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INTERNATIONAL HEALTH, COLONIALISM AND CROSS-BORDER CARE IN TIMES OF PANDEMICS: AN APPROACH FROM THE LATIN AMERICAN TRIPLE-BORDER

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INTRODUCTION

The International Bridge of Friendship, built in the 1960s, responsible for connecting the south of Brazil with the east of Paraguay, as well as the International Bridge of Fraternity[1], inaugurated (20) twenty years after the first, and which connects the northeast of Argentina with Brazilian territory, are considered landmarks of the contemporary integration of Latin America. Both buildings were built on the confluence of two of the most important rivers in South America: the Paraná and Iguaçu rivers. From the vertices of these rivers, the national borders of Paraguay, Brazil and Argentina were delineated.

Long before that, this territory belonged to the Guarani peoples and other autochthonous peoples. However, we know that in order to form Latin America, it was the producer and product of extensive processes of violence, especially against our native peoples. These first inhabitants of the place known today as a triple border used to move freely in their territory, their understanding of space did not admit physical borders, common to the advent of western modernity. Their sociocultural dynamics implied a coexistence with the rivers that allowed them to move between banks, which is currently considered border transit because they are different countries. The existence of the rivers, therefore, motivated the first settlements in the region and configured, simultaneously, the source of life for these communities and the condition of a naturally open frontier. The spontaneous settlement, distributed in the three ends of the river and the delineation of the border is an effect of this process.

The sharp population growth, associated with migratory flows as frequent as singular, gave greater strength to this region in the Latin American context. Today, the three border towns Ciudad del Este (Paraguay), Puerto Iguazu (Argentina) and Foz do Iguaçu (Brazil), each on its riverbank, total around 9,000 inhabitants and make up the densest triple border[2] in Latin American population terms. Pablo Dreyfus (2007) argued that the region we are referring to forms a very peculiar international urban system in relation to other border regions in South America, basically because it is not simply a matter of neighboring areas to a border layout. The areas are also contiguous in terms of economic, cultural, geographic and security aspects. Constituting, in this direction, a particular transnational economic dynamics and a strategic point of world dispute (Ceceña, 2006).

Research that has focused on social dynamics in the Argentina-Brazil-Paraguay triple border region has shown how these spaces of transnational contact work as a stimulating laboratory for socio-anthropological exercise (Silva; Procópio, 2019). On the one hand, by making it possible to understand the national and intranational historical movements that allowed the formation of these regions as a meeting point for the dividing lines. On the other hand, by observing the particular processes established from these very regions where different nations meet and communicate.

It is by taking the frontier in its analytical potential that, in this article, we face the processes of configuration of discourses and cross-border practices in health. It is

1. Although it is better known by this name on both sides of the border, the official name is Ponte Tancredo Neves. In reference to the Brazilian politician, elected president during the period of redemocratization, but who died without being able to assume the highest position in the country, in April 1985. Seven months before the bridge was inaugurated.

2. Although there are other regions in Latin American territory where three cities from different countries meet, the convergence zone of cities to which we are referring has become better known for the attention received by the international community (Silva & Procópio, 2019; Rabossi, 2013)

the border condition that marks the way cities in the region have decided to face the[3] Covid-19 pandemic – a disease caused by the new coronavirus (Sars-Cov-2). Here, we will discuss the ways in which health care and care networks are configured and, finally, we will dedicate ourselves to reflecting, from this context, on the characteristics and potential of south-south cooperation and health sovereignty in a border context.

The issue of health care in border areas still appears timidly in contemporary public debate. Although the first reflections date from the mid-2000s, most of them are essentially guided by the World Health Organization (Astorga, 2004) and guided by the interests of hegemonic power blocs.

THE CORONAVIRUS AT THE BORDER: DISCOURSES AND HEALTH PRACTICES

Even before the first case of covid-19 in Latin American territory was confirmed[4], the triple border was already feeling the effects of the spread of the new coronavirus in the world. And this was no accident, this region is the border territory that concentrates the largest flow of people and goods in South America (Albuquerque, 2008; Sausi; Odone, 2010; Cardin, 2012).

In the first twenty days of coronavirus in the country, there was an estimated drop of at least 70% in the movement of tourists on the Brazilian side of the border. The weakening of tourism, the economic sector that accounts for 2/3 of the revenue of the municipality of Foz do Iguaçu, has spread fear of unemployment. To give you an idea, in 2019 alone, the year before the pandemic, Foz do Iguaçu received 4 million visitors. In neighboring cities, to some extent dependent on this tourist and commercial movement, the impact would be even greater.

