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Structural competency in global perspective

Carlos Piñones-Rivera ^a, Seth M. Holmes ^{b,c,d}, Michelle Morse ^e, Joel Ferrall ^f,
Kavya Nambiar ^g and Ángel Martínez-Hernández ^h

^aDepartamento de Ciencias Sociales, Universidad de Tarapacá, Iquique, Chile; ^bEnvironmental Science Policy Management and Medical Anthropology, University of California, Berkeley, CA, USA; ^cDepartment of Social Anthropology, University of Barcelona, Barcelona, Spain; ^dICREA Catalan Institution for Research and Advanced Study, Barcelona, Spain; ^eHarvard Medical School, Boston, MA, USA; ^fKeck School of Medicine, University of Southern California, Los Angeles, CA, USA; ^gUC Berkeley-UCSF Joint Medical Program, Berkeley, CA, USA; ^hMedical Anthropology Research Center, Universitat Rovira i Virgili, Tarragona, Spain

ABSTRACT



This special issue aims to help fill two critical gaps in the growing literature as well as in practice. First, to bring together scholars and practitioners from around the world who develop, practice, review, and question structural competency with the aim of promoting a dialogue with related approaches, such as Latin American Social Medicine, Collective Health, and others, which have been key in diverse geographical and social settings. Second, to contribute to expanding structural competency beyond clinical medicine to include other health-related areas such as social work, global health, public health practice, epidemiological research, health policy, community organisation and beyond. This conceptual expansion is currently taking place in structural competency, and we hope that this volume will help to raise awareness and reinforce what is already happening. In sum, this collection of articles puts structural competency more rigorously and actively in conversation with different geographic, political, social, and professional contexts worldwide. We hope this conversation sparks further development in scholarly, political and community movements for social and health justice.

KEYWORDS

Structural competency;
social medicine; Latin
American social medicine;
critical medical
anthropology; health equity

Introduction: Do we need a structural turn?

Social structural processes¹ and the inequities they produce are the primary cause of who is healthy and who is sick - and in what ways along the continuum of health and sickness. A great deal of research around the world has shown that health inequities are ultimately determined by structural processes, such as political and economic power, the global distribution of wealth, and the oppressions derived from social class, structural racism, and sexism (to name a few) (Cfr. Agarwal et al., 2023; Bailey et al., 2017; Bränström et al., 2015; Castañeda et al., 2015; Gamlath & Lahiri, 2019; Gavurova et al., 2020; Gee & Ford, 2011; Hansen & Metzl, 2019; Krieger, 2014; Martyr et al., 2019; Ssenyonjo, 2022; Williams & Mohammed, 2013; Williams et al., 2019). However, we are experiencing a central paradox in global public health. The growing acknowledgment of the impact of social structures on health outcomes contrasts with the lack of response and the failure to address the underlying structural processes, whether

CONTACT Carlos Piñones-Rivera  carlospinonesrivera@gmail.com  Baquedano 1325, 1100000 Iquique, Chile
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in social policy, health policy, public health practice, or clinical practice (Fleming, 2020; Hespanha, 2019; Raphael, 1998).

Increased awareness of the centrality of structural processes to health has led to the development of structural approaches to public health and health care (Sommer & Parker, 2013). Different approaches have been developed in different geographic and social contexts, as we will touch upon further below. From these approaches, it is clear that addressing social inequities requires a fundamental shift in the way we think about health and a commitment to challenging and dismantling the social structures that perpetuate health inequities (Breilh, 2003, 2021, 2023; Holmes, 2013; Holmes et al., 2014; Horton, 2023; Metzl & Hansen, 2014; Metzl & Roberts, 2014; Neff et al., 2017; Stonington & Holmes, 2006).

The potentialities and challenges of this shift are precisely the problems we address in this Special Issue. Our fundamental question is: What frameworks do we need to advance in order to address and confront health justice problems in a transformative way? In other words, if inequity is structured based on interlocking axes of oppression (Farmer, 1996; Taylor, 2017), what frameworks or toolkits do we need to give health professionals, health systems planners as well as all of society so they can be part of the counter-hegemonic processes necessary to transform social structures and health itself? And, especially important in this volume, how might different frameworks and toolkits from different geographic and social contexts learn from one another and develop in conversation or in solidarity?

This article will next move into a consideration and definition of ‘structural competency’ and the context in which it first developed – U.S. clinical medicine – though it has moved far beyond in recent years. We then consider just a few of the other frameworks developed around the world – those especially relevant to this special issue – to understand and respond to the structural processes that produce social and health inequities. Next, we consider the importance of putting structural competency rigorously in conversation with these other frameworks as well as with different geographic, social and professional contexts. We end with a consideration of the several important interventions made in this direction by this collection of articles. We intend this volume to spur further mutual engagement and conversation between structural competency and other social and critical frameworks for health around the world – including many not yet touched upon in this volume.

As Hansen points out (this issue), the concept of ‘social structures’ has been largely absent in U.S. biomedicine. The dominance of biotechnological approaches to healthcare has overshadowed the recognition of social factors that contribute to poor health in both public policies and private healthcare investments. The U.S. healthcare system has strongly embraced a profit-driven model that prioritises privatisation and idolises new biotechnological devices and pharmaceuticals as personalised solutions capable of curing diseases or simply for the enhancement of individuals in the society in relation to achievement and commoditization. Consequently, the U.S. healthcare system tends to overlook social and structural causes of health issues and attribute widening health disparities to cultural disparities in the beliefs or behaviours of individuals and genetic differences between racial groups. This hybrid ideology between biologization and the commodification that characterises the neoliberal regime – supported by policies and economic incentives – has shaped the healthcare system and perpetuated the disregard for social factors. The education and training of U.S. health professionals also reflect this ideology, as they receive limited exposure to the concept of social structures and their influence on health outcomes (Hansen, commentary in this Special Issue).

In this context, and during the last decade, the structural competency framework has gained growing attention for comprehending and addressing the impact of social, political, and economic structures on health and healthcare. In fact, structural competency is newly included in the LCME (Liaison Committee on Medical Education of the U.S. and Canada) in ‘Standard 7.6’. First coined by Metzl (2009), the proposal reached its first comprehensive form in Metzl and Hansen’s joint paper (Metzl & Hansen, 2014).

In that pioneering text, structural competency is defined as the acquired skill to recognise that various issues categorised clinically as symptoms, attitudes, or diseases reflect the consequences of larger systems and processes such as healthcare systems, food distribution, zoning regulations, urban and rural infrastructures, medicalisation, and even the fundamental definitions of illness and health. Of course, it is not only about recognition. Structural competency seeks to dismantle medicine's support for an unjust social order; rejects the notion that social injustice is due to biological differences (for a discussion of structural racism, see Metzler & Roberts, 2014); shifts the focus from individual responsibility to societal responsibility for creating health-supportive conditions; works to transform the relationship between health professionals and communities, recognising the expertise patients and communities offer; and builds alliances with other disciplines and movements for social, economic, environmental, and health justice.

In sum, structural competency offers a positive model for systemic intervention to improve health and promote a more equal society (Hansen & Metzler, 2019, p. v-vi). This framework stands out in the context of social medicine for offering a pragmatic-critical relationship with the clinic (Piñones-Rivera et al., 2019a) and has contributed with a robust analysis of how clinical interactions, health institutions, and their legitimisation processes produce and reproduce health inequities (Harvey et al., 2023). Development and evaluation of structural competency training programmes suggest that it may decrease burnout (Neff et al., 2017, 2020) and increase empathy as well as the potential for solidarity (Neff et al., 2017, 2020), helping trainees avoid blaming patients as individuals or groups, but rather understand the unequal social processes in which all people are embedded (Caiola et al., 2022; Gholar et al., 2023). The approach also highlights that intersubjectivity and interdependence are inherent to the human condition.

