BMJ Global Health

Missing in action: a scoping review of gender as the overlooked component in decolonial discourses

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To cite: Nassiri-Ansari T, Rhule ELM. Missing in action: a scoping review of gender as the overlooked component in decolonial discourses. *BMJ Glob Health* 2024;**9**:e014235. doi:10.1136/bmjgh-2023-014235

Handling editor Seye Abimbola

► Additional supplemental material is published online only. To view, please visit the journal online (https://doi.org/10.1136/bmjgh-2023-014235).

Received 12 October 2023
Accepted 18 March 2024

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ABSTRACT

Introduction Race and gender were intimately intertwined aspects of the colonial project, used as key categories of hierarchisation within both colonial and modern societies. As such, true decolonisation is only possible when both are addressed equally; failure to address the colonial root causes of gender-based inequalities will allow for the perpetuation of racialised notions of gender to persist across the global health ecosystem. However, the authors note with concern the relative sidelining of gender within the decolonising global health discourse, especially as it navigates the critical transition from rhetoric to action.

Methods A scoping review was conducted to locate where gender does, or does not, appear within the decolonising global health literature. The authors reviewed the decolonising global health literature available on Scopus and PubMed online databases to identify peer-reviewed papers with the search terms "(decoloni* or de-coloni*) OR (neocolonial or neo-colonial) AND 'global health'" in their title, abstract or keywords published by December 2022.

Results Out of 167 papers on decolonising global health, only 53 (32%) had any reference to gender and only 26 (16%) explicitly engaged with gender as it intersects with (de)coloniality. Four key themes emerged from these 26 papers: an examination of coloniality's racialised and gendered nature; how this shaped and continues to shape hierarchies of knowledge; how these intertwining forces drive gendered impacts on health programmes and policies; and how a decolonial gender analysis can inform action for change.

Conclusion Historical legacies of colonisation continue to shape contemporary global health practice. The authors call for the integration of a decolonial gender analysis in actions and initiatives that aim to decolonise global health, as well as within allied movements which seek to confront the root causes of power asymmetries and inequities.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Colonisation was an undeniably racialised project and race continues to drive power asymmetries within global health today through the actively operating mechanisms of coloniality. Increasing momentum to decolonise global health has been observed as a result.

WHAT THIS STUDY ADDS

⇒ Colonisation was both racialised and gendered, resulting in what many have referred to as a sexual and racial hierarchy through which power is distributed. The gendered nature of colonisation is insufficiently acknowledged and addressed in the decolonising global health literature, leading decolonial initiatives and reforms to overlook and leave unchecked the perpetuation of racialised notions of gender, a crucial element of coloniality which continues to cause power asymmetries.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ An awareness of where and how gender appears in the decolonising global health literature with regard to research, practice and policy should encourage global health colleagues to be more intentional and inclusive in their work; failure to counter and confront the multiheaded beast of coloniality in its totality will otherwise allow gender-based inequities to flourish when reform efforts remain inadequate.

INTRODUCTION: EXPLORING THE GENDERED DIMENSIONS OF COLONIALISM AND COLONIALITY

Colonisation marked the advent of global capitalism, transporting structures of domination and subjugation across borders and oceans under the guise of ideological righteousness. To enable the large-scale exploitation of peoples and extraction of resources, a sexual and racial hierarchy was imposed by colonial forces to create and perpetuate significant power asymmetries, dehumanise large swathes of the world's population and reduce them to (re)productive labour in service of empires.[1 2] As Allotey and Reidpath state in correspondence with Abimbola and Pai, 'Decolonisation is fundamentally about redressing inequity and power imbalance. It cannot be achieved without also addressing gender inequity, racism, and other forms of structural violence'.[3 4] However, as calls to decolonise global health continue to gain momentum, we note with concern the sidelining of gender in discourses within this

space and the closing window of opportunity to embed intersectionality and allyship within the decolonising global health movement.