Once the rapid spread of the new coronavirus has been verified since its recognition in Wuhan (China), in December 2019; different countries, almost immediately, chose to close their national borders and increase border control. The perception that guided this practice – which we will discuss throughout the text – was the representation of the other, the migrant, as a vector of contamination, as a threat. However, this is a securitization practice as a strategy to face a health emergency that needs to be denaturalized and understood within a broader context. Borders are living spaces, agglutinating everyday social, political, economic and cultural practices and their closure or restriction of their flow as a health measure has an important impact on lives, bodies and economies (local, national and global).

Such impacts would be felt with greater intensity, obviously, in the most vulnerable and impoverished social segments, which find resistance strategies in the ways of living on the frontier and create opportunities for family subsistence (SASSEN, 2003). A border region such as this one is not significantly different from other Latin American urban centers, that is, it must be understood simultaneously as a historical product and a condition of the social relations of production; a field of contradictions, but also a place for building alliances and struggles for survival and reproduction of life.

In other words, borders have historically been used as global health barriers, in which the main purpose is the control of "unwanted"

3. On January 30, 2020, the World Health Organization (WHO) published an information note in which it declared that the outbreak of the new coronavirus constitutes a "Public Health Emergency of International Concern", just over a month later, on the 11th. In March 2020, the WHO declared that the disease from the new coronavirus had now reached the status of a pandemic.

4. The first case was registered in Brazil, on 02/25/2020. By then, 2,708 people in the world had already died from the virus.

subjects and bodies, giving rise to several violations of human rights and, in particular, the human rights of the migrant person, as Denise Ventura has already pointed out:

> the association between the foreigner and the disease accompanies the history of epidemics and is part of the process of building national identities in the West, keeping in contemporary times the potential to induce or justify human rights violations (2016, p. 61).

On February 6th, even before the first death or any other significant public health measure, one of the first actions proposed by the Brazilian government to face the pandemic was the control of its national borders [5]. The following month, in the same direction, the government of Paraguay decided to close its borders with Brazil and Argentina. This, in turn, since March 15 of last year, closed the border between Foz do Iguaçu and Puerto Iguazu. In the particular case of the border between Brazil and Paraguay, transit between the countries was released on October 15th.

In the Triple Border, before the pandemic, deep social inequality was already expressed as inequality in health at the same time that it configured the spatial hierarchy in neighboring cities, showing that segregation is a constitutive part of the production of border life. During the covid-19 pandemic, the modes of labor exploitation raised the level of existing asymmetries and signaled an imminent risk to the working class, especially the most impoverished people: the loss of the universal right to breath (Mbembe, 2020).

In this sense, it is possible to say that this pandemic is a historic event that makes visible and enhances the socially constructed inequalities in border territories, at the same time that it legitimizes the establishment of a state of exception; insofar as it determines new border regimes, based on the old and well-known militarized concept of border health.

We cannot fail to highlight that the closing of commercial activities during the pandemic was one of the measures most contested by the population of the region, both because of the direct relationship between commercial activity and urban daily life, as well as the pressure of commercial associations, in most of the times, alleging the need to protect small businesses and job creation. In this regard, it is important to emphasize that the pandemic has catalyzed changes in the retail commercial structure and, therefore, mutations in border cities. Here I am referring in a special way to Ciudad del Este and Foz do Iguaçu, cities in which the relationship between commerce and city life is umbilical, however, the changes potentiated by the sanitary emergency took place only in commercial forms, adapting to the new arrangements. productive and social. It is capital reinventing itself during the catastrophe.

These changes are directly related to the process of concentration and centralization of capital, which is the main trend in the sector in the face of the current crisis. Thus, parallel to the increase in the number of unemployed, the number of workers and informal and precarious workers grows, both in sales of goods and in deliveries. These and these are more exposed to the virus and in the calculation of life and death they are chosen so that the economy does not have greater damage. They are essential workers for the economy and irrelevant from the point of view of the social hierarchies that attribute value to lives. Thus, the relationship between the abstraction of property and economic growth and the concreteness of workers' bodies is uneven and accentuates the precariousness of life pre-existing the pandemic (Butler, 2019).