Although, as we shall see, structural competency is not a totally new creation, it has opened up new perspectives of conceptualisation, training, and praxis within medical training and beyond. It has been taken up by myriad medical, nursing, and other health professional schools as well as internships, residencies, and faculty groups – primarily in the U.S., though increasingly globally – and by several public health and county health departments. As mentioned above, it has newly been incorporated in national health education systems (in the U.S. and Canada) by the LCME.

Structural competency represents a strategic approach to medical education in the global north, where for almost 30 years a competency-based education model has been refined and consolidated. Given that this educational model extends throughout the world and that the biologist, behaviourist, reductionist, individualistic and culturalist ideology is hegemonic worldwide, the proposal of structural competency is being accepted in different contexts as part of counter-hegemonic movements (e.g. Campanera et al., 2023; Castro & Alarcón, 2023; Friedner, 2023; Harvey et al., 2022; Moscoso et al., 2023; Orr & Fleming, 2023; Orr & Unger, 2020; Piñones-Rivera et al., 2019a; Piñones-Rivera et al., 2022; Piñones-Rivera et al., 2023; Rodríguez-Cuevas et al., 2023; Szilvasi & Saitovic-Jovanovic, 2023). In most cases, this acceptance consists of dialogue and reciprocal transformation with existing critical health traditions developed throughout the history of social and right-to-health struggles in different territories.

As mentioned above, structural competency has focused firmly on the clinic and its importance and has also reflected on and moved into extra-clinical spaces (Piñones-Rivera et al., 2019a). When considered from the point of view of critical traditions like that of Collective Health and Latin American Social Medicine, this is one of structural competency's distinctive traits and something other traditions may consider adapting and incorporating in some way (Harvey et al., 2023). Moreover, structural competency extends beyond the clinic and introduces a different angle in the scenario of structural approaches: 'that of the skills, attitudes and sensitivities of the clinician or researcher. In this way, it appeals to their subjectivities to discern the scenario, to develop skills to detect the relationships established between large structures, local realities and the small subjective worlds of affliction' (Martínez-Hernández & Bekele, this volume). A structural turn is not feasible without a significant change in mindsets and practices.

Dialogue and epistemic justice with other traditions

Structural competency is one of several different frameworks, social fields, and movements aimed at rectifying social injustices that produce health inequities. We do not intend to review those different frameworks but only to indicate some of them, especially those that have nurtured the contributions that are part of this special issue and that are most visibly influencing structural competency.

Latin America has been a fertile ground for developing critical pedagogy and specific critical approaches to medical education. Without going through an exhaustive review of critical pedagogy (Cfr. Freire, 2000; Giroux, 2010; Matthews, 2014), we can confirm the transcendence that Latin American developments such as Freire-inspired popular education have had at the international level. In our Special Issue, Freire is quoted in Latin American works (Piñones-Rivera et al., this issue; Anderson et al., this issue), but also in others from the United States (Sridhar et al., this issue) and in transnational proposals (Katz et al., this issue). Likewise, other critical Marxian approaches to education have emerged on Brazilian ground, such as historical-critical pedagogy (Saviani, 2018).² These references nourish contemporary proposals on health education, present in a wide range of fields, such as state approaches to medical education, or counter-hegemonic alternatives, such as those of Ramos (2001), or Lemos (2010). Today, the Grupo de Estudos e Pesquisas em Educação, Trabalho e Saúde (GEPETS) at Universidade Federal de Goiás-Brazil, guided by Cristiane Lemos, is discussing in-depth the connections and differences between structural competency and the Social Determination Paradigm (Breilh, 2003, 2021, 2023)

Inside and outside the medical field, Latin American Social Medicine has raised the problem of medical education since at least the 1970s, with the pioneering work of García (1972). This discussion has been developed in Latin American countries, especially in Brazil, Mexico, Ecuador, and Argentina (Waitzkin et al., 2001).

In Europe, there is an important tradition with Gramscian roots, developed mainly in Italy (De Martino, 2009; Ferrari, 2014; Seppilli, 1996; Seppilli & Otegui, 2005; Signorelli, 2015), Catalunya and Spain (Comelles & Martínez-Hernández, 1993; Martínez-Hernández, 2008). For historical reasons linked to the massive post-war exile to Latin America, and especially to Argentina, this tradition is at the origin of and has been in dialogue with the significant developments of critical medical anthropology in Latin America (Menéndez, 1981, 2002, 2016; Sesia, 2015; Sesia et al., 2020). Inside that field of debate, it is clear that structural competency is not an *ex-novo* creation. As Martínez-Hernández and Bekele note, it condenses pre-existing elements in different disciplinary and national traditions, critical theories, as well as many postulates from medical anthropology (Harvey et al., this issue; Martínez-Hernández & Bekele, this issue).³ These traditions, among others, constitute a contemporary field of debate that has consistently illuminated the importance of processes of hegemony/subalternity in the ideological terrain, overcoming both economic reductionism and culturalist essentialism (Menéndez, 2018; Piñones-Rivera, 2015; Piñones-Rivera et al., 2019b).

Recognising that the structural competency framework arises from and draws on different historical and contemporary sources, we place ourselves in the reflexive line of the development of a meta-criticism, that is, of an alliance in which the different critical perspectives either within as well as those outside Eurocentric knowledge strengthen each other (Cfr. Breilh, 2003, 2021). We understand it as a strategy to counter the epistemic injustices common in Eurocentric approaches. As Fricker (2007) has pointed out, epistemic injustices acknowledge that someone is wronged in their capacity as a knowledge-producer; a reality that has been combated by counter-hegemonic, indigenous, feminist, LGBTQI, decolonial knowledge, among a long list of peripheral knowledges and perspectives, which teach us that there is no truth without social justice.

Therefore, it is crucial to outline and analyze the theoretical, practical, tactical, and strategic nuances between the perspectives developed in different contexts. From our perspective, the language, practices, and ideological assumptions should not be homogenised since we understand that each contribution is tributary to a context in which it seeks to have an impact; and there is no point of synthesis that intends to (impossibly) serve all contexts equally. However, we believe it is

critically important to put these different efforts into conversation to transform reality and work toward alliances and internationalist solidarity (Huish, 2014). With this objective in mind, knowledge of the languages, strategies, and practices throughout the world seems fundamental to us as a means for the construction of a strategy of transformation on a global scale. With this meta-critical, internationalist intent, this collection of articles puts structural competency more rigorously and actively in conversation with different geographic, political, social, and professional contexts worldwide. We hope this conversation sparks further development in scholarly, political, and community movements for social and health justice.

Examples of structural competency in global dialogue and beyond clinical medicine

Our special issue aims to contribute to filling two critical gaps in the growing literature and practice. First, to bring together scholars and practitioners from around the world who develop, practice, review, and question structural competency with the aim of promoting a dialogue with related approaches, such as Latin American social medicine, collective health, and others, which have been key in diverse geographical and social settings. Second, to contribute to expanding structural competency beyond clinical medicine to include other health-related areas such as social work, global health, public health practice, epidemiological research, health policy, community organisation and others. This conceptual expansion is currently taking place in structural competency, and we hope that this volume will help to raise awareness and reinforce what is already happening. This collection of articles has contributed to these goals even in unforeseen ways, as we will explore in the next section.