For this study, the working operationalisation of 'gender' goes beyond the binary, recognising both the full spectrum of gender identities and the structural manifestations of gender as a construct that operates at individual, institutional and systemic levels, resulting in inequities. While scholarship on decolonising global health does not entirely overlook the presence of patriarchal privilege,[5] the connection between gender inequities in health and the colonial construction of gender is often left either unsaid or uninterrogated. This presents a significant and ongoing impediment to the advancement of gender equality and health equity as part of the 2030 Agenda for Sustainable Development, as neither goal can be achieved so long as coloniality and the resultant power asymmetries that drive gender inequalities and health inequities remain unaddressed.

Lugones[1 2 6] outlines a 'coloniality of gender' which positions gender as a colonial construct introduced as part of broader efforts to categorise and control colonised peoples. Crucially, she points out that '[c]olonialism did not impose precolonial, European gender arrangements on the colonised'[1]; rather, a new system that took into account both gender and race was created, one which privileged European men for both their gender and race, European women for their race, colonised men for their gender and colonised women for neither. Put simply, Lugones tells us that as a direct consequence of colonisation, new gender hierarchies, differentials and relations were forced on colonised societies, where they then intersected with constructions of race to produce power dynamics and inequities that remain alive and well today.[1]

Lugones' work expands on Quijano and Ennis'[7] coloniality framework and the larger body of literature on decoloniality, which states 'that even with un-colonialism, coloniality remains'[8] and operates through three intersecting sites: power, being and knowledge. Quijano further conceptualised four processes through which coloniality exerts its power: 'control of the economy, control of authority, control of gender and sexuality, and control of knowledge and subjectivity'.[9] However, the control of gender and sexuality is frequently overlooked in analyses grounded in the three sites of coloniality, including those by Quijano.

If coloniality is understood as an invisible power structure that sustains colonial relations of exploitation and domination long after the end of physical colonisation, decolonial analysis and action must include and confront the gendered dimension of coloniality and its ongoing impacts on health. Not doing so risks failing to address the root causes of gender-based inequalities across the global health ecosystem and facilitating the perpetuation and manifestation of racialised notions of gender, from the domination of global health leadership by white men from high-income countries[10 11] to disparities in healthcare provision between Aboriginal women and their non-Aboriginal or male counterparts.[12] Whether one chooses decoloniality, feminism or a broader lens of equity as their entry point to assessments of power inequities in global health, it is crucial to develop an understanding of how local notions of gender and the resultant power dynamics and differentials, whether inherited from or shaped by colonialism, interact with other factors such as race, class and ability to affect implementation, access and uptake.

Previous works in the space of gender and health have identified coloniality in conjunction with racism and sexism as 'interconnected structures of power'.[13] Building on the work of Lugones and other decolonial feminist scholars,[14 15] we argue that racism and sexism are not only interconnected with coloniality and each other but are, in fact, different manifestations of the same root problem: a fundamental imbalance of power achieved by and perpetuated through the creation of hierarchies. We call not for gender to be 'added' to decolonial analysis and action but for it to be recognised as a core component of the colonial project which must be addressed in all decolonial attempts and initiatives which seek to challenge power inequities in all their manifestations. As a starting point, we offer this scoping review locating where and how interrogations of gendered power inequities are taking place in the decolonising global health literature.

METHODS: A SCOPING REVIEW IN SEARCH OF GENDER WITHIN THE DECOLONISING LITERATURE

To better understand where, why and how (in/frequently) gender appears in decolonising discourses, we undertook a scoping review of the decolonising global health literature. A literature search of the Scopus and PubMed online databases was conducted to identify peer-reviewed papers with the search terms "(decoloni* or de-coloni*) OR (neocolonial or neo-colonial) AND 'global health'" in their title, abstract or keywords published by December 2022. The search was restricted to papers in English as this is the working language of both reviewers. Unfortunately, the restriction of the search to English excluded discussions that are known to be occurring in French, Spanish, Portuguese, German, Chinese and others.[16] Other exclusion criteria included the following: not focused on global health, not focused on colonialism, no full text available and not a peer-reviewed article. To ensure a thorough review of the relevant literature, no start date exclusion criterion was applied; however, the cut-off date for new papers was the end of December 2022 to facilitate analysis. No registered review protocol is available.

