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Participation and diversity – the inclusive and multiepistemic construction of Global Health

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Abstract *The shaping of a new field to encompass health formulations and practices on a planetary scale must consider the multiple agents and territories involved and their differences and inequalities. The inclusion of different social segments in the decision-making processes and theoretical elaboration of Global Health, through participation, is presented as a strategic and necessary condition for facing transnational issues. This participation ensures political and epistemic diversity in establishing a global health committed to Global Health equity. The Latin American tradition that articulates research and action and the proposal for the Knowledge Meeting can contribute to participatory processes of constituting the field of Global Health in its practical and theoretical aspects.*

Key words *Global Health, Participation, Epistemic communities*

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Participation in the construction of Global Health

This essay assumes that participation is a strategic and necessary condition for establishing a new field, represented by Global Health (GH), dedicated to transnational issues identified more than ever on the planet. Participation both at the political and epistemological level and with effective sharing of power and knowledge in defining GH. Such participation must be qualified and attentive to the risks of subverting its principles, establishing an ethical reference for setting a GH committed to global health equity. Including different stakeholders would strengthen the consideration of the social health determination[1] within GH – that is, the relationships between the social and the biological spheres and between society and nature in the production of health and disease.

Participation can be considered a reference or a necessary condition for developing what have already been considered four key GH themes[2]: 1) the field's multidisciplinary and multisectoral composition; 2) the presence of an ethos guided by justice's principles; 3) governance that influences territories and countries beyond known borders; 4) the polysemy of a concept still under construction. We should add here the three principles proposed for GH by Garay et al. in 2013[3] – **health for all** (for people all over the world seeking equity), **health in everything** (emphasizing social determinations and promoting social cohesion), and **health through all** (including the several stakeholders in participatory fashion) – among which we highlight the last one, insofar as it seeks to provide the first two with the consideration of the existing particularities and specificities.

It has already been stated that GH would be a field[4], as proposed by Bourdieu (2010), which is equivalent to conceiving the existence of individual and institutional correlated agents, capital valued in this environment, a common *habitus*, and the recognition of issues in dispute or "game" played (*illusio*), per the French sociologist's formulations[5]. However, that has not happened yet. Despite efforts undertaken for over a decade to establish a GH concept[6,7], Salm et al. (2021) point out the profusion of divergent definitions about what would be GH's object, attributions, and commitments. Ambiguous meanings assigned to GH emerge in this study[2], feeding a lasting uncertainty[6]. While fruitless to establish a minimum benchmark, such proposed definitions are almost entirely from allegedly developed nations, some with special leading roles[8].

The divergence and even the dispute in defining what GH would be, mirrored in this conceptual polysemy, indicate that the field is currently a venue of ongoing social relationships and not an adequately established field. GH may become a field in the strict sense of the term, but for now, its contours derive from connecting and crossing points between agents from consolidated fields such as Public Health[9], Collective Health[10], and International Health[11].

Regardless of the condition of the social space or field in the making, GH's intention to standardize health initiatives at a wide range of levels and territorial scales requires special attention. After all, insofar as it is a field under construction to set measurements, parameters, and standards of global reach, its final format can be reproduced worldwide.

Therefore, the GH setting process must become sufficiently porous to the existing gaps between the territories on which it can act – and which run the risk of being amalgamated under the same mantle of globalized health. It seems necessary to broaden the debate, including institutions, other fields, and social movements in the countries, among others, in establishing purposes, normative references, discourses, research, and practices in GH – thus confronting the already identified hegemonic central countries[8] and the homogenization risk[12] – precisely because of the resumed traditions and proposals that allow exceptionally qualified participation.

Participation in the political plane

There is a permanent and growing risk that the status quo will impose a GH conception. Participation can be a privileged way to include concepts, visions, and experiences linked to the health-disease-care process, avoiding the single thought directed to life commodification and entrepreneurship. After all, we see many escalating neoliberalism examples that assumed the euphemistic internationalization format[13]. When addressing the health determinants and determinations in Latin America (LA), particularly in Brazil, we reproduce practices amid deep social contradictions such as the structural inequality that underpins our continent, the impact of fiscal austerity policies, and the consolidated neoliberal project.

Most democratic institutions and practices – to which the participation concept is unavoidably tributary – emerged in 17th century England and were consolidated in Europe and the U.S. until

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they were presented to the rest of the world as a desirable form of political establishment: separation of powers, parliaments, representation, elections, political parties, setting the basis on which participatory experiences have multiplied globally in recent decades. Such experiences have spread, encouraged by agents as diverse as left-wing parties, urban public policies, multilateral financing institutions, NGOs, and members of associative and community councils. The demand for more democracy, distribution of power, and recognition of local power in the face of an all-powerful State was one of the flags of urban social movements in the 1960s. Several participatory experiences emerged due to these struggles, such as public urbanism workshops in France and Italy and other community development experiences in English-speaking countries and the Third World[14,15], including the so-called health movements in the 1970s and 1980s in Brazil[16].

From the viewpoint of democratic theory, participation fits better in the so-called broad – with an exchange of viewpoints, joint defense of interests, and determination of priorities as rights – than narrow democracy concept. Thus, unlike restrictive democracy, which is predominantly instrumental, the strong perspective of democracy favors a relational theory in which participation plays a fundamental role[17,18]. This perspective implies establishing the field of GH considering the multiple knowledge and conceptions regarding the disease-health-care determinants and processes, including local communities that hold non-hegemonic practices and views on such determinants and processes.

