



OPEN LETTER

REVISED Invisibility in global health: A case for disturbing bioethical frameworks [version 2; peer review: 2 approved, 1 approved with reservations]

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Abstract

In recent years, the global health community has increasingly reported the problem of ‘invisibility’: aspects of health and wellbeing, particularly amongst the world’s most marginalized and impoverished people, that are systematically overlooked and ignored by people and institutions in relative positions of power.

It is unclear how to realistically manage global health invisibility within bioethics and other social science disciplines and move forward. In this letter, we reflect on several case studies of invisibility experienced by people in Brazil, Malaysia, West Africa and other transnational contexts. Highlighting the complex nature of invisibility and its interconnectedness with social, political and economic issues and trends, we argue that while local and targeted interventions might provide relief and comfort locally, they will not be able to solve the underlying causes of invisibility.

Building from the shared lessons of case study presentations at an Oxford-Johns Hopkins Global Infectious Disease Ethics Collaborative (GLIDE), we argue that in dealing with an intersectional issue such as

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invisibility, twenty-first century global health bioethics could pursue a more 'disturbing' framework, challenging the narrow comforting solutions which take as a given the sociomaterial inequalities of the status quo. We highlight that comforting and disturbing bioethical frameworks should not be considered as opposing sides, but as two approaches working in tandem in order to achieve the internationally set global health milestones of providing better health and wellbeing for everyone. Insights from sociology, anthropology, postcolonial studies, history, feminist studies and other styles of critical reasoning have long been disturbing to grand narratives of people and their conditions. To rediscover the ethos of the WHO Alma Ata Declaration—a vision of "health for all by the year 2000"—these thinking tools will be necessary aids in developing cooperation and support beyond the narrow market logic that dominates the landscape of contemporary global health.

Any reports and responses or comments on the article can be found at the end of the article.

Keywords

global health, bioethics, invisibility, inequality, decolonization

This article is included in the [Global Infectious](#)

GLIDE
Global Infectious Diseases Ethics Collaborative

[Disease Ethics Collaborative \(GLIDE\)](#) gateway.

EPIDEMIC
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This article is included in the [Epidemic Ethics:](#)
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REVISED Amendments from Version 1

Dear Readers,

We are excited to have prepared the next iteration of the article. First and foremost, Jon Schaffer was added as a co-author following his active involvement with writing, (re)conceptualisation and revision of this text. As such, we did our best to address the comments and push the article forward. Following rigorous peer review, we broadened the theoretical scope of the article, including by citing relevant literature suggested by the reviewers. We had to balance our stance and advocacy for re-discovering ethos of the Alma Ata declaration, the brief nature of this article format, and the reviewers' suggestions to push the concept forward and engage with other dimensions. As a result, we had to refute some of the suggestions, which perhaps could be explored in a follow-up article. Overall, we believe that these edits have adequately addressed the most pressing concerns raised by the reviewers, such as naming explicitly a definition of 'global health' for the article, clarifying the origins of the letter including its relationship to the GLIDE meeting beefing up the theoretical orientation and glossing the expansive literature on visibility within the social sciences, and why bioethics is a fruitful domain for this proposal.

Any further responses from the reviewers can be found at the end of the article

Disclaimer

This text represents the views of the authors and does not necessarily reflect the views of the agencies or institutions with which they are affiliated.

Encountering global health invisibility: a few empirical snapshots

The academic discipline of global health¹ (Farmer *et al.*, 2013) is increasingly acknowledging² that many social, political and economic aspects of health often remain structurally overlooked, underappreciated, or ignored (Chambers, 2010; Parry *et al.*, 2019; Rahman-Shepherd *et al.*, 2021; The Lancet Global Health, 2019; WHO, 2022). These problems are made invisible by the accreted, institutionalized ways of knowing and intervening on them that have constituted the field. The literature reports this 'invisibility' unfolding in unequal or otherwise divided environments marked by asymmetrical power relations, which characterizes most—if not all—global health contexts (Davis, 2017; Harman, 2016; Mac-Seing *et al.*, 2019; The Lancet Global Health, 2019). This means that global health invisibility offers a sharp challenge but also an opportunity to extend theory and practice.

In 2022, the Oxford-Johns Hopkins Global Infectious Disease Ethics Collaborative (GLIDE) organized a forum examining invisibility across a variety of global health contexts. The aim was to gain diverse perspectives to shift attention from the question of '*What* is invisibility?' to '*How* is invisibility

made and unmade in practice?' and 'How should ideas of invisibility be addressed in policy?' In this letter, we do not provide record of that meeting, but rather an analysis of shared empirics and an argument presented based on those presentations. We reflect on the invisibility case studies and suggest a distinction between 'disturbing' and 'comforting' global bioethics as both an analytic lens and a way of doing bioethics that can productively work on the stubborn problem of invisibility, even the invisibility of power itself operating within bioethics (Muntaner *et al.*, 2012). Moving forward and looking back, we argue that the ethos of the Alma Ata declaration (WHO, 1978) should be rediscovered and reinvigorated for tackling global health invisibility and disturbing the comforting yet limited solutions to chronic intersectional issues.