Search results were uploaded into the Covidence review platform and deduplicated; at this stage, papers were not yet excluded based on interaction with gender. The initial filtration based on the review of the title and abstract was conducted by a single reviewer (ELMR). We defined global health as 'an area of study, research and

practice that places a priority on improving health and achieving equity in health for all people worldwide'.[17 18] Papers that met the inclusion criteria explicitly discussed colonialism, the need for decolonisation or decoloniality and/or neocoloniality with respect to global health. In total, 167 papers progressed to the data charting stage, with the following information extracted:

- **Bibliographic**: Title, journal, publication year, article type, authorship (first, last and middle) and authorship affiliation with low-income and middle-income countries or former colonies.
- **Content**: Main theme(s), definition of (de)colonisation/coloniality, articulation of problem, articulation of solution, mention of specific colonised populations, intersection with gender and details of gender discussion (if applicable).

Full-text review and extraction were completed by ELMR and TN-A, with each paper in the database independently reviewed by both, followed by inductive thematic coding of the subset of papers that had any mention of gender, gendered population groups, gendered participation or gender of researcher(s). The initial coding round was conducted separately, with the coding frame further refined following discussions between ELMR and TN-A. The coding process allowed for a single paper to contain multiple themes. A second round of coding using the refined frame was undertaken by ELMR and TN-A to further categorise papers into two sub-subsets: those that included gender but did not interrogate its intersection with coloniality and those that did.

RESULTS: WHERE AND HOW DOES GENDER APPEAR IN THE DECOLONISING GLOBAL HEALTH LITERATURE?

Of the total 167 papers in our review (see figure 1), 53 (32%) engaged with gender; engagement with gender includes the use of the word 'gender' and its derivatives, mention of any gender identities or discussion of themes and topics related to gender, gender dynamics, gender norms and gender inequalities. A summary of the topics discussed by these 53 papers follows (see online supplemental file 1 for the complete dataset).

Papers that discussed (de)coloniality and engaged with gender covered a range of global health issues, from specific topic areas to broader concerns about governance and knowledge. Six papers focused on sexual and reproductive health and rights[19–24] with a further two papers specifically on maternal health,[25 26] while five papers focused on mental health,[27–31] three papers discussed health in humanitarian settings,[30 32 33] two papers focused on planetary health[34 35] and one paper focused on non-communicable diseases.[36] Five papers had a focus on pandemics, ranging from prevention[37] to transmission[38] to response,[39–41] and one highlighted the challenges surrounding the production and distribution of vaccines.[42] Nine papers had a service delivery focus which analysed the impact of (de)coloniality on service provision[21 25 39 43 44] and service providers,[23 36 45 46] while seven analysed community engagement in research methods[40 44 47–50] and programme design.[38] Seven papers concentrated on Indigenous health, of which four studied the health of Indigenous peoples[39 40 43 46] and three discussed Indigenous conceptions of health.[34 37 49]

The impact of persistent coloniality in global health research has been a notable feature of the broader decolonising global health discourse. Of the 53 papers that discussed (de)coloniality and gender, 18 articles focused on global health research encompassing research partnerships,[51–54] underlying epistemologies[45 55 56] and methodological approaches,[32 33 40 47 50] through to publication.[57] Some of these papers were focused at the level of the individual,[58] while others addressed structural and systemic factors driving inequity.[59–62] Nine papers reviewed and/or called for changes to global health[63] and medical education[27 28 61 64] and curricula[65–67] and reflected how current educational approaches 'hold back health equity'.[68]

Finally, six papers discussed changes to the broader global health architecture, exploring who holds power[60 69 70] and who can dictate agendas,[20 39 51] while two focused specifically on changing the approach to global health policy.[59 71]

For the purposes of this review, we were interested in papers that explicitly engaged with the intersection of gender and coloniality. Of the 53 papers that engaged with gender, just under half (49%, n=26) met this criterion, in contrast to 27 (51%) papers that simply mentioned gender, either referring to gender inequalities or discussing gender in the study design (see table 1).