When sliding from the notion of vulnerability or lack to the idea of common interest and, later, to rights – or more generally, from a democratic regime to a democratic society – openings can be found to establish creative and diversified participatory forms[18]. In Brazil, Dagnino[19] argues that participation attempted to overcome the State-civil society antagonism witnessed during the dictatorship. The author[19] states that the participatory project aims to share power and responsibilities between civil society and the State. However, the simultaneous use of expressions and concepts of *participation* (and others such as *civil society*, *citizenship*, and *democracy*) by different agents and political projects creates what the author calls a perverse confluence, leading to a discursive crisis. She[19] emphasizes the need to avoid participation to validate proposals that favor interests in expanding and reproducing national and international capital – particularly evident in the World Bank financing, in which participation is a condition to finance interventions that affect vulnerable communities. However, such participation forms are far from ensuring effective leadership to those involved, serving instead instrumental and perverted use (in the meaning provided by Dagnino[19]). The recent Ministry of Health initiative that postponed the vaccination of children aged 5 to 11 years against COVID-19, after its approval by the competent authority – the National Health Surveillance Agency – justifying the need to carry out consultation and public hearing before initiating childhood immunization is another example of perverting the meaning of participation.

What we consider in this topic indicates that the combination of practical, institutional, and theoretical aspects shapes the multifaceted character of participation, making attempts to give it a precise definition slippery, which, in turn, hinders attempts to systematize its possible effects and meanings[17]. Even so, the need to find adequate means for effectively including different health perspectives, conceptions, and practices seems imperative, establishing inclusive and participatory paths in the configuration of a potential GH field.

Participation in the epistemic plane

The effective circulation of knowledge and participatory processes in general and in GH, in particular, will not be ensured considering only the inclusion of interested/potentially affected parties, even with reduced distance and verticalization between groups. Different agents, movements, and institutions should be considered along with the several segments' different ways of knowing, from a multiepistemic perspective, in the interactions established. In Latin American countries, the democratization processes that started in the 1970s and 1980s were tributaries of a flourishing local associative life. In this direction, the reference to implementing participatory processes linked to the production of GH knowledge in our subcontinent can benefit from these regional productions. Such is the case of what Bringel and Versiani[20] called **militant research** – a set of different theories and actions linked to the challenges of the Latin American reality of knowledge production that combines critical and theoretical reflections with the practice of popular struggles – proposed by authors such as Orlando Fals-Borda, Paulo Freire, Carlos Rodrigues Brandão and Michel Thiollent[20].

The concept of militant research articulates the research-action binomial, resulting in the production of knowledge oriented toward transformative action and praxis, intertwining knowledge production with interventions in the real world. This characteristic makes militant research a necessarily collective and participatory process of defining what should be researched and its analysis, engaging people involved in social struggles. The Latin American roots of the so-called militant research and its critical adaptation of references from major countries facing intellectual colonialism and commitment to emancipation, among other characteristics, can offer epistemological, methodological, and political support to the constitution and advancement of GH in Latin America, per the Brazilian experiences in previous decades[16].

More recently, the proposed Knowledge Meeting (KM) establishes a concrete dialogue between knowledge through the inclusion of traditional knowledge in the curricula and traditional university teaching masters[21]. In synthesizing the first ten years of KM[21], we pointed out the proposal's implementation in dozens of Brazilian universities and other countries. We emphasized its interventional nature in essential dimensions of the academic world: ethnic-racial, political, pedagogical, and epistemic inclusion[22]. While focused on overcoming the limitations of the traditional university institution, the proposed KM converges with some aspects of militant research as mentioned above and represents advances in participation initiatives in the epistemological scope[13]. After all, the inclusion of groups, knowledge, and discourses systematically silenced since the creation of Brazilian universities becomes potentially inspiring for truly dialogic, interactive modes to establish GH. KM seeks data and information from those called to participate in the research and, above all, interact and learn with communities – in the figure of their masters – ensuring spaces for other ways of knowing and generating knowledge to be effectively considered. In the case of health intended to be global, the existence and use of references that allow us to understand how different communities conceive, elaborate, and act around the health-disease-care issues seem essential to shaping GH, mainly communities whose visions and practices are related to the concepts of "*health for all*", "*health in everything*" and "*health through all*", mentioned earlier based on Garay et al.[3].

Conclusions

By embracing a broad spectrum and facing health contingencies on a planetary scale, the GH must broadly address differences via participation, becoming a new global forum for democratic practices, debating the difficulties of producing health for all, in everything, and through all. The interests involved in the GH debate are broad and often contradictory, but this is not an insurmountable obstacle. The welfare state emerged, in the last century, from the unlikely union between the workers' movement that aimed at a social revolution, conservative currents that aimed to prevent it, rulers who tried to secure themselves in power, and humanitarian movements that supported people's improved living conditions. This unexpected confluence of stakeholders and viewpoints resulted, at least in Western countries, in a fertile and common ground on which very different variants of the welfare state could be built, from the social democratic model to the liberal and the conservative[23].

Discussions on GH will lose much of their meaning if they do not encompass the perspective of citizens, communities, and territories, who are the actual recipients of public health policies and other initiatives that require a multidisciplinary and transdisciplinary approach, transcending geographical and political borders, local-regional-global dimensions, and conflicts between public and private interests. In this sense, it seems necessary to broaden understanding and practices around the so-called epistemic community[24], adding to professionals who, from various disciplines, produce relevant knowledge on complex technical issues in public policies, the organized or traditional communities' ways of knowing, towards a multiepistemic community. In this sense, instead of a GH field, we may establish a true network of agents and knowledge interconnected by dialogic practice.

Collaborations

The authors also worked on the writing, review, and final version arising from these discussions.

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