Introduction
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Latin American critical medical anthropology (LA-CMA) is a product of its context. Social histories of inequality, ethnocide, racism and internal and external colonialism, aggravated by a spate of dictatorships interspersed by foreign military interventions, civil war and rebellion, have marked Latin America and its academic production as deeply as its richly diverse cultural and ethnic landscape. When universities took on a central social role during the decades of economic development in the 1940s–60s, academic voices began generating critical commentary regarding the human fallout of economic, political and social processes. Anthropological and sociological works that documented similar and contrasting social patterns in Central America, Mexico, the southern cone and Andean regions contributed to critical debates drawing on Marxist and Gramscian thought, dependency theories and Soviet-era communism, while Catholic liberation theology and indigenous epistemologies added ideological and ideational perspectives to interpretations of history, development, culture and wellbeing.

As we outline in this volume, Latin American critical theory has been particularly influential at the intersection of medicine, epidemiology and anthropology, leading to the development of whole fields of study. These have been pivotal in the development of Latin American social sciences since the mid-twentieth century. Yet in the ethnocentric anglophone-dominated academic world, where literature produced in languages other than English is little known and rarely cited, acknowledged contributions to the field of LA-CMA are scarce.¹ Waitzkin et al. (2001: 315) suggest that this lack of impact ‘reflects an erroneous assumption’ that the ‘intellectual and scientific productivity of the “third world” manifest a less rigorous and relevant approach to the important questions of our age’. Narotzky (2002) points out that hegemonic Anglo-American academia has systematically ignored anthropological
production published in Spanish, including by those who work from similar political economy perspectives. Martínez Hernáez (2008), for his part, argues that there are multiple ironies to this obliteration. This includes Anglo-American anthropologies’ and CMA’s claim to ownership of political economy and neo-Marxist theoretical approaches that originated in Latin American critical thought (such as dependency or under-development theories) or in southern Europe (Gramsci’s theory of hegemony), while they ignore social science production that builds upon these traditions in Portuguese, Spanish or Italian.

Other progressive theories such as collective health and social medicine have been marginalised and colonised, while the epistemic hierarchy of scientific knowledge production and the hegemony of the anglophone academic systems of ranking and qualification remain unchallenged (Santos 2014).

For these reasons, research about this region by Latin American theorists rarely has global impact. Concerned with this dismissal and well aware of theoretical contributions from Latin America, the editors of this book organised a series of events, beginning with a workshop in Oaxaca, Mexico, at which anthropologists working in the UK, Mexico and Brazil were invited to present their research on theory and practice in CMA. The event generated great interest and enthusiasm, covering fields as diverse as chronic diseases, ethnographies of maternal health, rare genetic diseases, judicialisation and human rights, violence and mental health. As a result, we learned of the breadth of CMA’s ongoing relevance to contexts across the globe as threats to social cohesion grow, as much among dementia patients in the UK as among Central American migrants.

Riding on the success of this event, a second meeting and a series of conference panels were organised in London, Lisbon and Florianópolis, Brazil, taking a deeper look at Latin American critical theory around health inequalities and drawing together critical anthropologists from Argentina, Brazil, Ecuador, Mexico, the UK and the USA. This book is a product of these collaborations. To the best of our knowledge it is the first to bring together Latin American ethnographic contexts and theories of CMA in the English language.

The editors sought to create a volume that included a significant number of authors whose work has rarely or never been published in English, with an implicit focus on both the ethnographic context and the generation or reinterpretation of Latin American critical theory. The book provides a showcase for cutting-edge ethnographically informed anthropological research focused on and informed by Latin American social and historical contexts, including original theoretical contributions. The collection includes work spanning four regions in Latin America (Mexico,
Brazil, Guatemala and Peru) as well as the trans-migratory contexts they connect and are defined by. It draws on research that is focused on diverse social practices and contexts pertaining to health, including reproduction, sex work, rare and chronic diseases and the use of pharmaceuticals. In doing so it addresses themes of central relevance to medical anthropology and global health, such as agency, identity, reproductive politics, indigenous health and human rights. Given the wealth of research being undertaken in Latin America and given its specific history of engagement with critical theory, there is an urgent need to provide wider access to this expertise for an English-speaking audience who can engage in dialogue with, and learn from, anthropological work being undertaken in the region.

Several of the chapters were co-authored by Latin American and European or North American scholars, providing a double perspective that adds value to this collaborative endeavour. The final product, we hope, explores the hugely valuable contribution that LA-CMA can play in understanding, explaining and potentially addressing some of the most pressing health concerns facing our globalised world today.