In this section, we briefly introduce five examples of global health invisibility that reveal only the tip of the iceberg, with far more serious problems lying underneath. Firstly, in Malaysia, since the turn of the century, invisibility has unfolded as an institutionalized practice, wherein undocumented migrants, subjected to a spectrum of health problems and especially mental health issues, were not identifiable in any registries, and nor did their health issues in effect 'exist', effectively turning invisibility into a local determinant of health and wellbeing. Secondly, In Brazil, in the context of the response to Covid-19, layers of invisibility came to the fore with the lack of gender-specific policies and institutionalized processes that oversimplified continuums of inequalities and rendered vulnerable populations invisible.

Thirdly, we discussed how internationally praised collaborative partnerships for Ebola research in West Africa contained invisible forms of precarity stemming from a dependency on Global North-based institutional funding. As a result, the entire local research and health care systems relied on its presence and constant flow, creating cycles of unresolvable and unsustainable issues. This unseen phenomenon was in sharp contrast to the formal rhetoric of building local capacity and equal partnerships between the Global North and South. Moreover, we discussed how the US-led, North-South collaborative partnerships on global health and bioethics contained hidden layers of inequality that proliferated despite attempts to achieve benchmarks of fairness, empowerment and egalitarianism. Finally, zooming out at the international level, invisibility was traced with regard to the unseen politics of death and dying, spanning global health as a whole. There are millions of dead bodies across the globe that remain unidentified, and this number is steadily increasing due to humanitarian disasters, infectious disease outbreaks and mass migrations. In such contexts, people from poorer and marginalized backgrounds are likely to be invisible in their death and dying.

Rethinking global bioethics: the case for disturbing and comforting methods

The collective discussion of such case studies brought up a key theme; namely, that topical and narrow solutions to

¹ That is, to say nothing of the patients or care providers embroiled in the workaday struggle to assuage suffering, prevent death, to heal.

² Arguably, too slowly.

invisibility will likely not be able to address the root causes of invisibility, however, they might be able to alleviate tensions locally. We further develop this idea and suggest that in order to address a complex issue such as global health invisibility it might be useful to maintain and utilize the analytic distinction between what we term ‘comforting’ and ‘disturbing’ global health bioethics. We argue that if it is true that invisibility is a function of coloniality within bioethics and global health more broadly, a two-pronged strategy of comforting and disturbing bioethics must be pursued, lest global health bioethics reproduce regimes of visibility and invisibility and the structural injustices they maintain.

The notion of visibility’ or ‘invisibility’ as a category of analysis within the social sciences (Brighenti, 2007) and studies of global health is not new (Brandt, 2013; Brown *et al.*, 2012). Visibility has been studied as a field of power, condensed and deployed by states and academic disciplines to manage and control populations, social problems, and expert knowledge respectively (Foucault, 1972; Foucault, 1973; Scott, 1998). Within global health, the notion of visibility has been theorized as the political construction and mobilization of justificatory and explanatory metrics, quantitative and qualitative facts in global health governance (Adams *et al.*, 2016; Benton, 2012). Subaltern and postcolonial studies have long emphasized the partial, positioned, and power-laden relationships that enable certain views, conceptions, and thus unequal knowledge and often reproduction of dominating transnational relationships and inequality (Grosfoguel, 2002; Grosfoguel, 2007). Scholarly claims of “invisibility” in global health may also be related to the linked political and moral economies of ignorance (Kourany & Carrier, 2020), secrecy, concealment, and hiding (Jones, 2014; Scott, 2009: 179–219), as well as social hierarchies of recognition and their relationship to legibility and care (Benton, 2015: 97–113). As this diverse social scientific literature demonstrates, the concepts of visibility and invisibility are inseparable from a normatively contested and highly unequal political economy that shapes the terrain of global health practice. A bioethics in and of global health must take note.

Reflecting on the snapshots of the case studies, we suggest that comforting bioethics builds upon the premise of creating new forms of normative engagement based on amendments to existing power structures, while effectively maintaining the status quo. In doing so, comforting bioethics effectively reproduces the idea of ethical commensurability, progress and Whig historiography (Lerner & Caplan, 2016) in suggesting that ethicality is being gradually accumulated over time. Hence, the solutions are ‘comforting’ as they address issues locally and do not intend to fundamentally challenge the features of the entrenched power structures and socio-political determinants of health inequities.

While we are sympathetic for the need for psychic and moral comfort in a turbulent and dangerous world, we nevertheless cannot ignore the fact that all of the cases above, one way or another, are linked to global patterns of economies of material extraction, violent labor conditions, and socioeconomic distress and disparity that exists beyond the traditional remit of

bioethics and global health analyses. Colonial history, the global acceleration of neoliberalism, and the neo-colonial integration of the Global South into global markets of unequal exchange, as well as patriarchal power dynamics, all play a role in creating and maintaining invisibility that we can no longer afford to overlook and oversimplify. Disturbingly, this could suggest that isolated attempts to address global health invisibility—without addressing or at least acknowledging the core issues and overarching patterns—risk misrepresenting the sheer magnitude of the problem. This, in turn, risks producing ‘cruel optimism’ (Berlant, 2011): a social change that is simultaneously desired but is not attainable within a given socioeconomic system and the solutions it offers.

