Resúmenes

De los determinantes comerciales de la salud indígena a los legados de la colonización: un análisis crítico

Daniel Eisenkraft Klein y Amy Shawanda

Hasta el momento no ha habido un esfuerzo importante para considerar la interrelación entre la colonización y los determinantes comerciales de la salud indígena. Es una omisión fundamental que este artículo se propone abordar. Planteamos cómo se interconectan cuatro pérdidas de tradición causadas por el colonialismo con cuatro respectivos determinantes comerciales de la salud indígena: 1) pérdida de las dietas tradicionales y la industria de los alimentos ultraprocesados; 2) pérdida de las ceremonias tradicionales y la industria del tabaco; 3) pérdida del conocimiento tradicional y la industria de la leche de fórmula para niños, y 4) pérdida de las redes tradicionales de apoyo y la industria licorera. Basados en los esfuerzos indígenas para descolonizar los espacios y reivindicar el control sobre sus propias vidas, sostenemos que analizando los mecanismos a través de los cuales las actividades industriales se intersecan con los legados coloniales, podremos mejorar la comprensión general de las disparidades de la salud indígena.

Palabras clave: tabaco, salud indígena, determinantes de la salud, justicia/equidad social, lactancia materna, seguridad alimentaria, alcohol

Las abuelas como recurso cultural para la salud y el bienestar de mujeres y niños a lo largo del ciclo de vida

Judi Aubel

Las abuelas están en todas las sociedades. En los países no occidentales del mundo mayoritario, donde las personas más viejas son altamente respetadas y ostentan la responsabilidad de transmitir sus conocimientos a las nuevas generaciones, existe especialmente una amplia evidencia anecdótica del papel de las abuelas en la promoción de la salud y en la curación. Sin embargo, debido a las opiniones eurocéntricas y reduccionistas de las familias y las comunidades, en investigaciones exhaustivas anteriores sobre asuntos de salud materna, infantil y adolescente a lo largo de África, Asia, Latinoamérica y el Oriente Medio, y en las sociedades indígenas de Norteamérica, Australia y Nueva Zelanda, se ha prestado poca atención al papel de las abuelas. Este artículo aborda esta omisión y apoya el imperativo para descolonizar la promoción de la salud en el mundo no occidental a partir de visiones del mundo, roles y valores no occidentales. Sobre la base de un cuerpo ecléctico de la literatura gris y la publicada, esta revisión presenta una extensiva evidencia de la participación de las abuelas durante el ciclo de vida de mujeres y niños, y las funciones centrales similares que ellas desempeñan a través de las culturas. Si bien en algunos casos las abuelas tienen una influencia negativa, en la mayoría de las ocasiones su implicación y apoyo benefician a las mujeres más jóvenes y a los niños en términos de consejos y cuidados. Para futuras investigaciones e intervenciones sobre la salud materna, infantil y adolescente, las conclusiones de esta revisión brindan un soporte importante tanto a la adopción de un marco de sistemas familiares que identifique las funciones y las influencias específicas de género y de generación, como a la inclusión de las abuelas en los programas de promoción de la salud comunitaria relacionados con las diferentes fases del ciclo de vida de mujeres y niños.

Palabras clave: sistemas familiares, abuelas, contexto sociocultural, salud infantil, salud materna, normas sociales, salud adolescente

Global Health Promotion 1757-9759; Vol 31(2): 92–94; 1252380 DOI: 10.1177/17579759241252380 journals.sagepub.com/home/ghp

Definir la salud a través de una óptica crítica de la economía política materialista

Stella Medvedyuk y Dennis Raphael

Desde la antigüedad se ha reconocido que la organización de la sociedad y la forma como distribuye los recursos son los principales determinantes de la salud. Sin embargo, la mayoría de las definiciones de la salud en las literaturas académica y práctica limitan su enfoque a la experiencia de salud y a las habilidades funcionales del individuo, descuidando las estructuras y los procesos de las sociedades en las cuales se está inmerso. Recurrimos a los desarrollos de la comunicación crítica en salud y la economía política materialista crítica de la literatura en salud para aportar una definición de salud que dirija la atención al papel que desempeñan los sistemas económico y político en la distribución equitativa o inequitativa de los recursos necesarios para la salud. Dado que estas distribuciones interactúan con las disposiciones biológicas y psicológicas únicas del individuo para producir salud, es importante identificar sus fuentes y recursos para hacer sus distribuciones más equitativas. Debido a que por medio de la comunicación los humanos interpretan a la sociedad, a ellos mismos y a los otros, es esencial una definición concisa de salud que llame la atención sobre esas características societales y sus roles cotidianos para promover o amenazar la salud.
Palabras clave: definición de salud, economía política, comunicación crítica en salud, análisis crítico

El espectro de la raza en las respuestas a la COVID-19: el futuro es decolonial

Madalitso Z. Phiri

La pandemia de la COVID-19 materializó las inequidades preexistentes predicadas sobre el racismo contra los negros, la cartografía geográfica imperial y el violento lenguaje del biomilitarismo. En este ensayo reflexivo, utilizo las herramientas de la sociología histórica para subrayar la importancia de la raza, del racismo, de la racialización y de las respuestas mundiales a la pandemia. Planteo las siguientes preguntas: primero, ¿cómo puede la sociedad mundial desarrollar ideas y conceptos para la imaginación de un régimen de salud mundial posimperial? Segundo, ¿se pueden imaginar futuros alternativos si el control monopolístico del poder, los procesos científicos mundiales y el régimen del conocimiento se enmarcan alrededor de una lexicografía problemática de un proyecto totalizador eurocéntrico del ser humano? Por último, si hay un consenso científico de que necesitamos futuros alternativos, ¿qué clase de conocimientos se requieren para generar un orden libre posimperial? El futuro del régimen de la salud mundial es decolonial y se basa en una nueva biopolítica. Planteo cuatro enfoques paradigmáticos para subvertir la salud mundial imperial: (i) pivotear el ecocidio en el régimen de salud mundial imperial; (ii) abandonar una conceptualización eurocéntrica de jerarquía y modernidad racial; (iii) desarticular la mercantilización de la salud pública, y (iv) organizar un nuevo orden mundial a través de reparaciones en salud.
Palabras clave: racismo contra los negros, biopolítica, pandemia, reparaciones, violencia, raza, racismo, Suráfrica, Brasil, Estados Unidos

Marco decolonial para aplicar la reflexividad y la posicionalidad en la investigación de la salud mundial

Thirusha Naidu, Gareth Gingell y Zareen Zaidi

Las prácticas contemporáneas de la investigación se relacionan con la creación y producción de conocimiento colonial e imperialista y pueden promover perspectivas perjudiciales para los grupos marginalizados y oprimidos. Presentamos un marco para un enfoque decolonial de la investigación en salud mundial y en

promoción de la salud aplicable en todos los contextos de la investigación. Este marco está encaminado a anticipar y aliviar las prácticas potencialmente nocivas inherentes a los métodos de investigación dominantes. Se enfoca desde una perspectiva de niveles macro y micro en tres díadas fundamentales: 'contexto' y 'rendición de cuentas'; 'identidad de la persona que lleva la investigación' y 'posicionalidad', y 'ética del proceso' y 'ética en la práctica'. Presentamos una guía para considerar la reflexividad y la posicionalidad tal como se aplican en este marco en la práctica de la investigación en salud mundial y en promoción de la salud.
Palabras clave: investigación de base comunitaria, investigación participativa, educación (incluye educación para la salud), equidad, justicia social