The first two papers expand the current discussion on structural competency in the field of global health. Katz, Chikwenhere, Essien, Olirus Owilli, and Westerhaus situate their impressive analysis in the field of global health. They propose that structural competency is and should be grounded in a counter-hegemonic social medicine. To this end, they develop a helpful systematization of the experience of the Social Medicine Consortium, one of the most important contemporary organisations with a pragmatic-critical orientation toward global health. The article gives continuity to and expands on the proposals that have been made in structural competency in global health (especially Harvey et al., 2022), emphasising the importance of dialogue with other traditions from the global south, such as the Latin American critical pedagogy of Freire (2000) and Boal (1974). The centrality given to Freire's concept of conscientization is notable throughout their proposal. The article analyzes the reproduction of power asymmetries and shows, acknowledging contradictions, how concrete programmes can address the power asymmetries and contradictions implied by structural processes, including colonialism and racism.

In a similar line of reflection, Sridhar, Alizadeh, Ratner, Russ, Sun, Sundberg, and Rosman propose a decolonial praxis cycle in global health education that incorporates decoloniality and global health equity. Grounded in critical pedagogy and specifically in Paulo Freire's work, they propose a 'praxis cycle' that integrates theory, reflection, and action in a curriculum designed to engage learners actively in understanding and dismantling colonialism and structural barriers to global health equity. Thus, the authors make a specific contribution to the already broad discussion of decolonisation in the field of global health education (Kwete et al., 2022; Mogaka et al., 2021; Wilson, 2022) and connect it to current developments in structural competency (Harvey et al., 2022; Metz & Hansen, 2014; Stonington et al., 2018). The authors emphasise the importance of intentionally incorporating a praxis cycle to help learners recognise their role in disrupting structural forces that promote inequities and actively dismantle the forces upholding systemic oppression. The paper highlights the challenges encountered during curriculum implementation, including cognitive dissonance, systemic barriers to changing one's practice, and complications in assessment. They share their experience building accountability by encouraging learners to seek feedback from global partners and in peer mentorship in small group discussions.

The next three articles show structural competency's usefulness in epidemiological and public health research more generally.

Martínez-Hernández and Bekele critically analyze the potential for a 'structural turn' in epidemiology. In the article, they think through the possibility of a broad adoption of their previously proposed 'SICES' Structural and Intercultural Competency in Epidemiological Studies. Building from social epidemiology, critical epidemiology, and Collective Health, they consider how structural competency could provide new opportunities by focusing both on the topic of focus in research (i.e. social and health inequity and equity) and on the attitudes and skills of the epidemiological professional (i.e. 'structural humility'). This latter aspect, incorporating reflexivity, offers a helpful challenge to epidemiology's traditionally positivist outlook and pushes the discipline to move further beyond the biomedical field to the social and collective levels.

Scott, Andazola, Smith, Castillo, de la Rosa, and Michael demonstrate the implementation of structural competency in two organisations in New Mexico, illuminating how the framework can be used to address health inequities at multiple levels beyond the clinic. They implemented structural competency in a large state government agency with more than 1,400 employees, focused on public health programmes, and in a small county coalition consisting of volunteer members with support from the county government. The paper provides three key lessons from these two experiences: 1. Structural competency can guide strategic planning for health equity goals in community and state organisations, enabling clear, actionable steps and member engagement at multiple levels. 2. When utilising the structural competency framework, we need to think carefully about the specific language we use, avoiding unnecessarily technical, discipline-specific jargon. 3. There is a strong need to build structurally competent communities (institutions, agencies, and individuals) to address our communities' health and wellbeing inequities more comprehensively. The paper moves outside the terrain of medical education and suggests an important focus on 'structurally competent communities.'

Kalkonde, Malik, Kaur, Pando, Paikra, and Jain show us how the structural vulnerability approach (one of the concepts often taught in structural competency trainings) allowed them to organise a multi-level analysis from which they approached the excess deaths within the indigenous Pando community in Chhattisgarh, India. As a collaborative group of public health professionals, community leaders, and public health scholars, their multi-level analysis combined public health, social medicine, and structural vulnerability frameworks, demonstrating a novel, actionable way of confronting excess deaths. Their biomedical approach found that scrub typhus was the most likely cause of the deadly fever. Nevertheless, in the social inquiry, community members attributed the excess deaths to a lack of Adivasi status certificates – a formal recognition as part of this 'Scheduled Tribe' community to whom the Indian government provides certain protections and provisions, education, and jobs. The lack of Adivasi status certificates prevents the community from acquiring government jobs and higher education and leaves community members vulnerable to exploitation by members of other castes in their village. This marginalisation and structural neglect manifests in hunger through inadequate food rations, immobility due to a lack of traversable roads, and thirst from a lack of handpumps for their wells. They conducted a structural analysis of the excess deaths and noted that healthcare provision to the Pando people was inadequate and normalised on three levels – bureaucracy, health system, and community. In sum, their participatory structural analysis allowed them to design a concrete strategy to reduce deaths in the Pando community.

The following two papers address the problem of direct violence and show how a structural competency framework can infuse broader awareness and action in response. Although one of the critical concepts of structural competency is that of structural violence, less analysis has been given in this field to direct violence suffered by health teams themselves. In the first article, Pasquini provides a glimpse into the Emergency Department (E.D.) in Italy and how healthcare workers use a structural competency approach toward visitors whom they consider to be at a higher risk of enacting forms of violence against the staff. Pasquini argues that identifying certain patients as 'ticking time bombs' allows practitioners to recognise structures that impact health and illness, to reflect on their

own positionality and agency, and to mobilise available resources to act on the structural processes that determine patient distress. Likewise, the health team showed the ability to improvise structural competency to deactivate (it. *Dissinescare*) potential outbursts of violence. This text is considerable for its nuanced addition to sociological understandings of the E.D. and recognising that structural competency can emerge from healthcare professionals' everyday practice and experience.

In the second of these articles, Orr and Fleming address the dilemmas of medical neutrality and its depoliticising effects among Israeli healthcare professionals in a context of ongoing political (and structural) violence. Following a content analysis of documents published by Israeli healthcare institutions and leaders of Israeli healthcare organisations in response to the May 2021 hostilities in the area, the authors note that while medical neutrality can ensure non-discriminatory care and protect staff from structural violence, it can also naturalise repressive systems and obscure the root causes of inequalities and the structural determination of health. In fact, the view of medical neutrality allows for a limited recognition of violence and the broader causes of conflict. In response, the authors suggest locally adapted structural competency trainings to promote a more appropriate socio-political engagement that helps practitioners take a holistic view of their patients and a more challenging role against hegemonic common sense. This would be an alternative conception of medical neutrality that does not entail states of denial, but an explicit recognition of political conflict as a health-determining process and the health sector's role in society.

The majority of the following articles put the structural competency proposal in direct dialogue with diverse realities and concepts in and from Latin America.