While comforting bioethics is well represented in applied bioethics and global health, we argue that the international community should practice more disturbing bioethics in order to achieve the internationally-postulated milestones for global health in the 21st century. Disturbing bioethics offers a different proposal: that ethicality can be achieved when power structures are challenged and reassembled in a structurally competent way. This simple yet crucial analytic point creates a justification for disturbing the comforting solutions and the sentimental morality they might entail. We suggest that disturbing bioethics could be enacted by drawing on insights from anthropology, sociology, studies of international development and globalization, postcolonial studies, community organizing and social movement studies and other styles of reasoning that have a record of disrupting power structures and challenging grand assumptions about people and their conditions. Disturbing bioethics, in essence, is an exercise in empirical reflexivity and a reminder that the contemporary world is marked by contingency, crisis and precarity. Such processes have been accelerating in recent years and now, without exaggeration, they pose an existential threat to humanity as a whole.

As a result, we encounter a timely and uneasy question for global health and bioethics: What are the ethical implications for offering reassuring and comforting interventions and frameworks to intersectional issues such as invisibility, knowing that it will, after being supposedly addressed in one given context, simply manifest somewhere else?

Disturbing guidance: The Alma Ata declaration revisited

Fortunately, we already have a milestone document that supports the claims of disturbing bioethics: WHO’s Alma Ata declaration (1978), which formulated health care as a fundamental human right that care should be available to all people regardless of their socio-economic status. The declaration called for a more horizontal approach to the structuring of infrastructures providing health care, education and wellbeing. Since this document was signed in the presence of 3,000 delegates from 134 countries and 67 nongovernmental organizations, the global rise of neoliberalism has resulted in the rapid marketization of health care, reductions in public expenditure, and the greater involvement of the private sector in public services (Exworthy, 2008) and the WHO played an instrumental part in this transformation (Navarro, 2008).

We view the Alma Ata Declaration of 1978 as perhaps the last effort, at the global stage, to call for and seek implementation of an expansive, community-organized, state-protected, rights-based approach to human health. Embroiled in peak Cold War ideological conflict (being held in Kazakhstan, then part of the USSR, was no accident), it was, no doubt, nearly immediately hemmed in by competing ideological policy frames advanced by the neoliberal Bamako Initiative, which forced individual clinics to purchase their own medicines and introduced fee for service models (Hanson & Mcpake, 1993; Knippenberg *et al.*, 1997), and the rapid expansion of World Bank (WB) loans and International Monetary Fund (IMF)-driven austerity conditions (Kentikelenis & Stubbs, 2023).

The pivot away from a human rights frame towards explicitly market allocated health services came with high costs. Despite significant economic growth, much of the Global South remained unable to invest the necessary resources to building effective, responsive and adequate health systems. The WB- and IMF-provided “development” loans and rapidly accruing debt left little “fiscal space” for national investments in basic services and provision of social and economic rights (Siddiqui, 2012).

Under this regime, the Declaration’s ethos of ‘health for all’ has been replaced with ‘health insurance for all’ (Pandey, 2018); health care for all who can pay. Fifty years later, principles of horizontality and social change outlined by the Alma Ata declaration are truly disturbing—some might even say radical—in the hegemonic global health prioritizing top-down, technologically driven health programs and market-based solutions to chronic health and social issues (Holst, 2020). Numerous academics and practitioners have expressed the concern that contemporary global health is rapidly departing from the principles of the declaration, and that now, more than ever, we need ‘reinvigorated social justice-based on political and social movements—an uphill struggle, to be sure, but a healthy one indeed’ (Birn, 2018). Reflecting on the concerns of invisibility in global health, the colonized state of both global health and bioethics, we suggest that the ethos of the Alma Ata Declaration could be reintroduced through the notion of disturbing bioethics and its central aim of challenging comforting yet heuristic solutions to chronic social and health care issues.

A range of important ‘disturbing’ bioethical contributions are needed to continue to make progress towards social justice in global health. The Alma Ata Declaration is by no means

the end of this conversation. We believe that it is simply a potent example example and perhaps a beginning of a new conversation.

Moving forward and looking back

Taken together, in pursuing the exercise in ‘comforting’ bioethics, we suggest that invisibility should be made central to normative action in accordance with the best practices in the field. More specifically, we suggest that funders and institutions could

- increase the funding of studies of invisibility in various global health contexts to gain a better understanding of the problem;
- establish local bottom-up collaborative partnerships to empower invisible communities and address invisible problems;
- collect qualitative, quantitative or mixed-methods data and prepare it for evidence-based policymaking, with the goal of reaching national and international regulators; and
- perform stakeholder analysis, review gaps in evidence concerning invisibility and identify topics for advocacy.

We believe that it is useful to understand global health invisibility as a product of global health political economy, or at least as a phenomenon unfolding in a political context. Accordingly, we would like to add three disturbing conceptual points to the list above, to make a grand total of seven:

- Politicize the emergence of global health invisibility and oppose the depoliticized operationalization of the term, further linking it with the notions of coloniality, precarity and neoliberalization
- Acknowledge that intersectional issues cannot be easily resolved by the vertical approaches that currently dominate the landscape of contemporary global health and applied global health bioethics

Advocate for distributive justice and a more horizontal approach to the conduct of health interventions as initially proposed by the WHO Alma Ata declaration, prioritizing cooperation, resistance and solidarity beyond the market logic.