What is Latin American critical medical anthropology?

Theoretical developments in LA-CMA offer sharp critical interpretations of the causes and contexts of health, illness, suffering and wellbeing because this academic work is based on research, practice and experience that reflect a shared history. In contrast to the ‘us and them’ that characterises much ‘northern’ anthropology, in Latin America there is a tendency to reflect on ethnographic experiences from within the historical, social and political contexts of Latin America, defined by highly unequal structures of race/ethnicity, gender and social class. This has been referred to as a ‘culture of social critique’, reflecting on ‘visible signs of extreme socio-political authoritarianism and inequality’ and ‘social unfairness in the global economy’ (Breilh 2008: 745). Several of the authors in this volume make reference to the work of the Mexican anthropologist Guillermo Bonfil Batalla (1935–1991) as a pre-eminent figure in this field who called attention to the conditions of inequality and marginalisation experienced in the mid- to late twentieth century, especially among indigenous populations (Bonfil Batalla 2006 [1962]), and the need for policy and practice interventions to overcome these conditions.

Latin American medical anthropologists and those of us who position ourselves within this sub-field tend in fact to be immersed in contexts of profound inequalities, which makes it almost inevitable
that our professional commitment, definition of research interests and subscription to theoretical orientations will fall within the field of CMA; this often occurs even if we do not openly label ourselves as critical medical anthropologists. These research orientations often reside on an ethnographically grounded and theoretically oriented understanding of social inequalities, often combining research and involvement in transformative action. This link between research and action – the attempt to understand and act upon multiple social inequalities – is one of the prime contributions of LA-CMA, and constitutes an underlying idea for many authors in this edited collection.

In contrast, CMA as a discipline of its own originated in the late 1980s in Anglo-American academia to account for a Marxist and, at times, practice-oriented perspective (Singer and Baer 1995; Morgan 1987; Singer 1986, 1990; Singer et al. 1990). Anglophone CMA evolved as an alternative to what was considered mainstream medical anthropology. From its inception, CMA embraced the political economy of health, sickness, health-seeking and healthcare delivery. It brought a materialist, systemic and macro-social perspective to medical anthropology in order to study how biomedicine, the biomedical model of care and the medicalisation of everyday life have expanded in North America and Western Europe as well as in most of the rest of the world. It showed how epidemiological profiles, social vulnerability and health resources are unequally distributed in today’s globalised and neoliberal world. It unravelled the corporate production of harm through the deregulated commoditisation of pharmaceuticals, food, cosmetics, guns, agriculture and medical implants (Singer and Baer 2009). Finally, it enquired into everyday micro-dynamics in health and illness to reveal underlying macro forces and deepening power asymmetries linked to monopoly capitalism and neoliberalism, persistent imperialist drives, colonial, neocolonial or post-colonial heritages, and even racist and ethnocentric nationalism and xenophobia.

In later years, Anglo-American CMA expanded to become more inclusive of post-structuralist cultural critiques of individuals’ and collectives’ experience of suffering, ill health and harm within contexts of structural or symbolic violence (Scheper-Hughes, 1992; Scheper-Hughes and Bourgois 2017); ideological and cultural processes behind the expansion of medicalisation, the role of the state and biopolitics; hegemonic social representations around entitlements, bodily regimes, health and welfare politics at the expense of the poor; and the production of knowledge and scientific discourse intertwined with dominant societal notions of gender, race and ethnicity.
Despite their different beginnings, in practice Latin American and anglophone CMA converge in many ways. Both have become theoretical and methodological orientations that are vigilant of structural determination and power relations around health, illness and healing, while their fields of inquiry include individual and collective responses (Seppilli and Otegui 2005). Both take a political economy approach within medical anthropology, generated through ethnographically grounded and theoretically oriented understandings of social inequalities and power asymmetries in health, sickness and healing combined with a keen interest in understanding and naming those problems in order to transform them (Farmer 1992, 1999, 2005; Freyermuth Enciso 2003; Freyermuth and Sesia 2006; Holmes 2013; Ponce et al. 2017; Singer and Baer 1995, 2009). CMA and LA-CMA have both demonstrated how epidemiological profiles, social vulnerability and health resources are unequally distributed in today’s globalised and neoliberal world. Both scrutinise micro-relations and subjective experiences of pathologies and health-seeking, within larger systemic issues and contexts of power and inequalities (Betancourt Rodríguez and Pinilla Alfonso 2011; Farmer 1992; Mendoza González 2011; Scheper-Hughes 1992; Holmes 2013). Perhaps most emphatically, the Latin American version acknowledges its debt to Marxism and the Gramscian concept of hegemony that is widely used, particularly by Eduardo Menéndez – one of the most influential Latin American medical anthropologists working today (see Menéndez 1981, 1984, 1990; Módena 1990).