Ortega and Rodrigues lead us to question to what extent the specific history of the structural competency model has led it to oppose the cultural competency proposal. The Brazilian experience that they present and analyze is one in which 'Brazilian collective health and psychiatric reform and the organization of post-reform services have somehow followed an inverted path, placing from the beginning the emphasis on the structural determinants of health practices and downplaying the role of cultural differences in health practices.' (Ortega and Rodrigues, 2023, p. 4). The authors argue that in a context like Brazilian collective health, it is politically important to highlight cultural difference, considering the ideology of cultural homogenisation that may be considered a 'silencing of culture.' According to them, the conceptualisation of the term *structural* in Brazil is somewhat more limited to a social class analysis, unlike what has developed in the USA.⁴ This paper leads us to consider whether experiences of structural competency developed in other contexts must necessarily be captured in the opposition of structure and culture or whether reflections and practices on structural and cultural relationships can and should be articulated in other ways.⁵

The paper by Anderson, Calvin, Covarrubias, Jiles, and Paley highlights the contributions of popular education in health to structural competency training, focusing on the experience of EPES in Chile. EPES (Educación Popular en Salud), founded in 1982 in the context of Chilean dictatorship, draws on various sources to improve health – including popular education, Latin American Social Medicine, liberation theology, and anti-dictatorship and anti-fascism social movements. The paper discusses how the EPES training programme addresses the underlying causes of poor health, promotes collective action in poor neighbourhoods, and transforms mindsets. In dialogue with the structural competency proposal, the authors analyze four competencies advanced by EPES in training health professionals: 1) Reflect on and propose interventions that incorporate a structural framework for health problems; 2) Identify how social, political, and economic structural processes generate and maintain health inequities. 3) Create and implement a work plan in cooperation with local organisations, and 4) Question the biomedical model's dominance and explore other health knowledge systems rooted in people's wisdom and life experience. The programme is practical and participatory, explicitly entailing creating and implementing work plans in cooperation with local organisations. Their approach emphasises participatory assessment, planning, and concrete actions beyond individual risk factors fostered by popular education principles that highlight

horizontal relationships and work to empower participants to assess community problems, develop action plans, and collaborate with social movements to advance social justice in underserved neighbourhoods.

Piñones-Rivera, Liberona, Jiménez, Corona, and García make the problem of ‘structurally competent communities’ (Scott, Andazola, Smith, Castillo, de la Rosa & Michael, this issue) the focus of their reflection. Their paper leads us to think that structural competencies are not developed only in health professionals but also in collectives that face structural violence as part of their political struggles. The example of an organisation of migrants and allies in the north of Chile shows the relevance of developing structural competencies outside formal educational spaces. This paper introduces the novel concept of ‘collective structural competency’ in addition to the previous focus on health professionals, their individuality, and cognitive achievements, instead highlighting collectives and the learning processes they deploy while fighting for their rights. The paper analyzes the case of this immigrant rights movement in Chile (AMPRO), whose struggle to fulfil their rights has taught them experientially, politically, and reflectively about structural violence and let them develop structural competency beyond the classroom. The term ‘collective’ manifests the important and growing cross-fertilisation between Collective Health and structural competency fields. For this reason, it is intimately connected with the last two papers of the special issue, both related to the work of Jaime Breilh and reflecting an effort to strengthen the dialogue, solidarity, and collaboration between both critical proposals.

In his innovative paper, Jaime Breilh proposes a *meta-critical* methodology for ‘responsible and reparative science’ to reform ethics and simultaneously advance human and nature’s rights. Rooted in critical epidemiology, the *social determination* approach, and Collective Health, the paper argues that a Cartesian-functional theoretical-methodological bias limits the current paradigm of bioethics and proposes a new ontology for bioethics and the right to health that involves understanding the *social determination of health* as a multidimensional process in contemporary global hyper-neoliberalism. Breilh discusses the challenges of transforming the paradigm of bioethics and the right to health beyond the biomedical horizon and proposes a new foundation for justiciability and rights in the hyper-neoliberal era. The paper introduces a set of proposals for healthy lives based on the struggles for the right to health, using the *4S’s of life* (sustainability, sovereignty, solidarity, and security) and *meta-critical* methodology as tools. Breilh argues that critical bioethics must focus on the social reproduction of life in historically determined spaces of private wealth accumulation and consider alternative knowledge from impacted communities and social movements who may be working with independent scientists, experts, and public agents in solidarity with contemporary projects of justice.

Harvey, Piñones-Rivera, and Holmes’ paper explores the intersection of the structural competency framework and the Latin American Social Medicine/Collective Health (LASM-CH) movement, highlighting especially in this case how the structural competency framework can learn from the LASM-CH movement. The authors identify four specific lines: 1. Theorising social structures instead as specific social ‘structural processes’ (ex., capital accumulation or colonialisation), overcoming certain analytical confusion that may result from an overly broad and diverse definition of social structure. 2. Using the *social determination of health’s* (rather different from the social ‘determinants’ of health focus) critical tools to go beyond ‘tip of the iceberg’ empiricism and Cartesian reductionism that could be implicit in some uses of the ‘structural determinants of the social determinants of health.’ 3. Moving from a criticism of cultural competency to embracing ‘critical interculturality’ that calls for long-term efforts among different groups to marshal culturally-specific practices, beliefs, knowledge, narratives, epistemologies, ontologies, and cosmologies in the service of collective political projects for liberation. 4. Learn from the history of LASM-CH’s illustrative examples of health workers collectively engaging in solidarity in social, political, and economic realms to change social structural processes. The paper emphasises the need for ongoing conversations and exchanges between different paradigms worldwide for social and health equity.

Spinelli and Martinovich offer a unique look at medical education. They problematise the epistemological level to overcome a reformist logic and move towards one that effectively allows understanding its 'ontological structuring': based not only on scientific-technical processes but on 'intersubjective relational processes, mediated by verbal and non-verbal language, radically contrary to the ontic conception of industrial models and their organisational and institutional formats embodied in the model of the factory, and constituted by reified relationships between subjects and objects' (Spinelli & Martinovich, this issue). The article then reflects on the experiences carried out within the Doctorate Program in Collective Health of the Universidad Nacional de Lanús (Argentina), which has opted for a hermeneutic approach to education, based on dialogue rather than on the transmission of contents: the 'classroom-workshop.' This would allow the recovery of a critical dialectic by analyzing which epistemic frameworks operate in medical practices. This pedagogical proposal seeks to recover the autonomy of the learning process by horizontalizing the action of understanding. Such horizontalization could allow leaving the 'unidirectional monody' of teaching and explaining and instead embracing 'the complex polyphony of learning collectively,' favouring a 'transformation towards the common', while recovering forms of knowledge discredited as invalid. This transcends a logic based on teaching social differences from predefined social blocks, with the preconceived and stigmatising readings they imply, and moves towards an 'open and interpretative listening, based on a dialogue whose horizon is mutual understanding' (Spinelli & Martinovich, this issue).

Finally, Helena Hansen's commentary – discussed above – provides an excellent framework for putting the work of this issue into context. Being one of the pioneers and leading theorists of the structural competency framework, Hansen clearly demonstrates the ideological background against which it arose: 'a privatized, profit-oriented approach to health care that fetishizes new devices and pharmaceuticals as molecular, individualized "magic bullets" curing our ills; an ideology fostered by corporations and government agencies throughout the 1980s-2000s era of the Human Genome Project and the Decade of the Brain' (Hansen, this issue). Eloquently, Hansen describes U.S. racial apartheid and details the historical relevance of the anti-racist struggle in the U.S. In this way, she explains why structural racism is at the centre of structural competency, depicting the continuity of structural competency not only with the traditions of social medicine but specifically with anti-racist struggle. As Hansen makes clear, racial justice movements have been one of the main drivers of innovations in social medicine in the U.S. Therefore, the commentary clearly states that social movements are central within the framework of structural competence: 'Structural Competency does not replace grassroots social movements; rather, it is designed to help clinical practitioners to align with those movements.' Her analysis entirely coincides with that of Latin American Social Medicine, which aims to 'start with grassroots community movements and expertise in practicing social medicine, rather than biomedicine' (Hansen, this issue) and fosters the strengthening of this process with the contributions of structurally informed biomedical practitioners. For Hansen, it is a matter of cultivating allies within biomedicine to enhance the impact of community health movements.