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Open Peer Review

Current Peer Review Status: ? ✓ ✓

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The authors have substantially improved upon their prior work and have constructively engaged with peer-review. This is now a more nuanced and careful argument for how we can think about the problems of invisibility in global health.

The manuscript would potentially benefit from a summary figure (perhaps a causal diagram?) that synthesizes the arguments in the manuscript.

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Public Health, LMIC research, Global Health, Health Outcomes

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Reviewer Report 01 February 2024

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My only comment for this much-improved essay addresses the link between the first sentence and

the second. Is the reader to assume that 'overlooked, underappreciated, or ignored' reside under the rubric of 'invisibility'?

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Global health, infectious diseases, political economy, Black studies

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Version 1

Reviewer Report 21 June 2023

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This is a challenging essay; it appears that what's at stake for the authors is how a range of inequalities and hierarchies are addressed in the fields and practices of public health and bioethics. Attempts to redress problems that are located within marginalized or precarious groups is to characterize them as invisible -- thus the intervention requires visibilizing for the sake of intervention. But the authors suggest that even as such inequalities may serve as the engine and fuel for a range of political, social and economic interventions for health, these same interventions might also produce and conceal those (and emergent) inequalities, sheltering them from view.

More importantly, they do not address what lies at the root of invisibility. Throughout, I found myself wondering: What analytical and empirical weight should be afforded to 'invisibility' as an organizing principle, when ignorance, concealment, etc have all been theorized in relation to similar power dynamics? Is it worth taking on this 'native' concept within global health? While the heuristic may help these analysts move beyond the descriptive (what is invisibility--though maybe the question is really 'what is invisible?'), toward practice and process ('how is invisibility made and unmade in practice'), I thought the authors called for something a bit more elemental: attention to the subjects and objects of in/visibility. To suggest that something is invisible is to also suggest an object and a subject of ocular perception, a visual aesthetics of power, a regime of visibility are all at play. Thus, attention to invisibility is a methodological and analytical move, guiding the transdisciplinary examinations alluded to in the letter's introduction: who and what is doing the perceiving, what is being perceived and 'apprehended' (in many senses of the word)? What is surfaced, concealed, and sublimated, through which means and to what end? What is at stake --

and for whom –in those concealments, sublimations and surfaces? And are these signs and secrets of the global health landscape only to be recognized and decoded by a certain set of social and cultural analysts via a specific set of conceptual frames? (This is a Simmelian argument, I think). I know that the tendency within global health critique is to offer solutions, answers, alternatives (and even some concessions) – and Alma Ata, as well as the disturbing/comforting framework, which reflects a general discomfort with liberal reform, have been offered in this critical position. But I wondered what would happen if the authors instead posed, irrespective of the disturbing and comforting effects of specific interventions, the elemental questions raised above: what has been settled as seen, what is to be unsettled and unseated, such that crucial underlying issues, hitherto ignored or concealed social and political problems, come to the surface?

I think that answering these question might have an impact on the first few recommendations offered. I also think that the 'disturbing' recommendations could be better integrated in the analysis in the earlier segments of the letter. Why not shake things up from the beginning?

Is the rationale for the Open Letter provided in sufficient detail?

Partly

Does the article adequately reference differing views and opinions?

Yes

Are all factual statements correct, and are statements and arguments made adequately supported by citations?

Yes

Is the Open Letter written in accessible language?

Yes

Where applicable, are recommendations and next steps explained clearly for others to follow?

Not applicable

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Global health, infectious diseases, political economy, Black studies

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

Author Response 22 Nov 2023

Arsenii Alenichev

Dear Adia Benton,

Thank you very much for an opportunity to make the article stronger. We would like

to sincerely apologize for the substantial delay: many of us got caught in the cycle of deadlines, much-needed holidays and other work commitments. It took us a really long time to reconnect about this conceptual article, and think through your insightful comments. We did our best to address your comments. Please let us know if there is anything else we can do to make it better, and again, sorry for such a delay. Here goes the summary of changes:

This is a challenging essay; it appears that what's at stake for the authors is how a range of inequalities and hierarchies are addressed in the fields and practices of public health and bioethics. Attempts to redress problems that are located within marginalized or precarious groups is to characterize them as invisible -- thus the intervention requires visibilizing for the sake of intervention. But the authors suggest that even as such inequalities may serve as the engine and fuel for a range of political, social and economic interventions for health, these same interventions might also produce and conceal those (and emergent) inequalities, sheltering them from view.

Thank you for this generous summary.

More importantly, they do not address what lies at the root of invisibility. Throughout, I found myself wondering: What analytical and empirical weight should be afforded to 'invisibility' as an organizing principle, when ignorance, concealment, etc have all been theorized in relation to similar power dynamics?

