

THEMES AND DEBATES

ALAMES in a Future Key. A Prospective Reflection on the 40 Years of Our Association*

ALAMES en clave de futuro. Una reflexión prospectiva en los 40 años de nuestra Asociación*

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DOI: <https://doi.org/10.71164/socialmedicine.v18i3.2025.2347>



Introduction

Surviving forty years is no small feat — especially for a current of thought that is counter-hegemonic, and for an organization with regional presence but scarce material resources. In the Latin American Association of Social Medicine and Collective Health (ALAMES), this is what we have achieved. We are proud of this, and hope to continue for many years to come. Taking advantage of this commemorative event, I would like to share a synthesis of the reflections I have developed regarding these first forty years of ALAMES: I) On the emergence of social-medical thought in the region, and of the Association itself; II) On some of the defining features of ALAMES' identity; and III) On possible strategic fronts for thought and action.

I. On the Emergence of Social-Medical Thought and of ALAMES

As Ailton —an Indigenous leader from the Amazon— expressed during this Conference, collective health was born from the bottom up, even though the social-medical current emerged in the region several decades before our Association.

I personally consider that, with roots stretching back a century in Western Europe —Germany, France, England, and Belgium—¹ social medicine began to take shape in Latin America in the mid-20th century. Particularly important were the attempts to integrate the social sciences into the field of health, as well as the rethinking of medical education. A notable milestone was the creation of

* Keynote address presented at the 40th anniversary celebration of the Latin American Association of Social Medicine and Collective Health (ALAMES), ALAMES 2025 Conference, August 4-8, Rio de Janeiro State University (UERJ), Brazil.



the Latin American Faculty of Social Sciences (*Facultad Latinoamericana de Ciencias Sociales*, FLACSO) in Chile in 1957, under the auspices of UNESCO, where some of the region's physicians and/or sociologists were trained. These professionals became interested in exploring the relationships and applications of the social sciences to health — and later went on to lead and cultivate this area of knowledge and action. It is possible that, unintentionally, the first milestone of the social-medical current in Latin America was the 1972 meeting on teaching social sciences in medical schools, held in Cuenca, Ecuador. The event was promoted by the Pan American Health Organization (*Organización Panamericana de la Salud*, OPS) and led by Juan César García, an Argentine physician and FLACSO-trained sociologist.

In the 1970s, centers of social-medical thought multiplied, among them those at FLACSO and at the School of Public Health of the University of Antioquia in Medellín. Graduate programs in Social Medicine (*Medicina Social*, MS) also began to emerge, notably the program at the Institute of Social Medicine of the State University of Guanabara in 1971 —today the Hesio Cordeiro Institute of Social Medicine at the State University of Rio de Janeiro (UERJ), host of our 18th Conference— and, in 1975, the Master's in Social Medicine at the Metropolitan Autonomous University, Xochimilco campus (UAM-Xochimilco), in Mexico. The latter was supported by officials from the Pan American Health Organization (OPS), such as Juan César García and María Isabel Rodríguez, and benefited from the participation of intellectuals from several countries, including my teacher and friend Asa Cristina Laurel, who is here with us today, as well as academics exiled by dictatorships and political persecution in the region, among them its first director, my teacher and friend Hugo Mercer, who is also here with us today. Research institutes devoted to social-medical studies also emerged in Quito, Ecuador; Rosario, Argentina; Santo Domingo, Dominican Republic; and Havana, Cuba. That same decade saw the production of several research works and theses that would serve as the foundation for the development of social-medical thought. I wish to highlight, among others, the doctoral dissertation of Sergio Arouca at the

Institute of Philosophy and Human Sciences of the University of Campinas, Brazil, in 1975, *El dilema preventivista (The Preventivist Dilemma)*,² that of Alberto Vasco in sociology at FLACSO in 1973, *Salud, medicina y clases sociales (Health, Medicine, and Social Classes)*,³ and that of Ana María Tambellini, *Epidemiología de los accidentes de tránsito (Epidemiology of Traffic Accidents)*.⁴

Latin American Seminars on Social Medicine have been held since 1981. In December 1983, another meeting on social sciences and health took place in Cuenca, led by Juan César García. Notably, it was at the Third Latin American Seminar on Social Medicine, held in Ouro Preto, Brazil, in November 1984, under the general theme “*Crisis, Health, and the Struggle for Peace*”, that the conditions came together for the decision to create ALAMES.⁵ In the founding document — the Act of Ouro Preto, dated November 22, 1984 — the circumstances that made its creation possible were laid out, along with the objectives to be pursued. These aimed to strengthen and develop the social-medical current on the continent; to ensure its presence and participation in research, teaching, health services, and community work; and to make solidarity effective with countries, institutions, and individuals in need.