In the perspective of our call to put structural competency in global perspective, Hansen answers by promoting continued and increased cross-fertilising of social medicine traditions across regions, even beyond those that this special issue has begun to bring together.

Lessons learned from structural competency in new geographic and social locations

We hope to highlight what is new in our special issue - or at least how it can contribute to important movements around the world concerning social issues and health. In what sense do these articles broaden the concept and praxis of structural competency? In what sense does a global perspective on structural competency contribute to the framework's development and to other movements for social and health equity?

- First, framing structural competency in global perspective is a concrete exercise of metacriticism (Breilh) and epistemic justice that strengthens our praxis and concepts toward transforming unequal social structural processes. Putting structural competence in global perspective means not only bringing together contributions from different geographical locations. More deeply, it implies promoting a constructive dialogue between different traditions of critical perspectives (Collective Health and Latin American Social Medicine, critical interculturality in health care in Southern Europe, and far beyond), which have thought and fought to transform the structural processes at the root of health inequity. This exercise has been fruitful, as demonstrated by the lessons outlined below.
- Second, this special issue clearly shows that structural competency is relevant not only to medical professionals, but also far beyond. The articles come from various disciplines, such as anthropology, social work, pedagogy, public policy, and epidemiology. This should not be surprising if we consider that approaching the health-disease-care process (Laurell, 1986; Menéndez, 1994) is not restricted to the medical profession and that not only in the health sciences but in practically all disciplines there are sub-disciplines or professional fields specifically devoted to health and disease (for example, anthropology of health, sociology of health, geography of health, health economics, health policy, etc.). This transdisciplinary background offers fertile ground for many new insights to be gained. Therefore, one critical lesson is to put the tools developed by structural competency at the service of transdisciplinary work and to move forward in overcoming the barriers imposed by the rigid medical hierarchy and disciplinary traditions. At the same time, this special issue indicates that one strength of structural competency is precisely an analysis and focus on clinical medicine and medical professionals. Articles in this special issue simultaneously show that other movement for health equity can learn from this strength.
- Third, beyond the professional field, this special issue broadens the social base from which structural competencies are considered. The structural competency framework recognises the experience, knowledge, and leadership present in social movements, community and grassroots organisations especially through the concept of structural humility. *Structural humility* gives centrality to the role of social movements, community, and grassroots organisations in the struggle to transform structural processes of oppression. However, concepts such as ‘collective structural competency’ (Piñones-Rivera et al., this issue) and ‘structurally competent communities’ (Scott et al., this issue) take the conceptualisation of structural competency further into communities and movements. Such broadening invites us to think about how the structural competency framework can learn from social organising processes outside the classroom and share its pedagogical tools to strengthen these collective processes of reflection and praxis.
- Fourth, this special issue opens new opportunities to rethink culture in relation to the framework of structural competency. Let us recall that one aspect in the early development of the structural competency proposal consisted in a critique of the essentializing use of the concept of culture in some versions of the cultural competency framework. However, not every consideration of culture is essentializing, as shown in various articles in this special issue – as well as by many others (e.g. Tervalon & Murray-Garcia, 1998). The experiences analyzed by Ortega and Rodrigues, Martínez-Hernández and Bekele, Breilh, as well as Harvey et al.’s reflections on Breilh’s work, show us interesting perspectives in this respect and remind us of the vital contribution that has been made in non-hegemonic traditions such as Latin American critical epidemiology or Gramscian critical medical anthropology (in its Italian, Spanish and Latin American versions), to think culture and structure together in a critical way. They all show how structural competency could benefit from embracing something like critical interculturality. These articles indicate the potential that the concept of critical interculturality can have in relationship especially with that of structural humility. Critical interculturality proposals arise from a profound questioning of the asymmetries of knowledge within colonial realities and point towards the development of broad alliances of the different critical perspectives that have emerged within and outside Eurocentric knowledge. Therefore, critical interculturality not only questions the

supremacy of one knowledge or social position over another but emphasises the meta-critical horizon (Breilh, 2003, 2021, 2023) in which alliances must be built and stresses the importance of the reciprocal strengthening of critical perspectives. In this vein, this special issue strengthens the development of structural competency and structural humility by looking at them also from a critical interculturality perspective.

- And fifth, the articles in this special issue confirm the vitality that critical perspectives have today in the context of the advance of fascist ideologies and the extractivist predation of capitalism. The dialogue we seek to encourage here allows us to visualise how related problems arise in different historical and geographical contexts and that different responses have emerged and have been reformulated, some in dialogue and others with absolute independence from structural competency. These related movements and experiences in conversation allow for a fuller understanding of and confrontation with the social structural processes that shape health, well-being, sickness, and everyday life for diverse populations.

Directions for future development in critical frameworks and practices in health

It is important to continue expanding, adapting, reformulating and questioning the development of structural competency in diverse disciplinary fields. This is not as obvious as it may seem, and to give an example, although training in disciplines like medical anthropology includes the incorporation of knowledge regarding the role of structural processes in the configuration of the health-illness-care process, most often there is not a focus on the development of concrete tools to influence and participate in the transformation of such structural processes. The same can be said concerning other disciplines, such as epidemiology, sociology, and psychology, to name a few.

Moreover, in problematising an approach to structural competence that is too discipline-centered, it seems key to develop a transdisciplinary perspective in the formation and development of frameworks. The emphasis placed on structural processes points to the recognition of a hierarchy existing at different levels of intervention. This hierarchy problematises approaches that prioritise the clinical level and calls again for transdisciplinary approaches, considering the fact that critical perspectives developed in each discipline illuminate some aspect of structural determination. The special issue simultaneously shows the importance of structural competency moving beyond clinical medicine – as well as the strength of the analysis of and response to clinical medicine that other frameworks for health equity might learn from structural competency.

But such transdisciplinarity should be accompanied by critical interculturality, which inheres broadening structural competency in conversation with and respect for non-Eurocentric knowledge. In this issue, we have advanced the idea that structural competency is developed importantly in professional teams, but also importantly in grassroots social organisations in their struggles against structural violence. The next step is to recognise that such struggles are organised based on popular knowledge and that, in many cases, this knowledge is not Eurocentric (Moscato et al., 2023). Progress in the construction of alliances for the transformation of structural processes requires the development of such critical interculturality (Breilh, 2003, 2021, 2023; Harvey et al. in this issue). In other words, there can be no lasting transformation or epistemic justice if we do not address the asymmetries of power constructed based on the colonial abyss that concentrates legitimacy in Eurocentric knowledge and disqualifies non-Eurocentric knowledge.

For strategic reasons, the discussion on structural competency has had to adopt the conditions imposed by an educational system deeply grounded on the competency-based education model. At the same time, there is strong criticism of that model in many parts of the world, particularly in Latin America (Chaves & Egry, 2013; Egry et al., 2006; Lemos, 2010; Ramos, 2011; Silva & Egry, 2003). One of the crucial lines of development consists in projecting the problem of medical education beyond the competency-based model in different contexts worldwide. Such proposals exist in all territories, and therefore, the discussion on structural competency can be nourished by these

developments that understand medical education beyond the commoditized assumptions naturalised in the competency-based education model (Chauí, 2018; Hirtt, 2009; Zarifian, 2010).