This is a fantastic point, and something that we have tried to expand our analysis of visibility to include. We have now included the following paragraph:

The notion of visibility' or 'invisibility' as a category of analysis within the social sciences (Brighenti 2007) and studies of global health is not new (Brown et al. 2012; Brandt 2013). Visibility has been studied as a field of power, condensed and deployed by states and academic disciplines to manage and control populations, problems, and knowledge respectively (Foucault 1972; 1973; Scott 1998). Within global health, the notion of visibility has been theorized as the political construction and mobilization of justificatory and explanatory metrics, quantitative and qualitative facts in global health governance (Adams et al 2016; Benton 2012). Subaltern and postcolonial studies have long emphasized the partial, positioned, and power-laden relationships that enable certain views, conceptions, and thus unequal knowledge and often reproduction of dominating relationships and inequality (Grosfoguel 2002; Grosfoguel 2007). Scholarly claims of "invisibility" in global health may also be related to the linked political and moral economies of ignorance (Kourany and Carrier 2020), secrecy, concealment, and hiding (Jones 2014; Scott 2009: 179-219), as well as social hierarchies of recognition and their relationship to legibility and care (Benton 2015: 97-113). As this diverse social scientific literature demonstrates, the concepts of visibility and invisibility are inseparable from a normatively contested and highly unequal political economy that shapes the terrain of global health practice.

Is it worth taking on this 'native' concept within global health?

Yes, we think it is - but perhaps in another paper. We have gestured to its need to be denaturalized in the paragraph above.

While the heuristic may help these analysts move beyond the descriptive (what is

invisibility—though maybe the question is really ‘what is invisible?’), toward practice and process (‘how is invisibility made and unmade in practice’), I thought the authors called for something a bit more elemental: attention to the subjects and objects of in/visibility. To suggest that something is invisible is to also suggest an object and a subject of ocular perception, a visual aesthetics of power, a regime of visibility are all at play. Thus, attention to invisibility is a methodological and analytical move, guiding the transdisciplinary examinations alluded to in the letter’s introduction: who and what is doing the perceiving, what is being perceived and ‘apprehended’ (in many senses of the word)? What is surfaced, concealed, and sublimated, through which means and to what end? What is at stake – and for whom – in those concealments, sublimations and surfaces?

Thank you for this incredibly thoughtful interpretation of the essay and its intervention. We agree with you, though you’ve captured it here in a much clearer and more potent way.

And are these signs and secrets of the global health landscape only to be recognized and decoded by a certain set of social and cultural analysts via a specific set of conceptual frames? (This is a Simmelian argument, I think).

This a very good point – our intention was not to imagine some delimited set critical theory-competent high priests capable of decoding the rightness or wrongs of various forms of occlusions and visions. Our intervention, particularly with the ‘comforting/disturbing’ frames is to actually try to disrupt the existing boundary work done within contemporary ‘global’ bioethics, and in fact expand the range of considerable and considered forms of method, analysis, critique, political action, practice.

I know that the tendency within global health critique is to offer solutions, answers, alternatives (and even some concessions) – and Alma Ata, as well as the disturbing/comforting framework, which reflects a general discomfort with liberal reform, have been offered in this critical position. But I wondered what would happen if the authors instead posed, irrespective of the disturbing and comforting effects of specific interventions, the elemental questions raised above: what has been settled as seen, what is to be unsettled and unseated, such that crucial underlying issues, hitherto ignored or concealed social and political problems, come to the surface?

We think that this would be a fantastic follow on essay building from the initial intuitions presented here.

I think that answering these question might have an impact on the first few recommendations offered. I also think that the ‘disturbing’ recommendations could be better integrated in the analysis in the earlier segments of the letter. Why not shake things up from the beginning?

Competing Interests: No competing interests were disclosed.

Reviewer Report 21 June 2023

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Ahmad Ozair

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The authors have submitted an insightful and thought-provoking open letter on invisibility in global health, wherein they highlight the 'comforting' and 'disturbing' frameworks needed by global health bioethics.

While the work is interesting, it should be revised further. Given below are my comments in no particular order:

1. Several of the statements in the manuscript need citations but are not supported by any. This issue exists throughout the manuscript but is especially problematic with regard to the "Encountering global health invisibility: a few empirical snapshots" section where all the examples provided need references. These references may be non-academic in nature as well.
2. The manuscript's statement of "we call for taking seriously" implies the rest of the academic world has not taken this seriously at all in the face of a substantial global reflection on these considerations.

I would recommend authors make the language less boisterous and more academic so that readers can focus on the argument itself.

3. I do not fully agree with several of the recommendations that the manuscript makes, given that little quantitative data has been provided to demonstrate that the recommendations provide substantial global health returns on the time, energy, and funds invested.

I am particularly concerned by the strong recommendation made for 'politicizing global health' efforts (invisibility alleviation), particularly since the current version of the manuscript does not provide evidence to support this recommendation.

While in evidence-based medicine, we are utilizing the GRADE approach to go from evidence to decision (EtD) (i.e., recommendations), here, the manuscript states several recommendations without providing evidence, let alone critically appraising it or performing quantitative synthesis.

Is the rationale for the Open Letter provided in sufficient detail?

Yes

Does the article adequately reference differing views and opinions?

Partly

Are all factual statements correct, and are statements and arguments made adequately supported by citations?

Partly

Is the Open Letter written in accessible language?

Yes

Where applicable, are recommendations and next steps explained clearly for others to follow?