This positionality within CMA has been particularly well developed in Latin America, where anthropologists have critically examined intercultural perspectives on health and the relationship between ‘traditional’ and ‘hegemonic’ models. In so doing they have also explored and expanded on the classical anthropological notions of disease and illness, and wider efforts to study this as a process that is socially determined.

These orientations have led to the development of influential theoretical concepts such as structural violence (Farmer 1999 and 2005), which has been widely applied to regional realities by critical medical anthropologists within Latin America. Other conceptual categories, such as medical pluralism (Leslie 1980), were rediscovered and repurposed in LA-CMA in the context of the hegemony of biomedicine and its simultaneous asymmetrical coexistence with other medical models, including indigenous traditional medicine and domestic health-seeking or self-care. This sub-field is complemented by theoretical developments such as salud intercultural (intercultural health; see Campos Navarro 2016; Fernández Juárez 2004, 2006; Ramírez Hita 2009), intermedicalidade (intermedicality; see Greene 1998; Follér 2004; Langdon 2018), la
determinación social de la salud (the social determination of health; see Breilh 2008, 2013), and proceso salud/enfermedad/atención (the health/illness/care process), autoatención (self-care) and el modelo hegemónico bio-médico (the hegemonic biomedical model; see Menéndez 1984; 1990). These conceptualisations of the relationship between different societies and medicine have enjoyed a broad dissemination within LA-CMA for their ability to explore and explain socio-medical realities that are widespread in the region. However, their theoretical applicability transcends Latin American borders, and yet they are almost unknown outside the region.

LA-CMA did not follow one specific route, but many. Although its embeddedness in a social context of inequality established CMA as a branch of social critique, within this broad field LA-CMA follows a variety of anthropological traditions linked to the development of different national schools in Argentina, Brazil, Colombia, Mexico and Peru – to name but a few. These national traditions developed throughout the twentieth century in conjunction with specific hegemonic projects of state formation in each country; they were also influenced by Anglo-American and French anthropological schools to varying degrees. In Mexico, the influence of North American anthropology was predominant, although medical anthropology developed from the 1950s very much building on the work of Gonzalo Aguirre Beltrán (1908–1996), whose theoretical orientation was inspired by structuralist Marxism and a historicist approach (1955; 1986). Brazilian anthropology, on the other hand, was more influenced by French ethnology; here too, a national anthropological tradition coalesced around the development of an anthropology of health whose distinctive ethos was linked to Brazil’s specific historical and social processes (Langdon and Follér 2012). The idea of a Latin American anthropological tradition in CMA as a coherent and homogeneous field is challenged by these diversities, including the existence of linguistic barriers between the Portuguese and Spanish languages that limit dialogue. In this sense, this book is also a wager on strengthening these regional dialogues.

**Structure of the book**

This book is structured across four thematic sections that bring new insight and understanding to how critical medical anthropology is being examined and addressed by those both living and working in Latin America.
Intercultural health: Critical approaches and current challenges

The first section of the book focuses on intercultural and indigenous health in Latin America, rethinking critical approaches and current challenges. Intercultural health has often been defined in terms of the ‘integration of western and traditional indigenous medicine’ (PAHO 2002). For some time it has been an area of concern and engagement by a wide range of medical anthropologists working in Latin America, who have demonstrated the diversity of practices, hegemony and power involved in these relationships and the failure of intercultural health policies in a majority of regions (Campos Navarro et al. 2017; Menéndez 2012). The chapters in this section shed further light on these dynamics, demonstrating how efforts at developing ‘intercultural’ approaches must be critically and reflexively examined in relation to questions of power, interdisciplinarity and activism.

Esther Jean Langdon and Eliana Diehl reflect on how the emergence of the public health system in Brazil in the late 1980s, as a product of two decades of campaigning by the sanitary reform movement, also created opportunities for the involvement of indigenous participation in specific areas of Brazilian healthcare organisation and delivery. They show how this has shaped the ‘anthropology of health’ in Brazil as distinct from critical ‘medical anthropology’ in North America. Most importantly, they draw attention to the ambivalent involvement of indigenous communities and representatives, illustrating how, as the specific case of the Kaingang NGO highlights, external priorities force indigenous NGOs to work within a centralised and bureaucratic landscape that undermines efforts at intercultural healthcare. The authors also draw on Menéndez’ work to demonstrate how Latin American CMA has not achieved the influence of North American anthropology, despite the incredible diversity of therapeutic processes analysed and examined.