In sum, it is essential to continue strengthening – including through challenging – the proposal of structural competency through dialogue with related frameworks and movements worldwide. We understand that one way to strengthen the proposal of structural competency is through sustained dialogue with other Eurocentric and non-Eurocentric and non-English-speaking perspectives. While in this special issue, we have expanded the dialogue of the field of structural competency to other traditions, especially Latin American Social Medicine, Collective Health, and the critical medical anthropology of Southern Europe, it is necessary to expand and deepen the dialogue with diverse Indian, African, African diaspora, Indigenous, critical disability studies, trans and queer studies, and many other important traditions and movements. The strengthening of structural competency does not interest us in and of itself (Piñones-Rivera et al., 2023), but rather as one step in strengthening all of the critical proposals that are part of the necessary construction of a metacritique capable of counteracting biomedical, colonial, and racial capitalist hegemony and proposing and working toward viable alternatives.

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Notes

1. ‘By “social structure,” we mean durable patterned arrangements – from language barriers and social hierarchies to policies, economic systems, and other institutions (such as judicial systems, and educational systems) – that produce and maintain social inequalities and health disparities, often along the lines of social categories such as race, class, gender, and sexuality’ (Stonington et al., 2018, p. 1959)
2. Saviani defines historical-critical pedagogy as follows: ‘In short, what I am interested in translating with the expression historical-critical pedagogy is how to move from the critical-mechanistic, critical-a-historical vision to a critical-dialectical and, therefore, historical-critical vision of education. This formulation includes the need for education to be understood from its historical-objective development and, consequently, from the possibility of articulating a pedagogical proposal whose point of reference, whose commitment, is to transform society and not to leave it as it is, to perpetuate it.’ (Saviani, 2018, p. 112)
3. For a reflexive genealogy of Structural Vulnerability and Structural Competency Cfr. Piñones-Rivera et al. (2019a)
4. Moreover, the terms ‘structure’ and ‘structural’ have a more restricted meaning in Brazilian mental health than in U.S. discussions around structural competency and structural violence. In the former, structure and structural mainly refer to class, class stratification and socioeconomic inequalities, whereas in the U.S. literature those terms indicate hierarchies of not just class but also racialised groups, gendered groups, etc. Many authors use ‘structural violence’ to include the harm done by these hierarchies that are based not just in class but also race, sex, gender, sexuality, ability, among others (Bourgois et al., 2017; Farmer, 2004; Metzl & Hansen, 2014; Metzl & Roberts, 2014; Stonington et al., 2018).
5. For example, in LASM/Collective Health, the objective of interculturality is fundamentally political, putting various sources of knowledge – Western and non-Western, academic and non-academic – at the service of a collective, emancipatory project. (Harvey et al., 2022)

ORCID

Carlos Piñones-Rivera  <http://orcid.org/0000-0002-4771-3345>

Seth M. Holmes  <http://orcid.org/0000-0002-2244-2868>

Michelle Morse  <http://orcid.org/0000-0002-3272-4690>

Joel Ferrall  <http://orcid.org/0000-0002-8054-4096>

Kavya Nambiar  <http://orcid.org/0000-0002-0967-7363>

Ángel Martínez-Hernández  <http://orcid.org/0000-0002-5122-7075>

References

- Agarwal, S., Wade, A. N., Mbanya, J. C., Yajnik, C., Thomas, N., Egede, L. E., Campbell, J. A., Walker, R. J., Maple-Brown, L., & Graham, S. (2023). The role of structural racism and geographical inequity in diabetes outcomes. *Lancet (London, England)*, 402(10397), 235–249. [https://doi.org/10.1016/S0140-6736\(23\)00909-1](https://doi.org/10.1016/S0140-6736(23)00909-1)
- Bailey, Z. D., Krieger, N., Agénor, M., Graves, J., Linos, N., & Bassett, M. T. (2017). Structural racism and health inequities in the USA: Evidence and interventions. *The Lancet*, 389(10077), 1453–1463. [https://doi.org/10.1016/S0140-6736\(17\)30569-X](https://doi.org/10.1016/S0140-6736(17)30569-X)
- Boal, A. (1974). *Theater of the oppressed*. Pluto Press.
- Bourgeois, P., Holmes, S. M., Sue, K., & Quesada, J. (2017). Structural vulnerability: Operationalizing the concept to address health disparities in clinical care. *Academic Medicine*, 92(3), 299–307. <https://doi.org/10.1097/ACM.0000000000001294>
- Bränström, R., Hatzenbuehler, M., & Pachankis, J. (2015). Sexual orientation disparities in physical health: Age and gender effects in a population-based study. *Social Psychiatry and Psychiatric Epidemiology*, 51(51), 289–301. <https://doi.org/10.1007/s00127-015-1116-0>
- Breilh, J. (2003). *Epidemiología Crítica. Ciencia Emancipadora e Interculturalidad*. Lugar.
- Breilh, J. (2021). *Critical epidemiology and the people's health*. Oxford University Press.
- Breilh, J. (2023). *Epidemiología crítica y la salud de los pueblos: ciencia ética y valiente en una civilización malsana*. Universidad Andina Simón Bolívar.
- Caiola, C., Nelson, T. B., Black, K. Z., Calogero, C., Guard, K., Haberstroh, A., & Corral, I. (2022). Structural competency in pre-health and health professional learning: A scoping review. *Journal of interprofessional care*, 922–10. Advance online publication. <https://doi.org/10.1080/13561820.2022.2124238>
- Campanera, M., Gasull, M., & Gracia-Arnaiz, M. (2023). Food security as a social determinant of health: Tackling inequalities in primary health care in Spain. *Health and Human Rights*, 25(1), 9.
- Castañeda, H., Holmes, S., Madrigal, D., Young, M., Beyeler, N., & Quesada, J. (2015). Immigration as a social determinant of health. *Annual Review of Public Health*, 36(36), 375–392. <https://doi.org/10.1146/annurev-publhealth-032013-182419>
- Castro, M., & Alarcón, A. (2023). The commoditization of ecosystems within Chile's Mapuche territory: A violation of the human right to health. *Health & Human Rights: An International Journal*, 25(1).
- Chauí, M. (2018). *La ideología de la competencia: de la regulación fordista a la sociedad del conocimiento (Vol. 2027)*. Ned Ediciones.
- Chaves, M. M. N., & Egry, E. Y. (2013). Competência avaliativa do enfermeiro para o reconhecimento e enfrentamento das necessidades em saúde das famílias. *Cogitare Enfermagem*, 18(4), 729–735.
- Comelles, J. M., & Martínez-Hernández, A. (1993). *Enfermedad, cultura y sociedad*. Eudema.
- De Martino, E. (2009). *La terra del rimorso. Contributo a una storia religiosa del Sud (Vol. 83)*. Il saggiatore.
- Egry, E. Y., Marques, C. M. S., & Fonseca, R. M. G. S. (2006). A avaliação de competências na perspectiva crítico-emancipatória. *Ciência, Cuidado e Saúde*, 5(2), 236–242.
- Farmer, P. (1996). On suffering and structural violence: A view from below. *Daedalus*, 125(1), 261–83. JSTOR, <http://www.jstor.org/stable/20027362>.
- Farmer, P. (2004). An anthropology of structural violence. *Current Anthropology*, 45(3), 305–325. <https://doi.org/10.1086/382250>
- Ferrari, F. M. (2014). *Ernesto De Martino on religion: The crisis and the presence*. Routledge.
- Fleming, P. (2020). The importance of teaching history of inequities in public health programs. *Pedagogy in Health Promotion*, 6(6), 253–256. <https://doi.org/10.1177/2373379920915228>
- Freire, P. (2000). *Pedagogy of the oppressed (30th anniversary ed.)*. Continuum.
- Fricke, M. (2007). *Epistemic injustice: Power and the ethics of knowing*. Oxford University Press.
- Friedner, M. (2023). Disability justice as part of structural competency: Infra/structures of deafness, cochlear implantation, and re/habilitation in India. *Health and Human Rights*, 25(1), 39.
- Gamlath, S., & Lahiri, R. (2019). Health expenditures and inequality: A political economy perspective. *Journal of Economic Studies*, 46(46), 942–964. <https://doi.org/10.1108/JES-05-2018-0178>
- García, J. (1972). *La Educación Médica en la América*. Organización Panamericana de la Salud.
- Gavurova, B., Ivankova, V., Rigelsky, M., & Suhanyi, L. (2020). Impact of gender inequalities in the causes of mortality on the competitiveness of OECD countries. *International Journal of Environmental Research and Public Health*, 10(17), 3698. <https://doi.org/10.3390/ijerph17103698>
- Gee, G. C., & Ford, C. L. (2011). Structural racism and health inequities: Old issues, new directions. *Du Bois Review: Social Science Research on Race*, 8(1), 115–132. <https://doi.org/10.1017/S1742058X11000130>
- Gholar, V. M., Palokas, M., & Tacy, J. (2023). Structural competency curriculum in health sciences education: A scoping review. *JBI Evidence Synthesis*, 21(7), 1408–1452. <https://doi.org/10.11124/JBIES-22-00101>
- Giroux, H. A. (2010). Rethinking education as the practice of freedom: Paulo Freire and the promise of critical pedagogy. *Policy Futures in Education*, 8(6), 715–721. <https://doi.org/10.2304/pfie.2010.8.6.715>
- Hansen, H., & Metz, J. M. (Eds.). (2019). *Structural competency in mental health and medicine: A case-based approach to treating the social determinants of health*. Springer