Yes

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Public Health, LMIC research

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

Author Response 22 Nov 2023

Arsenii Alenichev

Dear Ahmad Ozair,

Thank you very much for an opportunity to make the article stronger. We would like to sincerely apologize for the substantial delay: many of us got caught in the cycle of deadlines, much-needed holidays and other work commitments. It took us a really long time to reconnect about this conceptual article, and think through your insightful comments. We did our best to address your comments. Please let us know if there is anything else we can do to make it better, and again, sorry for such a delay. Here goes the summary of changes:

The authors have submitted an insightful and thought-provoking open letter on invisibility in global health, wherein they highlight the 'comforting' and 'disturbing' frameworks needed by global health bioethics.

Thank you for this supportive comment!

While the work is interesting, it should be revised further. Given below are my comments in no particular order:

1. Several of the statements in the manuscript need citations but are not supported by any. This issue exists throughout the manuscript but is especially problematic with regard to the "Encountering global health invisibility: a few empirical snapshots" section where all the examples provided need references. These references may be non-academic in nature as well.

Thank you for this important feedback. We have added a new paragraph and significantly expanded our theoretical survey of 'visibility' as an analytic category within social sciences and global health. For instance, we have added this:

The notion of visibility' or 'invisibility' as a category of analysis within the social sciences (Brighenti 2007) and studies of global health is not new (Brown et al. 2012; Brandt 2013). Visibility has been studied as a field of power, condensed and deployed by states and academic disciplines to manage and control populations, problems, and knowledge respectively (Foucault 1972; 1973; Scott 1998). Within global health, the notion of visibility has been theorized as the political construction and mobilization of justificatory and explanatory metrics in global health governance (Adams et al 2016). Subaltern and postcolonial studies have long emphasized the partial, positioned, and power-laden relationships that enable certain views, conceptions, and thus unequal knowledge and often reproduction of dominating relationships and inequality (Grosfoguel 2002; Grosfoguel 2007).

2. The manuscript's statement of "we call for taking seriously" implies the rest of the academic world has not taken this seriously at all in the face of a substantial global reflection on these considerations.

I would recommend authors make the language less boisterous and more academic so that readers can focus on the argument itself.

Thank you for this suggestion, we agree with you. We have scratched the "we call for" language.

3. I do not fully agree with several of the recommendations that the manuscript makes, given that little quantitative data has been provided to demonstrate that the recommendations provide substantial global health returns on the time, energy, and funds invested.

Thank you for this perspective. We believe that it is ok to disagree on these points (partly, to our understanding, this is what the purpose of these Wellcome letters are for!). But, providing an econometric analysis of the outcomes of our proposed recommendations is not within scope of this particular piece. We will consider doing this in a potential follow up article.

4. I am particularly concerned by the strong recommendation made for 'politicizing global health' efforts (invisibility alleviation), particularly since the current version of the manuscript does not provide evidence to support this recommendation.

Reflecting on numerous social studies of Global health, we would like to highlight the fact that it has already been politicized (how could it not be?). From its global institutional forms, policies advanced or declined, modes of financing pursued, ideas and enforcement of human rights or market allocation of crucial health goods and services, structures of global debt and state-level fiscal allocation to basic service provision and care, to forms of scholarship and the views and perspectives privileged to be counted as evidence-based or scientific. This is all political. We are calling for a recognition that this is the case

and perhaps this is disturbing. While in evidence-based medicine, we are utilizing the GRADE approach to go from evidence to decision (EtD) (i.e., recommendations), here, the manuscript states several recommendations without providing evidence, let alone critically appraising it or performing quantitative synthesis. Thank you, but we will not be able to incorporate that point into this brief letter piece. We might explore it in a follow up article.

Competing Interests: No competing interests were disclosed.

Reviewer Report 19 June 2023

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Sridhar Venkatapuram 

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This open letter seeks to report on a 2022 meeting on the topic of invisibility in global health, and then present a manifesto of sorts on how funders and institutions should act in light of the identification of the 'invisibility' phenomenon in global health. Before the 7 point call to action, the authors first link three different ideas. First, they seek to establish through 5 case studies (empirical data) that there are diverse kinds of invisibility in global health. Second, they posit that addressing the complex and deep rooted sources of global health invisibility requires an analytical distinction and two pronged approach entailing "comforting" and "disturbing" bioethics. Third, the authors then assert that global health goals of the 21st century would be more likely to be achieved through a disturbing bioethics, and such an effort should be motivated by the ethos of the WHO Alma Ata declaration of 1978.

I will first address some minor points and then offer some broader thoughts.

1. A direct ref to the Alma Ata declaration is needed so that readers can see what the document actually said. Other writers have commented on what they think the declaration said, what has gone wrong since, etc.
2. It would be good to see explicitly what conception of global health is being used in this letter. The refs in the first para are all about health concerns in LMICs.
3. It is not clear where in the letter discussion moves from reporting on a meeting to making an argument based on the discussion at the meeting. It's a bit awkward trying to see if the

reasoning being presented is record of the meeting, or an argument being presented on the basis of the meeting. Reviewing a meeting record is different that reviewing analyses or argument.

On a more general level, I am clear about the first of the 3 points, but less convinced about the second parts.