5. Law nº 13.979, of February 6, 2020, sanctioned by the president of Brazil and signed by the ministers of health and justice at the time: Luiz Henrique Mendetta and Sérgio Moro.

One of the main health characteristics of the Triple Border region is the disparities in the organizations and functionalities of health systems in neighboring countries. Due to this aspect, there is a flow of users to the Brazilian territory in search of support and care networks. The scarcity of health services in the Paraguayan border city and the excessive secession of services from the Argentine system, compromise the necessary articulation between the different administrative levels in the border region and give rise to serious inequality in the provision of public health services to the population.

The condition of health systems in border regions becomes the agenda of international debate much more because of the consequences of the economic reorganization, due to the crisis in the 1990s, than because of the recurrent manifestation of population dissatisfaction with their health care networks. In any case, it is certain that research in the field of health made it known – to managers and proponents of health policies – that the increase in flows of people, pendular migration, the dynamics of services and products resulting from the integration processes regional, directly affect the health and demographic indicators of border towns (Arboleda-Florez et al, 1999, apud Giovanella, 2004).

However, the conceptualization of transboundary global health must incorporate the notion that health must be safeguarded cooperatively by international political actors. With regard to global health policies, there is a demand for the restructuring of countries related to governance in health, which must engage in the realization of human rights in health, surpassing the simple reactive fight against epidemics and pandemics, and incorporating integral health care with increased well-being for all citizens in their national systems (SAMPAIO; VENTURA, 2016).

HEALTH AS AN INTERNATIONAL THEME: BETWEEN SANITARY COLONIALISM, PANAMERICANISM AND THE CONSTRUCTION OF A SUBJECTIVITY OF/ON THE BORDER

The scenario configured from the cross-border expansion of Sars-Cov2 favored the resumption of sanitary controls used in contexts considered threatening to public safety. As, for example, it extended procedures adopted in situations characterized as terrorism, drug trafficking and smuggling, also for health surveillance. Controlling borders and safeguarding the health of national populations has a close historical relationship in Latin America.

These discourses and health practices in the border region are not new and isolated facts. They are organized and structured with and from ideas consolidated throughout the 20th century. XIX, through international relations established with the countries of the global north. European nation-states, for example, defend an idea of sovereignty based on strict control of population and resources in their border territories. This control was given, fundamentally, by their national armies. Such a posture established the jurisdiction, that is, the scope of the laws that exercised within the sovereignty. Thus, borders began to define the relationships that were established between the different national states. It is in this scenario that the idea of foreigners and the understanding that they represent a threat are configured.

Border regimes are broader than specific border limits and constitute a space responsible for the operation or functioning of borders in terms of their daily dynamics (terrestrial, matrimonial and air) based on

the processes of securitization, they configure the relations of power in the border space and a cross-border political economy not only legally but also illegally.

This state discursive device organizes a set of technologies and government practices to create the national/foreign distinction. Which materialize in identity documents, passports and technological resources of facial recognition; instruments that naturalize some forms of violence and legitimize the imposition, on those designated as foreigners, of procedures to contain the flow, such as: confinement, detention and deportation – in addition to the attribution of the stigma of "illegal". At this point, it is worth recalling the history of epidemics and pandemics in the world, the circulation of infectious diseases and pathogens, when defined as threats to the global North, unfolds in the obligation of countries considered underdeveloped, or if we prefer, the nations of the global south, to adopt a series of health measures that respond to the vulnerabilities of Western States and not to their real public health needs.

Thus, from the point of view of border governance, these management technologies develop from extraterritorial international relations. The practices of diplomacy, embassies and consulates play a central role in the attempt to extend the interests of colonialism and this way, mark the processes of interference and intervention with the objective of guaranteeing the interests of the hegemonic countries.

In this regard, it seems important to revisit the doctrine of Pan-Americanism and consider its implications for health thinking in Latin America. I have so far argued that the responses to the SARS-CoV-2 public health emergency in the border region were guided by their own rationality. The state structure, health systems and services promoted adaptive adjustments in their care and attention networks based on the circumstances of an external and hyper-complex environment. The epidemiological scenario, read from a reductionist perspective, was simplified into specialists, protocols, phases, quarantines and hygienism (Basile, 2020a).