- Harvey, M., Neff, J., Knight, K. R., Mukherjee, J. S., Shamasunder, S., Le, P. V., Tittle, R., Jain, Y., Carrasco, H., Bernal-Serrano, D., Goronga, T., & Holmes, S. M. (2022). Structural competency and global health education. *Global public health*, 17(3), 341–362. <https://doi.org/10.1080/17441692.2020.1864751>
- Harvey, M., Piñones-Rivera, C., & Holmes, S. M. (2022). Thinking with and against the social determinants of health: The Latin American social medicine (collective health) critique from Jaime Breilh. *International Journal of Health Services*, 52(4), 433–441. <https://doi.org/10.1177/00207314221122657>
- Harvey, M., Piñones Rivera, C., & Holmes, S. M. (2023). Structural competency, Latin American social medicine, and collective health: Exploring shared lessons through the work of Jaime Breilh. *Global Public Health*, 1–5.
- Hespanha, P. (2019). The impact of austerity on the Portuguese national health service, citizens' well-being, and health inequalities. *e-cadernos CES*, 31, <https://doi.org/10.4000/eces.4187>
- Hirtt, N. (2009). El planteamiento por competencias: Una mistificación pedagógica. *L'École Démocratique*, 3, 1–34.
- Holmes, S. (2013). *Fresh fruit, broken bodies: Migrant farmworkers in the United States* (Vol. 27). University of California Press.
- Holmes, S. M., Greene, J. A., & Stonington, S. D. (2014). Locating global health in social medicine. *Global public health*, 9(5), 475–480. <https://doi.org/10.1080/17441692.2014.897361>
- Horton, R. (2023). Offline: Health's intercultural turn. *The Lancet*, 401(10370), 12. [https://doi.org/10.1016/S0140-6736\(22\)02594-6](https://doi.org/10.1016/S0140-6736(22)02594-6)
- Huish, R. (2014). Why does Cuba 'care' so much? Understanding the epistemology of solidarity in global health outreach. *Public Health Ethics*, 7(3), 261–276. <https://doi.org/10.1093/phe/phu033>
- Krieger, N. (2014). Discrimination and health inequities. *International Journal of Health Services*, 44(4), 643–710. <https://doi.org/10.2190/HS.44.4.b>
- Kwete, X., Tang, K., Chen, L., Ren, R., Chen, Q., Wu, Z., Cai, Y., & Li, H. (2022). Decolonizing global health: What should be the target of this movement and where does it lead us? *Global Health Research and Policy*, 7(1), 3. <https://doi.org/10.1186/s41256-022-00237-3>
- Laurell, A. C. (1986). El estudio social del proceso salud-enfermedad en América Latina. *Cuadernos Médico Sociales*, 37, 3–18.
- Lemos, C. (2010). *A concepção de educação da política nacional de educação permanente em saúde* [PhD]. Universidade Federal de Goiás.
- Martínez-Hernández, A. (2008). *Antropología médica. Teorías sobre la cultura, el poder y la enfermedad*. Anthropos.
- Martyr, M., Kivlighan, D., & Ali, S. (2019). The role of telepsychology training clinics in addressing health disparities with rural latinx immigrant communities. *Translational issues in psychological science*, 5(5), 346–354. <https://doi.org/10.1037/tps0000208>
- Matthews, C. (2014). Critical pedagogy in health education. *Health Education Journal*, 73(5), 600–609. <https://doi.org/10.1177/0017896913510511>
- Menéndez, E. (1994). La enfermedad y la curación ¿Qué es medicina tradicional? *Alteridades*, 4(7), 71–83.
- Menéndez, E. (2018). *Poder, estratificación social y salud: Análisis de las condiciones sociales y económicas de la enfermedad en Yucatán* (Vol. 15). Publicaciones Universitat Rovira i Virgili.
- Menéndez, E. L. (1981). *Poder, estratificación y salud: Análisis de las condiciones sociales y económicas de la enfermedad en Yucatán*. CIESAS.
- Menéndez, E. L. (2002). *La parte negada de la cultura: relativismo, diferencias y racismo*. Bellaterra.
- Menéndez, E. L. (2016). Intercultural health: Proposals, actions and failures. *Ciência & Saúde Coletiva*, 21(1), 109–118. <https://doi.org/10.1590/1413-81232015211.20252015>
- Metzl, J. M. (2009). *The protest psychosis: How schizophrenia became a black disease*. Beacon Press.
- Metzl, J. M., & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine*, 103, 126–133. <https://doi.org/10.1016/j.socscimed.2013.06.032>
- Metzl, J. M., & Roberts, D. E. (2014). Structural competency meets structural racism: Race, politics, and the structure of medical knowledge. *Virtual Mentor*, 16(9), 674–690. <https://doi.org/10.1001/virtualmentor.2014.16.09.spec1-1409>
- Mogaka, O. F., Stewart, J., & Bukusi, E. (2021). Why and for whom are we decolonising global health? *The Lancet Global Health*, 9(10), e1359–e1360. [https://doi.org/10.1016/S2214-109X\(21\)00317-X](https://doi.org/10.1016/S2214-109X(21)00317-X)
- Moscoso, A., Piñones-Rivera, C., Arancibia, R., & Quenaya, B. (2023). The right to health care viewed from the indigenous research paradigm: Violations of the rights of an Aymara Warmi in Chile's Tarapacá region. *Health & Human Rights: An International Journal*, 25(1), 81–94.
- Neff, J., Holmes, S. M., Knight, K. R., Strong, S., Thompson-Lastad, A., McGuinness, C., Duncan, L., Saxena, N., Harvey, M. J., Langford, A., Carey-Simms, K. L., Minahan, S. N., Satterwhite, S., Ruppel, C., Lee, S., Walkover, L., De Avila, J., Lewis, B., Matthews, J., & Nelson, N. (2020). Structural competency: Curriculum for medical students, residents, and interprofessional teams on the structural factors that produce health disparities. *MedEdPORTAL*, 16, 10888. https://doi.org/10.15766/mep_2374-8265.10888
- Neff, J., Knight, K. R., Satterwhite, S., Nelson, N., Matthews, J., & Holmes, S. M. (2017). Teaching structure: A qualitative evaluation of a structural competency training for resident physicians. *Journal of General Internal Medicine*, 32(4), 430–433. <https://doi.org/10.1007/s11606-016-3924-7>
- Orr, Z., & Fleming, M. D. (2023). Medical neutrality and structural competency in conflict zones: Israeli healthcare professionals' reaction to political violence. *Global Public Health*, 18(1), 1–20.