In line with these objectives, over its first forty years the Association has carried out a wide range of academic, political, outreach, and solidarity activities, the achievements, difficulties, and challenges of which we have been discussing in recent days, and which are recorded in the report presented at this Conference.

II. Some Features of ALAMES' Identity

I will briefly outline just four of the many characteristics that define our Association.

1. *Beyond Conventional Public Health: Building Critical Thought in Health*

The social-medical current emerged as part of a break with the theoretical foundations and practice of both biomedicine and, especially, conventional public health and preventive medicine. Following a series of meetings on its teaching in the 1950s in several European countries, in the United States, and in Latin American countries such as Chile and

Mexico, the gates were opened for a profound critique of its scope and limitations. The thesis by Arouca in Brazil at the beginning of the 1970s, *El dilema preventivista*—already cited here—⁶ can be considered one of the milestones in this theoretical rupture. The tensions between Mexico's classical school of public health and the Master's program in Social Medicine at UAM–Xochimilco are also concrete expressions of the process of breaking away from the old model and of the emergence of the new current. In the case of Brazil, the Faculty of Medicine at this State University of Rio de Janeiro introduced far-reaching changes in 1967.⁷

In every case, it involved a critique of uni or multi-causalism and an opening toward understanding the social determination of processes related to life, health, illness, and death; the resulting insufficiency of the bio-natural sciences to account for these processes, and the need to open the doors and integrate the contributions of the social sciences, especially anthropology, economics, sociology, and history; the limits of quantifying isolated phenomena and the need not only for qualitative methods, but for a dialectical approach; dissatisfaction with the techno-bureaucratization of the public health sector and the verticality of its programs, and the need for more scientific foundations, programs more connected to social dynamics, and practices that are more situated and politically committed. These changes, in turn, redefined how to approach topics already included within the concerns of public health—such as occupational health, tropical diseases, and the relationships between the State and health—and opened space for other subjects, such as the right to health, the relationship between democracy and health, crises and health, environmental issues, and the questions and proposals put forward by feminist movements. In addition to the works already cited, among those that first propelled and later consolidated these ruptures are the works of Cristina Laurel,^{8,9} Juan Samaja,¹⁰ Luz Madel,¹¹ Saúl Franco, Everardo Nunes and Jaime Breilh,¹² Jaime Breilh,¹³ Everardo Duarte¹⁴ and Mario Testa.¹⁵

Although considerable progress has been made on these fronts of rupture and an alternative current of critical thought is taking shape, with various streams of thought and intense internal debate, the path ahead and the upcoming challenges are

immense. It can still be said that the social-medical current in Latin America is under construction, and that ALAMES, as the institution that has sought to promote and organize it, now faces challenges and tasks even greater than those envisioned in 1984. Fortunately, it already possesses a rich thematic, methodological, and practical heritage that allows it to look to the future with optimism and confidence.

2. *Health in Politics and Politics in Health*

The awareness that the field of health is essentially political is nothing new. Well known is the expression of Rudolf Virchow, made in mid-19th century Germany: “Medicine is a social science, and politics is nothing more than medicine on a large scale” (Rosen, 1985, p. 79).¹⁶ His thinking clashed then, and continues to clash today, with conceptions and practices that seek to keep health issues, institutions, and personnel—particularly in public health—at a distance from politics, in the name of certain interests and approaches grounded in a supposed scientific and technocratic neutrality. But if the entire realm of life (and death) is permeated by networks of power, and if health and illness processes cannot be understood or experienced outside the interactions among different fields of knowledge, cultural exchanges, economic-political structures, and ideological tensions, it is clear that the world of health is essentially political.

The Latin American social-medical current has contributed to substantiating, documenting, and debating each of the elements that define this political character of health. The works of García on state medicine in Latin America¹⁷ of Mario Testa¹⁸ and Carlos Bloch on the state and health (ALAMES, 1987); the collection of essays organized by Sonia Fleury on the state and social policy;¹⁹ the contributions of the Quito Center for Health Studies and Advisory Services, *City and Infant Mortality*²⁰ (; of Franco on malaria in Latin America,²¹ among many others, attest to this contribution in shaping the political dimension of the health field.