Below, we present an analysis of the 26 papers that examined the intersection of gender and coloniality.

DISCUSSION: WHAT DOES THE LITERATURE TELL US ABOUT THE GENDERED DIMENSIONS OF DECOLONISING GLOBAL HEALTH?

Through our analysis of the 26 papers that presented a clear link between gender and coloniality, four key themes were identified. The first two themes address the coloniality of being and knowledge; in other words, how colonial constructs continue to shape the ways in which we assign value to ourselves and each other as human beings, as well as the hierarchy by which we evaluate and assign legitimacy to different epistemologies and ways of knowing. The latter two themes discuss the implementation impacts of coloniality on health policies and programmes and explore the value of applying a decolonial gender lens in such analyses to inform action for change.

Intersecting colonial constructs of race and gender continue to drive contemporary inequities

Colonialism oversaw the institution of a racialised and gendered colonial hierarchy which "supposed the innate superiority of Christian European white males over every 'other' group";[20 37 56 60 68] eleven papers[19 20 26 29 34 35 37 39 56 60 68]

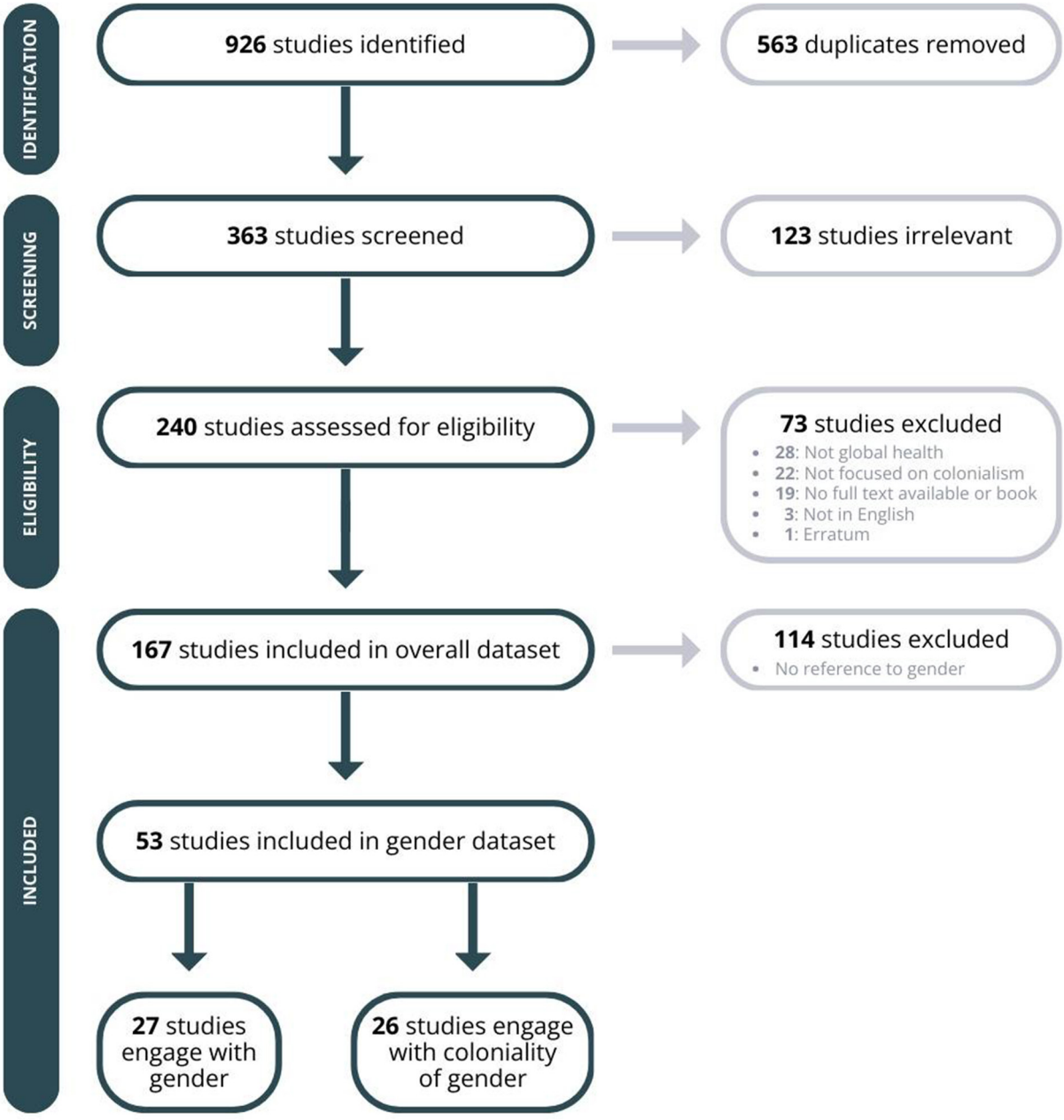

Figure 1 Preferred Reporting Items for Systematic Reviews and Meta-Analyses flowchart of the literature search.

in our analysis discussed the ramifications of this hierarchisation of society based on the assumed value of individuals. Within this hierarchy, colonised subjects were framed as 'less than fully rational, closer to nature and thus less than fully human'[56] with gender overlayed. The native male body was viewed as an uncontrollable vessel of sexual urges in need of subjugation and control,[19] while the native female body was a casualty of the 'redemptive sacrifice' required to bring about civilisation and thus reduced to a site of (re)productive labour.[34]

Through and due to this enactment of a racialised and gendered hierarchy, 'a series of codes, norms, typographies and ideas concerning sexuality'[20] rooted in Eurocentric ideals were introduced and continue to drive gender inequities in health even today. Some papers explored the pathologisation of gender identities and sexual orientations that sit outside of what Lugones describes as the 'modern/colonial gender system', driven by a 'colonial, Eurocentered capitalist construction' of gender and characterised by 'biological dimorphism (and) the patriarchal and heterosexual organisation of relations'.