Building on more than a decade of ethnographic work with Mexican indigenous communities, Jennie Gamlin and Lina Berrio’s chapter gives an overview of critical medical anthropology with indigenous communities, focusing on what long-term ethnographic work and ‘practivists’ or intellectual activists have learned from the field and the theoretical contributions that these relationships have made to key theories within LA-CMA. Drawing on case studies from their own work on maternal health with Mexican indigenous communities, the authors point to the role of responsive indigeneity and indigenous anti-colonial resistance in the development of new theories. They propose that by its very nature intellectual activism generates theory that must be attributed as much...
David Orr and Frida Herrera make use of comparative ethnographic research in Mexico and Peru to revisit classic anthropological terrain concerning how to understand and interpret a condition that is common across Latin America, susto, often defined as ‘soul loss’ or ‘fright sickness’. They demonstrate the value of committing to an approach that aligns critical medical anthropology and its attention to structural inequalities with recent work in the anthropology of emotions, suggesting that the failure to do so has in part been due to a colonial legacy of seeing susto in terms of ‘non-Western somatisation’. In doing so they not only highlight the variability and diversity of how susto is experienced in different regions of Latin America but also ask important questions concerning the need to better integrate structural inequalities, subjective accounts and phenomenological approaches to better understand what it means to ‘live in conditions of fright’.

Drawing on a political economy framework, Rebecca Irons provides another important perspective on questions of intercultural health and health pluralism as ‘self-care’, focusing on the use of ‘post-coital’ pills in Lima, Peru. Drawing on rich ethnographic data, she shows how in a context of limited resources and options for low-income women in Lima, the meanings of these pharmaceuticals are multiple, deeply dependent on both flexible interpretations of religious beliefs and local understandings of the temporalities that configure conception and foetal development. It is this situation, however, that ultimately both reflects and reproduces inequalities, given how structures of reproductive governance in Peru fail to address and account for these differences in developing appropriate interventions for low-income and indigenous women.

Globalisation and contemporary challenges of border spaces and biologised difference

In the second section of the book we turn to examine how globalisation, whilst a contested and diverse phenomenon that is neither homogeneous nor unidirectional (Lowenhaupt Tsing 2005), nevertheless creates new contexts and challenges for examining how structural inequalities are entangled with and help to create ‘border spaces’ as well as biologised boundaries of difference. The first comes sharply into focus in the discussion of two chapters which examine how Central American migrants’
lives and experiences in the US–Mexico border region are shaped at a nexus in which structural inequalities, vulnerabilities and discrimination inform life trajectories and opportunities. In the discussion by Olga Hernández we see how drug consumption among specific migrant communities in the US (mostly Mexican men, in this case) is pursued and made meaningful as a form of ‘self-care’, even as this is shaped by injustice, inequality and violence. By foregrounding individual experiences and daily physical and emotional struggles that contribute to the precarity of migrants’ lives, we witness the diverse embodied contexts and consequences of drug use as a ‘care’ strategy in efforts to overcome the challenges of social, economic and political inclusion in the new environments that these Mexican migrants now live in. Similarly focused on the border spaces of the US–Mexican region, Rubén Muñoz Martínez and his co-authors focus on the specific vulnerability that Central American male migrants experience in relation to drug use, sex work and HIV exposure. Adopting a ‘social mapping’ approach, this chapter importantly highlights how particular public/private spaces in urban border cities in Mexico create and facilitate the structural vulnerability of these migrants in specific ways, as they navigate highly precarious ‘border spaces’ of the Mexico–Guatemala frontier.