In addition, as expressed by Armando de Negri in the Juan César García lecture at the ALAMES Conference in Paraguay: “If politics is the construction of a collective ethic,²² Latin American

Social Medicine has helped build this sense of collective ethic” (De Negri, A., 2016). This collective ethic has also been developed by several members of the Latin American social-medical current, among them Giovanni Berlinguer²³—Italian by birth but deeply connected to Latin America—and Víctor Penchaszadeh.²⁴

For ALAMES, health has not been a political matter merely in theoretical terms. It has been equally, if not more, important as a political practice. Based on the conception of health as a fundamental human right and as a field for the exercise of citizenship and democracy, the social-medical current has actively and consistently participated in several countries of the region in processes of social and grassroots organization for the right to health; for the defense of sovereignty and the self-determination of peoples; for confronting dictatorial regimes and achieving the return or preservation of democracy; for non-market, public, universal, and high-quality health systems.²⁵ and for upholding Human Rights and International Humanitarian Law in cases of armed conflict. Its stance toward the dictatorships of the Southern Cone, toward the revolutionary processes in Cuba, Nicaragua, and El Salvador, toward progressive governments in Mexico, Argentina, or Venezuela, and its active role – at times one of leadership – in processes such as health reform and the struggle for the Unified Health System in Brazil, the reform of the health system in Colombia, and the proper inclusion of health issues in the new constitutions of Ecuador and Bolivia, all reflect this political practice consistent with its stated theoretical principles.

That said, neither thought nor political actions are static or free from contradictions. On the contrary, they are intensely and constantly changing, full of nuances, tensions, and—at times—contradictions. In part, the Latin American social-medical current has debated, absorbed, and endured such tensions and contradictions. There has been internal discussion about the roles played by ALAMES members while serving in local or national government positions in countries such as Mexico, Brazil, Venezuela, Colombia, or Argentina. There is ongoing debate over the position the Association should take regarding processes such as those in Nicaragua and Venezuela, which, in my view, have taken a

direction different from that which initially drew the sympathy and support of our Association. New proposals for changes to the health systems of various countries are also under discussion. In my opinion, however, what is needed is an urgent and deeper self-critical reflection on the concrete political practice of ALAMES, both retrospectively and, above all, in light of the current complex panorama of the region and the emerging alternatives. I dare to think that the very future of the Association is closely tied to its capacity to understand and accurately interpret the political moment and outlook of the region, and to set the right guidelines for action.

3. Latin American Consciousness and Purpose

From its beginnings, as initially outlined, this medico-social movement understood itself—and was shaped—as having a distinctly Latin American character and scope. The Cuenca meetings, the research centers, and the specialized or related postgraduate schools and programs all bore this imprint, and both researchers and teaching staff, as well as students in the field, came from different countries across the region.

However, the “Latin American” aspect has not been limited to the origin of its participants or the locations of its events, so far, Conferences have been held in Mexico, Nicaragua, Brazil, Colombia, Venezuela, Argentina, Cuba, Peru, Uruguay, El Salvador, Paraguay, Bolivia, and the Dominican Republic. There has been a constant effort to address problems from a regional perspective, to build shared interpretive frameworks, and to venture proposals with regional reach. Whether in selecting the theme for each Association Conference, in approaching the issues of interest to medico-social thought, or in formulating projects and proposals, the stage, the frame of reference, the ultimate objective has always been Latin America.

It is worth noting that, in these forty years of ALAMES, the Latin American reality has never negated or overshadowed national realities. On the contrary, it has contextualized, drawn upon, and transformed them into subjects of political interest and action, and, when needed, of solidarity. The dictatorships in each of the Southern Cone countries became matters of concern, study, and

solidarity in the other member countries of the Association. The course of the Cuban situation has been woven into the very fabric of ALAMES since its founding. Brazil's Unified Health System – SUS— received, from its inception, important contributions from Latin American medico-social thinkers—among them and especially Mario Testa.²⁶ It has served as an inspiration for the struggle toward similar systems in many countries of the region and continues to receive the constant support and sympathy of ALAMES members everywhere. The new Constitutions of Bolivia and Ecuador, drafted in the early years of this century, incorporated significant health-related contributions from members of the Association in various countries. Many more examples could be given, but these suffice to illustrate the role ALAMES has played as a network of communicating vessels among the countries of the region.

4. *The Genetic Mark of Solidarity.*

Even before ALAMES was born, the Latin American medico-social movement had been, at its core, essentially solidaristic. Solidarity is, and has been, bound to the understanding of life and health in this current of thought and action. It has been a solidarity with a political perspective, exercised both collectively, in the capacity of an organizational body, and individually by each of its members. The holding, for example, of the second Latin American seminar-Conference on Social Medicine in Managua, in September 1982, was an act of solidarity with the revolutionary process in Nicaragua, to which leaders of social medicine from various countries in the region actively committed themselves. The official Declarations of the Association's Conferences constitute a kind of record of solidarity with the countries, sectors, and causes of different moments. The Declaration of Ouro Preto, in 1984, made explicit the solidarity of the attendees with the struggles for peace in the region; with the people of Honduras, then invaded by the United States; with the peoples of El Salvador and Guatemala, at that moment victims of genocide; with the struggles of the peoples of Chile, Bolivia, and Argentina for the restoration of democracy. In Medellín, at the 4th Latin American and 5th World Conference on Social Medicine (which included a delegation from Australia),

solidarity extended even to the Australian Aboriginal peoples in their two-century struggle for recognition of their culture and their rights.