- Orr, Z., & Unger, S. (2020). Structural competency in conflict zones: Challenging depoliticization in Israel. *Policy, Politics, & Nursing Practice*, 21(4), 202–212. <http://doi.org/10.1177/1527154420948050>
- Ortega, F., & Rodrigues, M. (2023). Rethinking structural competency: Continuing education in mental health and practices of territorialisation in Brazil. *Global Public Health*, 18(1), 2157034.
- Piñones-Rivera, C. (2015). *La Mala Hora. Articulaciones en el pluralismo médico de agricultores precordilleranos aymaras chilenos* [Doctoral dissertation]. Universitat Rovira i Virgili. <https://www.tdx.cat/handle/10803/320188>.
- Piñones-Rivera, C., Liberona, N., & Montecino, B. (2019b). La subordinación ideológica del saber médico andino en la salud intercultural chilena. *Polis (Santiago)*, 18(54), 224–244. <https://doi.org/10.32735/S0718-6568/2019-N54-1407>
- Piñones-Rivera, C., Liberona, N., Muñoz, W., & Holmes, S. M. (2022). Ideological assumptions of Chile's international migrant healthcare policy: A critical discourse analysis. *Global Public Health*, 17(12), 3353–3367.
- Piñones-Rivera, C., Martínez-Hernández, Á., Morse, M. E., Nambiar, K., Ferrall, J., & Holmes, S. M. (2023). Global social medicine for an equitable and just future. *Health and human rights*, 25(1), 1–8.
- Piñones-Rivera, C., Quesada, J., & Holmes, S. M. (2019a). Structural vulnerability and new perspectives in social medicine on the health of immigrants: Interview with James Quesada and Seth M. Holmes. *Salud Colectiva*, 15, 1–9.
- Ramos, M. (2001). Os limites da noção de competência sob a perspectiva da formação humana. *Movimento-revista de educação*, 4.
- Ramos, M. (2011). *A pedagogia das competências: autonomia ou adaptação?*. Cortez Editora.
- Raphael, D. (1998). Public health responses to health inequalities. *Canadian Journal of Public Health*, 89(89), 380–381. <https://doi.org/10.1007/BF03404078>
- Rodríguez-Cuevas, F., Maza-Colli, J., Montañó-Sosa, M., de Lourdes Arrieta-Canales, M., Aristizabal-Hoyos, P., Aranda, Z., & Flores-Navarro, H. (2023). Promoting patient-centered health care and health equity through health professionals' education in rural Chiapas. *Health and Human Rights*, 25(1), 119.
- Saviani, D. (2018). *La pedagogía histórico-crítica: Primeras aproximaciones*. Autores Asociados.
- Seppilli, T. (1996). Antropología médica: fundamenti per una strategia. *AM. Rivista della Società italiana di antropologia medica*, 1(1–2), 7–22.
- Seppilli, T., & Otegui, R. (2005). Presentación: antropología médica crítica. *Revista de Antropología Social*, 7–14.
- Sesia, P. (2015). Enfoque intercultural aplicado a la salud materna. Herramientas culturalmente apropiadas. In M. Freyermuth (Ed.), *25 años de buenas prácticas para reducir la mortalidad materna en México. Experiencias de organizaciones de la sociedad civil y la academia* (pp. 109–115). CIESAS.
- Sesia, P., Gamlin, J., Gibbon, S., & Berrio, L. (2020). Introduction. In J. Gamlin, S. Gibbon, P. Sesia, & L. Berrio (Eds.), *Critical medical anthropology-perspectives in and from Latin America* (pp. 1–16). UCL Press.
- Signorelli, A. (2015). *Ernesto De Martino: teoria antropologica e metodologia della ricerca* (L'Asino D'Oro Edizioni). L'Asino d'Oro.
- Silva, C. C., & Egry, E. Y. (2003). Constituição de competências para a intervenção no processo saúde-doença da população: desafio ao educador de enfermagem. *Revista da Escola de Enfermagem da USP*, 37(2), 11–16. <https://doi.org/10.1590/S0080-62342003000200002>
- Sommer, M., & Parker, R. (Eds.). (2013). *Structural approaches in public health*. Routledge.
- Sennyonjo, A. (2022). Beyond “lack of political will”: Elaborating political economy concepts to advance “thinking and working politically”. *International Journal of Health Policy and Management*, <https://doi.org/10.34172/ijhpm.2022.7297>
- Stonington, S., & Holmes, S. M. (2006). Social medicine in the twenty-first century. *PLoS medicine*, 3(10), e445. <https://doi.org/10.1371/journal.pmed.0030445>
- Stonington, S. D., Holmes, S. M., Hansen, H., Greene, J. A., Wailoo, K. A., Malina, D., Morrissey, S., Farmer, P. E., & Marmot, M. G. (2018). Case studies in social medicine – attending to structural forces in clinical practice. *New England Journal of Medicine*, 379(20), 1958–1961. <https://doi.org/10.1056/NEJMs1814262>
- Szilvasi, M., & Saitovic-Jovanovic, M. (2023). Social accountability and legal empowerment initiatives: Improving the health of underserved Roma communities in Eastern Europe. *Health and Human Rights*, 25(1), 67.
- Taylor, K. Y. (Ed.). (2017). *How we get free: Black feminism and the Combahee River Collective*. Haymarket Books.
- Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of health care for the poor and underserved*, 9(2), 117–125. <https://doi.org/10.1353/hpu.2010.0233>
- Waitzkin, H., Iriart, C., Estrada, A., & Lamadrid, S. (2001). Social medicine then and now: Lessons from Latin America. *American Journal of Public Health*, 91(10), 1592–1601. <https://doi.org/10.2105/AJPH.91.10.1592>
- Williams, D., Lawrence, J., & Davis, B. (2019). Racism and health: Evidence and needed research. *Annual Review of Public Health*, 1(40), 105–125. <https://doi.org/10.1146/annurev-publhealth-040218-043750>
- Williams, D. R., & Mohammed, S. A. (2013). Racism and health I: Pathways and scientific evidence. *American Behavioral Scientist*, 57, <https://doi.org/10.1177/0002764213487340>
- Wilson, C. (2022). Engaging decolonization: Lessons toward a theory of change for transforming practice. *Teaching in Higher Education*, 2(1), 1–16. <https://doi.org/10.1080/13562517.2022.2053672>
- Zarifian, P. (2010). O modelo da competência: trajetória histórica, desafios atuais e propostas. In P. Zarifian (Ed.), *O modelo da competência: trajetória histórica, desafios atuais e propostas* (pp. 192–192). SENAC.