The political action of the authorities in the Triple Frontier region of Latin America is no different from the response to the pandemic of countries belonging to the periphery of the world. It is a consequence of these influences, of the conceptions of global health security and public health created by colonial thinking in health (Granda, 2004), which underestimates the ability of local communities to produce social consensus that provides collective care and attention in the context that demands a response. to emergencies and disasters (Basile, 2020b).

Although Pan-Americanism (Martínez, 1957) has described itself as a mechanism to achieve Latin American fraternity, it is necessary to return to the definition of Pan-Americanism (Rapoport, 2008) as a doctrine driven by North American diplomacy with collaborative strategies and policies that since its emergence was crossed by the interests of the foreign policy of the United States and it was reinforced in 1904 with the ideals of the Monroe doctrine. In other words, the Pan-Americanist perspective sees Latin American borders (and not just them!) as a territory of exploration, domination and expansion of geostrategic, military, commercial and, as times and problematized in this section, sanitary interests.

This way, analyzing the doctrine of Pan-Americanism in Latin America is an essential conceptual exercise, because the geopolitics will have a direct impact on the birth and growth of developmental regionalism in health. In other words, recovering Gonzalo Basile (2019), the field of international health in our region is not fully understandable

without knowledge of its Pan-American matrix (Basile, 2019). which is interested in

> analyzing the situation of population health or the health of the region as a whole ("the Americas"), but always thought and guided from workshops located in Washington. In particular, they are treated preferentially, as the main analysis unit, the diseases that cross the borders of the countries, their control and the role of the State-Nación. An international public illness that draws on its genetics the military tradition and its methodological language: "watch", "fight", control", "eradicate", "eliminate". (Basle, 2020c)

From a critical epistemological position on colonialism, it is important to point out Pan-Americanism as a current and a way of thinking that became hegemonic in international public health in Latin America and the Caribbean since the end of the 19th century and throughout the following century (Godue, 1999).

If we consider the asymmetric characteristics of the border regimes in which we are, the social determinations of health, the strategies of reproduction of knowledge and powers that are expressed in the center/periphery relationship, we will realize that Pan American international health and liberal global health have become a power reproduction apparatus. These are two violent expressions of the contemporary world-system (Silva, 2020).

And, therefore, these health practices and discourses are inserted within a capitalist, colonialist, imperialist context that are made viable by the units of analysis that consider national states, diseases, borders and national societies.

BORDERS, SANITARY SOVEREIGNTY AND SOUTH-SOUTH INTEGRATION

During the 1970s, Latin America experienced the development of a field of knowledge called Social Medicine. It was posed as a response to a developmental model that had been exhaustively implemented in Latin American policies, and as a result, had marked effects in the field of public health (Nunes, 1994).

The idea that circulated on the continent at the time was that economic growth would lead to an automatic improvement in living and health conditions, however, the opposite was found. Although the macroeconomic indicators showed an improvement, the social ones were falling apart. A new scenario was taking shape: while health expenditures increased and new technologies flourished, access to health remained restricted and general health conditions worsened (Iriart, 2002).

In this scenario, the correlation between health conditions and social inequality became explicit. Several authors, concerned with understanding what was seen, with diversified theoretical-methodological approaches, began to produce critical scientific knowledge that was sensitive to social issues.

The new attempts at emancipatory critical reflection – in this text evidenced in the studies of critical thinking in health, anti-colonial and decolonial – engendered mainly in the global south, must not be understood only as a recommendable diversification of theoretical references, a recurrent recommendation of hegemonic multiculturalism. More than a geopolitical expression of knowledge, it is about understanding that philosophical reflection can "far exceed modern rationality, with its areas of light and shadow, its strengths and weaknesses" (Meneses, 2008). These epistemological foundations strengthen the thinking and link a perspective that puts into perspective the colonial peculiarity of western expansion: its cultural project (Cf. Cajigas-Rotundo, 2007).

Not for nothing, the Portuguese sociologist Boaventura de Sousa Santos, in 1995, suggested the concept of "epistemology of the South". Motto from which this debate in the field of Social Sciences came together. The proposal is not only to learn that the South exists; after all, unlike modernity, this new epistemological proposition is not a destination or finality. It is also necessary to learn from the South and with the South.