And, having personally been a beneficiary, I must highlight another form of solidarity that ALAMES has always practiced: its generous welcome to those in exile. Struggles—whether revolutionary in scope or simply in defense of democracy, freedoms, and human rights—often result in the exile of leaders or activists. Our Association has understood this and has practiced, and continues to practice, an active solidarity, not one of pity, but of humanity and political commitment.

We can conclude, then, that in essence ALAMES has been (and must continue to be) *a current for the production and application of critical–historical–territorial thought* in health from Latin America; *an encounter space* for academic–political–emotional and social convergence, *with thematic networks* in constant operation; and *a school of effective solidarity*.

III. Strategic fields for thought and action

Out of respect for the creativity of ALAMES and its members, for the materials already produced and presented, and for the debates currently underway, I will limit myself to listing only five of what I consider to be the essential fields and priority tasks for medico-social thought and action in both the present and the future.

1. *Life in peace in Latin America*

Our horizon as humanity must be life in peace—not life in the abstract, but life in motion, in the full exercise of organized matter and energy in movement. In Quechua: *sumak-kawsay*. Or better yet, the dignified life, *el buen vivir (the good life)* envisioned and practiced by our Andean ancestors. Three decades ago, I formulated the concept of the *proceso vital humano (vital human process)*,²⁷ which I believe can contribute to this discussion. And peace—not only as the absence of war, or, worse yet, as the product of force, as is taught and practiced today by Russia, Israel, or the United States—but as the calm coexistence of equitable societies that guarantee rights and resolve their

conflicts and tensions without resorting to killing one another.

to housing, food, education, information, and power.



From the field of collective health we have worked toward this, but we must intensify our efforts and find new arenas of both thought and action to help society make life in peace its central goal and commit to achieving it. In her recent contribution on the challenges of collective health in Latin America, Sonia Fleury concludes:²⁸

To think about how health can be a lever for emancipation, for the defense of life and democracy, is our challenge today and always.

2. Relentless struggle against all inequities.

Equity in health has been a recurring theme in critical health thought. In fact, two ALAMES Conferences (Cuba, in the year 2000, and Brazil in 2007) addressed it as one of their central themes. And the struggle for health equity has inspired the work of the medico-social movement for health reforms in the countries of the region.

But inequities in health, serious as they are, are only one part of the vast inequities across all fields of social life: in gender relations, in income, in access

From the medico-social movement we must intensify the struggle against all inequities in our region and throughout the world. This entails strong attunement to the various national realities and mobilizations, the systematic denouncing of inequities, renewed argumentation on the value of equity, and constant connection with the social and popular organizations and movements that fight for it.

3. For the effective guarantee of the right to health.

The conceptualization of health as a fundamental human right and the consequent struggle for its guarantee have also held a priority place in ALAMES. In countries such as Mexico, Brazil, Colombia, Argentina, Venezuela, Chile, Bolivia, Peru, and Ecuador, there is a solid body of theoretical work on the subject, along with significant mobilizations in defense of this right. Six of the eighteen ALAMES es held to date (Argentina, 1997; Peru, 2004; Brazil, 2007; Uruguay, 2012; Bolivia, 2018; and this one in Brazil) have included it as a central theme, fostering

a rich intellectual output and helping to strengthen its inclusion in national and regional political agendas.

Since concrete achievements in guaranteeing the right to health are still scarce, it is necessary to increasingly activate both intellectual work and political action, as well as social mobilization. And it bears repeating that, as a fundamental right, it requires not only sector-specific mobilization, but persistent social mobilizations— for which it is essential to establish and maintain relationships with other organizations and fronts of political action.

4. Relations with Nature and the Environmental Problem

We must recognize that we came late to the issue of the environment. Although the Andean ancestors had a clear awareness of our belonging to nature and the vital need to maintain appropriate interrelationships, and although some theorists and the environmental movement had already raised the alarm about problems of global warming, the climate crisis, and environmental depredation, the Latin American medico-social current only began to seriously take up this issue at the beginning of the last decade. Several think tanks, some postgraduate training programs, and some of the Association's thematic networks began to address the different facets of the problem. And it was precisely at the Conferences in Paraguay in 2016, Bolivia in 2018, and the Dominican Republic in 2021 that the issue received priority attention and environmental awareness became part of ALAMES' agenda.