[1] Others examined the ways in which academia and medical science have replaced European religion as the primary arbiters of these 'norms' which designate colonised subjects and their descendants as 'lesser' gendered beings of colour. For example, Sastry and Dutta share how in Bangladesh, the dehumanising trope of 'the uncontrollable sexual urges of the native male body' was perpetuated by (and to some extent, informed and drove) programmes advocating for male sterilisation funded by the U.S. President's Emergency Plan for AIDS Relief.[19] This coloniality of (gendered) being alienates

Table 1 The final set of 53 papers reviewed, categorised by nature of engagement with gender

Papers that discussed (de)coloniality and gender (n=27)	Papers that discussed the intersection of (de)coloniality and gender (n=26)
Abouzeid et al[53]	Abimbola et al[69]
Bourbonnais[24]	Báez and Soto-Lafontaine[20]
Capella and Jadhav[27]	Baquero, Benavidez Fernández and Acero Aguilar[34]
Chapman et al[25]	Besson[60]
Cullen et al[43]	Bhandal[64]
Demir[61]	Brisbois, Spiegel and Harris[55]
Dhar[28]	Büyüm et al[59]
Douedari et al[32]	Gumbonzvanda, Gumbonzvanda and Burgess[48]
Egid et al[47]	Hankivsky[71]
Eni et al[46]	Hindmarch and Hillier[56]
Finkel et al[58]	Jolly[37]
Giuliani et al[65]	Jones, Reid and Macmillan[35]
Irfan and St Jean[38]	Lane, Ayeb-Karlsson and Shahvisi[22]
Khan et al[70]	Mulumba et al[44]
Kronick, Jarvis and Kirmayer[30]	Munro[23]
Lazaridou and Fernando[31]	Naidu[68]
Mbali and Rucell[62]	Olivar et al[39]
Montgomery[51]	Racine[45]
Olivar et al[40]	Sastry and Dutta[19]
Olusanya, Mallewa and Ogbo[57]	Singh et al[33]
Price et al[67]	Somerville and Munguambe[36]
Rambukwella[41]	Tomori[26]
Sekalala et al[42]	Wallace et al[21]
Skopec et al[63]	Warner, Kurtiș and Adya[29]
Smith, Penados and Gahman[49]	Wong, Gishen and Lokugamage[66]
Voller et al[54]	Yoeli et al[50]
Walsh, Brugha and Byrne[52]	

individuals, silences identities and replaces worldviews in a destructive and harmful process that continues today.[68]