1. "Invisibility" is not new to global health. If we are to go along with the idea that HIV/AIDS invented global health (Brandt 2013) then we have to recall that silence=death was a call to arms to fight against invisibility, shame, social marginalization, willful blindness, purposeful erasure, minimization, neglect, etc. Even before HIV/AIDS activism, historians such as those building "[subaltern studies](#)" have argued for dismantling grand narratives and big man histories to tell the stories of the subaltern. Given the authors argue for trans-disciplinary examination of invisibility in global health it is slightly odd to not have some acknowledgement of important efforts in global health as well as other fields.
2. It is unclear why or how invisibility in global health is to be addressed through "global health bioethics"? What is this global health bioethics and what is its significance in global health? As the authors are recommending actions for funders and institutions, is global health bioethics the tool or language these actors most often use, or something else?
3. There is a tension in the letter which asserts that "ethicity can be achieved when power structures are challenged and reassembled in a structurally competent way." And then the authors make recommendations to just such funders and institutions to challenge themselves and reassemble them selves.
4. There is an over idealization of the Alma Ata declaration of 1978. One could argue that the AA declaration sought to achieve sufficiency/ or apply a basic needs approach to health. Every citizen would receive a basic package of healthcare accessed through local health centres. There is much to be valued in a such an approach and also much to be skeptical about. How did the countries that applied the AA declaration address HIV/AIDS, disability, women's health, and other health issues that were not linked to a profile of an "average citizen".
5. The letter does not make any reference to the [Astana Declaration of 2018](#) which was aimed to be a 40 year follow up to the AA Declaration. It will be clear that the Astana Declaration focuses on Primary Health Care, and that is because we now recognize that the AA declaration was really focused on one level of health care provision. What this means is that all the spaces of invisibility in contemporary global health, that the authors are concerned about, will not be sufficiently addressed by the ethos of the AA declaration which is really focused at the local service delivery level.
6. Rather than just a primary health care framework and ethics of the local, what would better serve making all forms of health injustice visible is a theory that gives moral significance to every individual's health and wellbeing, and which has a scope from the local to the global. The ethics of AA declaration had limited scope and may be silent on various forms of injustice we now recognize.

Is the rationale for the Open Letter provided in sufficient detail?

Partly

Does the article adequately reference differing views and opinions?

No

Are all factual statements correct, and are statements and arguments made adequately supported by citations?

Partly

Is the Open Letter written in accessible language?

Yes

Where applicable, are recommendations and next steps explained clearly for others to follow?

Partly

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Global health, public health, health inequalities, applied ethics, political philosophy, social justice theories, health ethics, public health ethics, development theory.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

Author Response 22 Nov 2023

Arsenii Alenichev

Dear Sridhar Venkatapuram,

Thank you very much for an opportunity to make the article stronger. We would like to sincerely apologize for the substantial delay: many of us got caught in the cycle of deadlines, much-needed holidays and other work commitments. It took us a really long time to reconnect about this conceptual article, and think through your insightful comments. We did our best to address your comments. Please let us know if there is anything else we can do to make it better, and again, sorry for such a delay. Here goes the summary of changes:

This open letter seeks to report on a 2022 meeting on the topic of invisibility in global health, and then present a manifesto of sorts on how funders and institutions should act in light of the identification of the 'invisibility' phenomenon in global health. Before the 7 point call to action, the authors first link three different ideas. First, they seek to establish through 5 case studies (empirical data) that there are diverse kinds of invisibility in global health. Second, they posit that addressing the complex and deep rooted sources of global health invisibility requires an analytical distinction and two pronged approach entailing "comforting" and "disturbing" bioethics. Third, the authors then assert that global health

goals of the 21st century would be more likely to be achieved through a disturbing bioethics, and such an effort should be motivated by the ethos of the WHO Alma Ata declaration of 1978.

I will first address some minor points and then offer some broader thoughts.

1. A direct ref to the Alma Ata declaration is needed so that readers can see what the document actually said. Other writers have commented on what they think the declaration said, what has gone wrong since, etc.

Thank you for addressing this omission. We have now included a citation to the Alma Ata declaration.

2. It would be good to see explicitly what conception of global health is being used in this letter. The refs in the first para are all about health concerns in LMICs.

Thanks for this helpful feedback. We've added a citation to Farmer et al's *Reimagining Global Health* and clarified that we mean that the 'academic discipline' of global health is what we are referring to when we refer to 'invisibility in global health.'

3. It is not clear where in the letter discussion moves from reporting on a meeting to making an argument based on the discussion at the meeting. It's a bit awkward trying to see if the reasoning being presented is record of the meeting, or an argument being presented on the basis of the meeting. Reviewing a meeting record is different than reviewing analyses or argument.

Thanks for this great point- we understand this confusion, or lack of clarity. We have tried to improve the language throughout to make clear that this is not a record of the meeting, but rather an analysis of shared empirics and an argument presented based on those presentations.

On a more general level, I am clear about the first of the 3 points, but less convinced about the second parts.