While we are making progress – with imbalances between countries and subtopics – we can still say that we are in our infancy when faced with the complexity of the issue, the persistent denial in large sectors of the countries most responsible, and the powerful interests at stake. Fortunately, the issue is already on the global agenda, and we can feel the vigorous presence of environmental movements of different profiles.

The slogan of the COP16 summit held last year in Cali, Colombia, can serve as a guide for our work on this matter: ***Peace with nature***. This means

feeling ourselves as part of nature and not its owners; recognizing it as a subject of rights; respecting and caring for it; returning the land to those who have been dispossessed; and subjecting the logic and mercantile interests that deforest the Amazon, pollute rivers, and overexploit the subsoil to the logic of life. It is a broad and sufficiently powerful slogan, and it connects us with our supreme challenge: life in peace in Latin America.

5. Social Medicine in Post-Pandemic Times and Digital Health

Possibly the pandemic – or syndemic – marks a before and after in our era, as Mario Róvere noted in his address for the Juan César García lectureship at the last ALAMES Conference in Buenos Aires, whose central theme was precisely: “*Syndemic, Reconfiguration of the World, and the Struggle for Buen Vivir*”. Without a doubt, the COVID-19 pandemic has been the health event of greatest significance and deepest consequences that we have faced and may yet face. At the Buenos Aires Conference, important contributions were made to understand the pandemic and to reposition ourselves in light of its future implications. Even so, neither the full set of questions it raised, nor the conditions that made it possible, nor an assessment of how we confronted it, nor the scope of its consequences are yet sufficiently clarified, evaluated, or absorbed. There is still work we can and must continue to do.

One of the many consequences of the pandemic was its contribution to the definitive establishment of digital technologies: big data, artificial intelligence, and genomics. Since the previous Conference in Buenos Aires, the topic of ***digital health*** has begun to appear on ALAMES's agenda. And just yesterday, in a panel on this topic led by recognized experts such as Naomar de Almeida, Luiz Vianna, and Angélica Baptista, the current moment, its possibilities, its risks, and its challenges were set out as clearly as possible. There was discussion of the need for a kind of “digital literacy,” the need to work to prevent the use of digital technologies from becoming a new factor of inequity, the defense of digital sovereignty, and the move toward digital health reforms. What remains now is the task of finding ways to integrate this new reality of digital health, critically, into the life of ALAMES, into

health training and research processes, and into the struggle for health reforms.

I want to close this commemorative message with two essential and heartfelt notes. *The first: in memory of the teachers and colleagues who are no longer physically with us*, but who continue to inspire us as forerunners, founders, or co-workers of the Latin American medico-social and collective health movement. At the risk of omitting some, for which I offer my apologies in advance, I allow myself to name: Juan César García, Giovanni Berlinguer, Sergio Arouca, Hesio Cordeiro, Mario Testa, Juan Samaja, Susana Belmartino, Carlos Bloch, Alberto Vasco, Edmundo Granda, Miguel Márquez, Francisco Rojas Ochoa, Catalina Eibinchutz, Francisco Javier Mercado, José (Pepe) Blanco, and Francisco de Assís Machado. To them, our recognition, our gratitude, and our commitment to continue working for the causes, ideas, and dreams they planted in us and helped us cultivate.

And the second and final note can be summed up in a single phrase: **THANK YOU**. Thank you to the founders of ALAMES, wherever you may be today. Thank you to those who organized and, through their visible or invisible work, have made possible the eighteen Conferences, including this one we conclude today and from which, without excluding any person or institution, I feel it is only fair to name CEBES and Professor and friend Ana María Costa, its general coordinator. Thank you to those who have coordinated the Association throughout its history, including its current collegial coordination, for their work and dedication. Thank you to those who could not attend, but who we know have been and continue to be with us, such as our tireless teacher and friend María Isabel Rodríguez, and our companions in so many struggles, Oscar Feo and Mario Hernández. And above all, thank you to all of you who, with your presence, experiences, presentations, posters, debates, patience, and warmth, have made this Conference another solid step forward on our path and another link in this network of knowledge and action for Life, health, equity, and Peace that is, and will continue to be, our Latin American Association of Social Medicine and Collective Health, now renewed and strengthened by *the wave of youth* that has joined us at this Conference, whose cultivation and expansion must be an imperative for our future.

Many thanks

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Social Medicine

Health For All

ISSN: 1557-7112