Gendered notions of expertise and evidence perpetuate colonial conceptions of knowledge

Coloniality is an inherently destructive endeavour, predicated on the eradication and replacement of one or many things with a hegemonic 'default'. Eight papers[21 35 36 45 48 55 60 69] discussed how coloniality put into place a hierarchy of knowledge and its gendered dimensions and impacts. This hierarchy of knowledge is a clear extension of the racialised and gendered hierarchy which governed colonial and colonised societies, with white men identified as 'the only legitimate purveyors'[60] of knowledge, a knowledge that is derived from Eurocentric epistemology. This imposition of 'the coloniser's model of the world'[69] as the default has left in its wake a trail of 'silenced subaltern voices',[45] including colonised women and LGBTQIA communities who are often relegated to being 'objects' of science rather than experts and practitioners[55] and 'systematically denied platforms'[6] for 'knowledge production and idea generation'.[48]

While the arbiters of knowledge remain largely unchanged from colonial times, with a majority of global health journals not only headquartered in the North but also managed by editors based in the North,[72] they continue to wield this power not only through the violent and visible destruction of epistemologies but through domination over knowledge production, dissemination and validation. Within global health, the continued existence of this hierarchy has significant consequences in research, policy and practice as it reinforces the hegemony of Eurocentric ways of knowing, gatekeeps priority-setting power and silences voices deemed to be inferior in decision-making fora.[21 45 55] Even for those seeking to interrogate and challenge gendered inequalities in health, Somerville and Munguambe caution that there is an ever-present risk of falling 'into the same problematic space of taking as starting point conceptualisations of gender that are born of a theoretical tradition that is firmly Western', which runs counter to contemporary understandings of gender as a colonial construct and risks creating perceptions of gender equality as a 'neocolonial imposition'.[36]

Coloniality drives gendered impacts of health programmes and policies

The Eurocentric worldview which determines, among other things, prevailing paradigms in how the bodies of 'others' are viewed, has impacted the way that global health has been, is and might be implemented. 10 papers[19 21–23 26 36 44 59 64 71] in our study explored these facets in more detail, illustrating how 'ethnic stereotypes and gendered racial ideas' affect programme design, targeted populations and service delivery.[19 22 23 59 64] Coloniality, through the legacies imprinted in both postcolonial governance and health systems, continues to produce ripple effects in local implementation efforts. For instance, Wallace *et al* note that efforts to deliver reproductive healthcare in Timor-Leste are complicated by remnants of Portuguese colonisation in the form of Catholic values and haunting memories of Indonesia's coercive and restrictive population control policies, both of which 'shape availability and access to reproductive health services' as well as the acceptability of those services to communities.[21]

Global health is undeniably shaped by the broader sociopolitical environment within which it operates, including the impacts of colonial values on legal and health systems that postcolonial countries continue to grapple with.[44] Furthermore, the international nature of global health means that considerations of the contemporary political economy must extend beyond national borders, practically demonstrated by the way in which the Global Gag Rule (GGR) impacts the funding, service implementation and agency of organisations in receipt of US global health assistance during Republican administrations. As observed by Lane, Ayeb-Karlsson and Shahvisi, the GGR not only imposes restrictions on grant recipients

and beneficiaries in the USA but also 'on women living in global South countries, who have no input or involvement in the elections or policies of the U.S.',[22] and often with disproportionate effects on the most vulnerable and marginalised communities such as sex workers, men who have sex with men and transgender people.