If diverse aspects of biological, cultural and social globalisation shape how the fluid border spaces of migration are lived, they can also entail the remaking of other, more entrenched boundaries and categories of difference. In their chapter Melania Calestani and Laura Montesi examine how the globalising discourse of genomics (Gibbon et al. 2018), and the recent enormous investment in genomic research aimed at elucidating how genetic difference relates to categories of race and ethnicity (Wade et al. 2014; Saldaña-Tejeda and Wade 2018), are central to understanding and intervening in health disparities. Providing an important comparative perspective, they examine how discourses about population difference and genetic aetiologies, as this concerns type 2 diabetes in Mexico and chronic kidney disease in the UK, undermine a necessary wider focus on how health inequities are embedded in broader social histories, neoliberal ideologies and ‘infrastructures for racialization’ (Lee 2005). Drawing on Breilh’s concept of ‘critical epidemiology’ (2008) and also pointing to an emerging field of epigenetic research and recent social science work on the ‘somatisation’ of race, they urgently underline the need for an approach that includes the biological as always situated within wider social and material ecologies in addressing and intervening on health disparities.
Political economy and judicialisation

A political economy perspective has been a central tenet of the critical medical anthropology approach, which is attentive to how historical and political forces and social institutions shape the distribution of economic resources in diverse healthcare arenas. Whilst such a perspective continues to be of vital importance to many of the contributors in this edited collection, a number of them are also attentive to the changing parameters within which these dynamics function in specific Latin American contexts, and the uneven consequences this has for action and agency with regard to how rights and choices relating to health are sought and secured. In the final section of the book we explore these questions through the lens of three contributions. The first, by Rosa María Osorio, directly examines the uneven benefits and burdens that are brought about by the incorporation of new forms of privatised primary healthcare services within pharmacies in Mexico – a phenomenon that has expanded rapidly in the last 10 years, particularly in urban areas. Whilst these novel public/private alignments in the provision of healthcare in Mexico reflect the ‘niche’ expansion of the pharmaceutical industry, multiplying both its markets and consumers, we also see that this is not sufficient to understand the complex dynamics at stake in these developments. These include greater and easier access to professional medical care for a wider range of often poorly served publics even as this community, rather than the state, absorbs the cost of this expanded but not closely regulated form of healthcare provision. Yet as this chapter outlines, these clinics ‘annexed’ to pharmacies constitute an easy and relatively swift way of expanding healthcare that is nevertheless gradually displacing efforts to redress deteriorating public health services.

A similar sense of complexity and also ambivalence is evident in the two chapters that constitute the final section of the edited collection, reflecting in complementary and contrasting ways on the expanded space of judicialisation in Latin America for pursuing human rights and accessing healthcare services and biomedical resources. In the penultimate paper of the book Paola Sesia examines how novel forms of ‘counter-hegemonic’ activism have emerged in the context of maternal care in Mexico in response to persistent racial discrimination against indigenous women. Drawing on one particular high-profile case, Sesia shows how these have become mobilised through media visibility and an articulation of what is described as ‘obstetric violence’. Accompanied by judicial actions, these processes appear to offer a mode of public redress, compensation and potential transformation of the healthcare system.
Yet it is clear that whilst judicialisation can be successful in the field of human rights and maternal care in Mexico, it is not a panacea. The ongoing gap between the immediate success achieved in one high-profile case and wider efforts to shape healthcare institutions and infrastructures illuminates how judicialisation is only ever at best a partial and temporary solution.

The final chapter in the collection turns to another arena in which questions of activism, political economy and the expanding realm of judicialisation have become complexly entwined in the context of rare genetic disease in Brazil. Waleska Aureliano and Sahra Gibbon examine how an exponential increase in efforts to secure healthcare services and resources in Brazil by entering into judicial actions in relation to a wide range of disease conditions, including HIV/AIDS medications and cancer, have also become significantly evident in the context of rare genetic diseases – conditions that are thought to affect between 13 and 15 million people in Brazil. Drawing on ethnographic research and analysis of media and public discourse, they examine how a discourse about the ‘right to life’ is diversely mobilised by implicated communities that include government, civil society and the pharmaceutical industry in disputes that oscillate between the budgetary limits of the state and the commercial interests of the market. They powerfully show how in a context where the commodification of health weakens the public health system, rare-disease patients and their families are placed in situations of profound uncertainty and instability, with little choice but to judicialise.