This effort is necessary because a colonial correspondence between scientific production and circulation persists (not only in investigations in the field of health). The countries of the global north reinforce their hegemony through the imposition of a centralizing epistemic agenda in order to perpetuate health issues and practices in which the hierarchical content of North-South relations reproduces colonial relations. In the words of the Puerto Rican philosopher Maldonado-Torres, the coloniality of knowledge-power

> it lives on in learning manuals, in the criteria for good academic work, in culture, in common sense, in the self-image of peoples, in the aspirations of subjects and in many other aspects of our modern experience. In this sense, we breathe coloniality into modernity on a daily basis. (2007, p. 131).

The nodal point of the constitution of modern rationality, or the coloniality of being, knowing and feeling, here for our debate, is the reflection on the epistemological implications of the hegemonic Eurocentric project in health discourses and practices, especially in the region of the triple -border and how this model of seeing, thinking and acting in the world has shaped actions and responses to the health crisis caused by COVID-19. We consider that the geopolitics of power and the geopolitics of knowledge are comprehensive axes of health in the border context.

Current cross-border sanitary practices are characterized by militarization and control of migratory posts to contain the flow of people, interventionism in the conceptions of sanitary surveillance and monoculturalism, insofar as it disregards the plurality and cultural diversity that constitute the border region in the creation of programs. prevention and health promotion.

The tyranny of Latin American peripheral capitalism revealed itself during the pandemic through the voracity of pharmaceutical industrial complexes, markets, corporations and elites. And it did so insofar as it turned every disaster and emergency into profit. Naomi Klein (2017) in her book *The Shock Doctrine: The Rise of Disaster Capitalism* shows how the so-called "Disaster Capitalism" uses fear as an instrument of domination and submission of the population, without allowing them to see any other solution to the crisis context. that is not linked to the system of commodification of life, in return it offers a false promise and sense of security. Thus, as Basile pointed out, even though global and regional capitalism seems to be inflicting a self-disintegration (see the crisis discourse), it also seems to configure itself in the scenario to adjust and perpetuate asymmetric relations and the concentration of capital (Basile, 2020c). Covid is not an exception, it is the rule. To paraphrase Darcy Ribeiro, Covid-19 may have arrived as a crisis, but it turned into a project.

It is precisely for these reasons that a change in the coordinates of thought around the health field has become essential. In this direction, south-south international health is born out of European or developmental modernity. It is not the domestication of the South-South, it is not a Latin American perspective of Pan-Americanism, it is a new epistemology that does not originate in the centers of Pan-Americanism and therefore

does not seek to decolonize the premises of global health, but to produce a health of the south (epistemology and production of an emancipatory theoretical-methodological body, conceptual bases conceived and concerned with inequalities). This is precisely why it considers diversity and community health knowledge and seeks to think and act as a political subject, based on the plots of social movements and regional support networks.

Building health from the South implies facing the pillars of hegemonic power of international health, which extends its tentacles in different spheres (geopolitics, technical-operational and financial flow). It also implies rejecting liberal global health, which has as its unit of analysis the process of globalization and globalization and is anchored in individual freedoms, fostering asymmetrical relationships.

The situation of the pandemic in the border region confirmed the urgent need to rebuild networks of cooperation, coordination of actions and decision-making from another geopolitical and epistemological position, producing a new regional health sovereignty. This way of taking part in the public debate of the so-called health crisis will revitalize Latin America's integration and regional autonomy in an emancipatory sense. In other words:

> An international salud on the south that on the ground implies waiting for the government of the State to achieve new intergovernmental relations as a basis for new foundations of political-sanitary sovereignty. This path starts from and with the societies of the global South: between our networks, territorialities, intercultural dialogues and transmodern relationships. As Rita Segato expressed it: "we only looked at the government of the State, we lost society". It is not a definition, but a new epistemic-political-ethical option for the need for health from the south. (Basle, 2020c)

Aware of the character and nature of our current health dependency, we can move towards Sanitary Sovereignty. Not to return to the theses of borders, nation- state and sovereignty of national states. It is a concept that takes up the theory of dependency to think how in the condition of the periphery, with all the obvious disadvantages, there is also a space to build interrelational autonomy. It means seeking to maximize decision-making capacities in the context of the prevailing center-periphery, building capacities to formulate policies and strategies based on our own actors and decisions, promoting autonomy in health knowledge and practices.