1. "Invisibility" is not new to global health. If we are to go along with the idea that HIV/AIDS invented global health (Brandt 2013) then we have to recall that silence=death was a call to arms to fight against invisibility, shame, social marginalization, willful blindness, purposeful erasure, minimization, neglect, etc. Even before HIV/AIDS activism, historians such as those building "[subaltern studies](#)" have argued for dismantling grand narratives and big man histories to tell the stories of the subaltern. Given the authors argue for trans-disciplinary examination of invisibility in global health it is slightly odd to not have some acknowledgement of important efforts in global health as well as other fields.

These are fantastic points, and we have tried to expand our discussion of past scholarship and theorization of visibility in global health by adding a new paragraph that offers at least a gloss of these important contributions. Currently, the new paragraph reads: The notion of visibility' or 'invisibility' as a category of analysis within the social sciences (Brighenti 2007) and studies of global health is not new (Brown et al. 2012; Brandt 2013). Visibility has been studied as a field of power, condensed and deployed by states and academic disciplines to manage and control populations, problems, and knowledge respectively (Foucault 1972; 1973; Scott 1998). Within global health, the notion of

visibility has been theorized as the political construction and mobilization of justificatory and explanatory metrics in global health governance (Adams et al 2016). Subaltern and postcolonial studies have long emphasized the partial, positioned, and power-laden relationships that enable certain views, conceptions, and thus unequal knowledge and often reproduction of dominating relationships and inequality (Grosfoguel 2002; Grosfoguel 2007).

2. It is unclear why or how invisibility in global health is to be addressed through "global health bioethics"? What is this global health bioethics and what is its significance in global health? As the authors are recommending actions for funders and institutions, is global health bioethics the tool or language these actors most often use, or something else?

We would like to highlight that we think that global health bioethics, as an explicitly normative discipline, has an even stronger opportunity than basic empirical social science (and perhaps even an obligation) to engage not just with the moral possibilities and consequences of global health programs, policies, actions, and plans, but to also consider, comment on, and seek to shape the normative content, structure, and methods of production of knowledge within the discipline itself. For this reason, this intervention is a plea for the discipline to not simply stay blinkered by what is institutionally rewarded and may feel "comfortable" for scholars, particularly in the Global North, but to also incorporate and explore ways of knowing, forms of knowledge, and political engagements that may challenge those ways of knowing and doing business. This goes beyond normalized institutionalized efforts and, in our opinion, it is about seeking to attend to and in fact value modes of bioethical research and practice that may be institutionally disturbing.

3. There is a tension in the letter which asserts that "ethicality can be achieved when power structures are challenged and reassembled in a structurally competent way." And then the authors make recommendations to just such funders and institutions to challenge themselves and reassemble them selves.

We would like to highlight the broader scope: we live in a moment of upheaval, contentious politics, social movements, and organized action. Perhaps this is intended as a warning shot across the bow.

4. There is an over idealization of the Alma Ata declaration of 1978. One could argue that the AA declaration sought to achieve sufficiency/ or apply a basic needs approach to health. Every citizen would receive a basic package of healthcare accessed through local health centres. There is much to be valued in a such an approach and also much to be skeptical about. How did the countries that applied the AA declaration address HIV/AIDS, disability, women's health, and other health issues that were not linked to a profile of an "average citizen".

We agree that we need to make the motivation for our focus and attention on the Alma Ata declaration clearer. We have included the following paragraph: We view the Alma Ata declaration as the perhaps last effort at the global stage to call for and seek implementation of an expansive, community-organized, state-protected, rights-based approach to human health. Embroiled in peak Cold

War ideological conflict (being held in Soviet Kazakhstan was no accident), it was, no doubt, nearly immediately hemmed in by competing ideological frames such as the neoliberal Bamako Initiative (which forced individual clinics to purchase their own medicines and introduced fee for service models) (Knippenberg 1997;) and the rapid expansion of World Bank loans and IMF-driven austerity conditions (Kentikelenis and Stubbs 2023).

5. The letter does not make any reference to the [Astana Declaration of 2018](#) which was aimed to be a 40 year follow up to the AA Declaration. It will be clear that the Astana Declaration focuses on Primary Health Care, and that is because we now recognize that the AA declaration was really focused on one level of health care provision. What this means is that all the spaces of invisibility in contemporary global health, that the authors are concerned about, will not be sufficiently addressed by the ethos of the AA declaration which is really focused at the local service delivery level.

We understand that the spirit of the Alma Ata declaration continues to be invoked in drips and drabs, but we believe that declarations in this spirit, such as the Astana Declaration, continue to leave absent the 'disturbing' fact of the necessity of redistributive financing mechanisms to achieve any of their noble goals. In our view, this is part of the need for a disturbing bioethics, to perhaps name the normative and moral content of what is too often assumed a neutral, level political economic playing field.

6. Rather than just a primary health care framework and ethics of the local, what would better serve making all forms of health injustice visible is a theory that gives moral significance to every individual's health and wellbeing, and which has a scope from the local to the global. The ethics of AA declaration had limited scope and may be silent on various forms of injustice we now recognize.

We agree with you – a range of important 'disturbing' bioethical contribution are needed to continue to make progress towards social justice in global health. The Alma Ata Declaration is no means the end of this conversation, simply an example and perhaps a beginning. We have added a couple lines to this effect.

Competing Interests: No competing interests were disclosed.