Concluding remarks

The process of editing this collection has provided a valuable opportunity to reflect upon the wider relevance of LA-CMA beyond this region, to Europe and North America, as well as further afield within the Global South. When we initially conceived of this project several years ago, the socio-political context of Latin America appeared to stand out as a global example of how neoliberalism, unabated and unchallenged, in a context of extreme inequality and built upon fragile states with segmented populations, had created complex scenarios of violence, apparently unsolvable social frictions often based on racial and ethnic divisions and varying responses from within civil society, academia and the political economy itself. Within Latin America, Brazil and Mexico are two powerful recent examples of how people and political systems are responding on the Right and Left, each hoping that an institutional effort can solve their national crises.
Three chapters in particular allude to this in different ways: Paola Sesia gives a human face to human rights activism around obstetric violence; Jennie Gamlin and Lina Berrio talk about how indigenous women are subtly seeking ways to influence unequal gender relations through maternal health; and Sahra Gibbon and Waleska Aureliano describe activist processes around access to medications. These are examples of responses to the human fallout of a political economy that has not sought to ensure health and wellbeing or social justice for the population as a whole. They are examples of structural violence where the means and knowledge required for greater wellbeing exist, but resources are unequally distributed to the detriment of certain groups within society. As we conclude the editing of this book, it becomes evident that what once appeared to be confined to the socio-historical context of Latin America and the Global South – regions and nations that to varying degrees and for different time frames have been, or continue to be, subject to colonial rule – is in fact a pattern that is diversely repeated the world over. Populist governments, racially motivated massacres, climate denial, the post-truth society, social media corporations usurping democracy, whole political systems falling apart under the weight of divided populations – all these are signs of the dysfunctional, even dystopian state of globalisation. This context leaves no doubt about the relevance of LA-CMA to the health of the world population, now and in the coming turbulent times.

While we can clearly vouch for the global relevance of LA-CMA, any attempt at an overview of this broad and diverse field will face the impossibility of including each and every one of the many themes and populations that it comprises. The large number of works on the health of indigenous peoples included in the book demonstrates their importance in Latin American anthropological production, including medical anthropology. Urban populations are also amply represented, from Central American and Mexican migrants in Mexico and the United States to migrants of multiple nationalities in the UK and middle-class sectors in Brazil and Mexico. However, we have been unable to include work on the health of Afro-descendant populations, despite their numerical importance in the region and the conditions of vulnerability that most of them face. In 2015 the Economic Commission for Latin America estimated the total number of people of African descent in Latin America to be 130 million people, equivalent to more than 20 per cent of the total Latin American population. The majority are located in Brazil with 97 million, followed by Cuba, Colombia, Mexico, Ecuador and Venezuela.
(Del Popolo and Rangel 2017: 51). We are also indebted to rich regional productions, particularly from Brazil and more recently research carried out in Colombia and Ecuador, on the characteristics and health conditions of Afro-descendant populations, even more so considering that we are writing during the Decade of People of African Descent (2015–24). Promoting a greater circulation of anthropological works in this field should undoubtedly be considered a priority for further research on CMA. We also recognise regional specialisations, in particular the considerable body of theoretical work produced in Argentina, which has been relevant and influential in its own national context as well as to research at a theoretical-methodological level throughout the region, and is host to landmark journals within this field including the influential *Salud Colectiva*. In conclusion, by drawing attention to some of the thematic and theoretical gaps in this current volume, as well as the absence of work from the Andean area and southern cone of Latin America, we hope to stimulate further research in the region, and more importantly to highlight the rich opportunities for ongoing engagement with and development of critical medical anthropology in and from Latin America.

Notes

1. This exclusion encompasses medical anthropological production from Italy and Spain, besides Latin America. At the same time, there has been significantly a high degree of cross-fertilisation between LA-CMA (especially from Argentina and Mexico) and CMA from southern Europe (Seppilli and Otegui 2005: 8).

2. Martínez Hernáez (2008: 153) ventures that this exclusion is the result of two concomitant phenomena: intellectual domination (others would label it ‘intellectual colonialism’) and the commodification of knowledge production in English-speaking academia. Intellectual domination is argued to occur because anglophone academia suffers from a peculiar form of ethnocentrism that consciously or unconsciously excludes all production in languages other than English as invalid, irrelevant or non-existent. The commodification of knowledge refers to a relentless process of theoretical innovation that is constantly and mostly produced in the English language to be consumed in the global academic market – a phenomenon from which even CMA cannot escape.

3. Breilh (2008), a leading critical epidemiologist from Ecuador, highlights that when European social and health scientists developed the social determinants of health model for WHO in 2005–8, they disregarded pioneering social medicine and collective health literature produced since the 1970s by Latin American critical thinkers. He argues that this omission cannot be explained simply by linguistic barriers. It may be due instead to an epistemic and political disinclination to include a critical approach that deeply questions power relations in an increasingly unequal market society. Social medicine integrates capitalist accumulation and exploitation, gender domination, racism and ethnic discrimination into its theoretical analysis of historically structured health profiles and lifestyles among individuals as well as collectives.

4. In this category we include the many ‘adopted’ anthropologists and committed academics from Europe and North America who have dedicated much of their life’s work to the development of Latin American anthropology and/or working in Latin American academia.
References