In general, we can define health sovereignty as the ability of a country (or group of countries) to produce the knowledge, knowledge, policies, systems, technologies and inputs necessary to satisfy the health needs of the population, guaranteeing their right to health. One of the biggest obstacles to health sovereignty is that health has become a space for capital accumulation, especially large private corporations belonging to the medical-industrial-financial complex [6], whose main business is illness. Building Sanitary Sovereignty requires the consolidation of a public, universal, participatory health system.

In this direction, before concluding this analysis, it is important to point out the existence of at least two different ways of understanding integration and cooperation. The first is tutored and expresses political and economic interests of the countries of the global north; the other emerges among peers and is decolonial and emancipatory. This exists within the framework of relations of solidarity and complementarity between the global south.

The current perspective of international cooperation is guided by conceptions of Pan-Americanism and liberal global health.

6. Here I refer to the pharmaceutical industry, the technomedical industry, the service industries and the insurance and banking industries.

Expressions of the coloniality of power and knowledge. It is determined by political and economic interests of countries and philanthropic institutions. To a large extent, current cooperation is marked by loans that convert into external debts and, consequently, by the presence of multiple constraints that make investments difficult, placing cooperation at the service of companies and consultants in their countries.

FINAL CONSIDERATIONS

To talk about the discourses and practices in health and to understand the attention and care in the border region in the context of the pandemic, it was necessary to mention the issue of social determination: the fundamental causes of diseases or lack of health is located in neoliberalism. That is, we live in a region and in a society that produces and reproduces inequalities. Therefore, it seemed important to analyze the inequalities connected to the global context. In the last decades of the century. In the 20th century, a neoliberal globalization took a turn that influenced all aspects of life. In the field of health, the accumulation of wealth, the encouragement of a cheap workforce and the flexibilization of the labor market, privatization of the public sector and the commodification of human rights have proliferated (Guinsberg, 2014).

In recent years, the expansion of neoliberal subjectivity (Dardot & Laval, 2016) marked by individualism has supported the perception that events in society are the responsibility of the individuals involved in them, rejecting the collective and social character of life. This world perspective underlies the naturalization of inequalities by society and makes political actors understand them as the result of individual problems, minimizing the expressions of injustice and, therefore, contributing to the scarcity of government policies and actions to minimize them.

To deal with the issue of health in a border region, it was necessary not to reduce space to a simple surface, or to think of it as a mere material substrate on which human relations unfold, this would be to limit the political power of our action in the world. Our understanding of the frontier is expressed in the words of British geographer Doreen Massey "the argument here is that space is equally alive and equally challenging, and that, far from being dead and fixed, the very enormity of its challenges means that strategies for dominating it have been many, varied and persistent" (Massey, 2015, p. 33). Like her, we try to problematize the health policy that is overly concerned with the control or regulation of space.

Nowadays, in Brazil, we live under a militarized management of health and securitization of health emergencies. In the health systems of the countries that make up the triple border, there is fragmentation and segmentation of health care. In the border region, there was an old conception of borders as fixed territories. All cross-border cooperation remains grounded in the control of roles and people.

Introducing ourselves to south-south cooperation (geopolitics) is to change the unit of analysis, rupture of paradigm and cosmovision. Thinking from an indiscipline of knowledge in health, breaking with the simplifying reductionism of social phenomena. It is a theoretical-epistemic construct constructed from the periphery.

The world system imposes on us the perception that there is only one way to understand health, or even a periodization of health. This idea shows that dependence is not only an external phenomenon, of conditions and asymmetry of power, but also manifests itself in internal forms and structures: social, political, ideological, scientific that create a character of dependence in health

knowledge, in health policy, in the forms and evidences of health.

In the border context, the dimension of interculturality is fundamental and it is an important facet for the construction of an emancipatory health system. Interculturality is not assumed as an instrumental and communicative measure (Walsh, 2009) that is reduced to a kind of recognition of the existence of languages and symbols different from those of the West, producing asymmetrical multiculturalism – a mark of Western colonial thought that respects cultural diversities, but maintains the asymmetries. It is a political dimension that implies de-Westernization, and does not require the distribution of power – in health systems and in health services.

Throughout this text we try to demonstrate that there is a north-south geopolitics, in which transnational corporations have used the gears at the service of the colonial logic in health in border regions. Also in these spaces the world-system works in a delocalized, denationalized and local way. Our understanding is that it is necessary to break with these limited structures of cooperation and promote health care that does not perpetrate the violence inherent to neoliberal capitalism.

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