A decolonial gender analysis can inform action for change

While the impacts of colonialism and coloniality on global health are well documented, seven papers[20 33 35 48 50 66 69] in our study explored how a decolonial gender analysis could improve health outcomes and increase health equity. As Singh *et al* eloquently implore, we must move 'beyond the performative dimensions of being gender-sensitive and decolonial, towards understanding what it means to equitably share power… in a meaningful way that challenges traditional methods' and be explicit in considering how 'gender intersects with other axes of power'.[33]

In this vein, this subset of seven papers called for changes in where we look for expertise and leadership, with an emphasis on 'intersectional black, woman and feminist movements'[20 69] and approaches developed across the global South,[50] changes in the knowledge that we refer to with respect to underlying epistemological stance[20 35] and the generation of 'new' knowledge,[33 50] and a reconfiguration of how individuals and organisations work together.[33 48 50 69]

While significant changes are required at both the individual and structural levels, these papers highlight that there is no need to reinvent the wheel; there are strong traditions of praxis available to draw on, from both within and beyond global health[35 48] (see also the work of Tuhiwai Smith[73]). However, we must acknowledge that any attempt to shift power will be perceived as a challenge to conventional bodies of authority[20] and that there will be a need to provide, and perhaps reimagine, 'safe spaces' as is being advocated for within a range of activist spheres.[48]

Only when we have 'safe spaces' in which a cross-section of stakeholders and actors can come together through collective action will we be able to work on much-needed structural reforms, including: challenging the dominance of a narrative that 'others' and disempowers those that are 'consistently categorised as vulnerable and needing protection or rescuing, which takes away their agency and power of action';[33] 'dismantling barriers to healthcare by groups oppressed under colonial regimes'[66] encompassing political, legal, ethical and cultural norms; and addressing how the next generation of (global) health professionals are educated.[20 66]

Taken as a set, these four themes tell a story about the ways in which intersecting colonial constructs of race and gender continue to drive contemporary inequities, how these constructs about individual and collective value and legitimacy bleed into modern notions of knowledge, how these forces continue to affect the implementation of health programmes and policies and, finally, how a decolonial gender analysis can inform action for change.

CONCLUSION: A CALL TO INTEGRATE A DECOLONIAL GENDER ANALYSIS IN GLOBAL HEALTH AND ALLIED MOVEMENTS

This review identifies gender as a frequently overlooked dimension of decolonial discourses in global health, which is incommensurate with the role gender played in the colonial project and the influence that the coloniality of gender continues to have. While there has been a noticeable increase in discourse, with 93% (n=156/167) of the papers in our decolonising global health dataset published in the last 6 years, less than a third (n=53) had any reference to gender and only 16% (n=26) explicitly engaged with the intersection of gender and coloniality. As these 26 papers demonstrate, historical legacies of colonisation continue to shape racialised and gendered ideas about who is worthy (or not), limit the imagination of what programmes or interventions may be needed and affect what is possible to implement today.

We call for the integration of a decolonial gender analysis in approaches to decolonise global health research and programmes, acknowledging and confronting the multiheaded beast that is coloniality in its totality so that we do not risk allowing some forms of inequity to flourish unchecked while we confront others. This requires the recognition of the inextricable linkages between historical colonial constructs and contemporary gender inequalities and the use of intersectional feminist principles to interrogate and challenge power imbalances rooted in the coloniality of gender. Accompanying this call, however, are also words of caution. First, we reiterate Somerville and Munguambe's warning to avoid using constructs of gender that are colonial in origin as our analytical starting point. Failure to do so would not only risk perpetuating a limited and limiting understanding of gender but also serve as ammunition for those who seek to deride and dismiss all efforts towards gender equality as a vehicle to impose 'Western ideals' on the rest of the world.[36] At the same time, those working within global health must resist the urge to present a simplistic view which demonises all Western methodologies while reifying non-Western ways of knowing unquestioningly. Finally, it is crucial to remember that gender and decoloniality are just two of the many lenses that individuals and institutions are attempting to integrate,[69] and this process must be carefully navigated to avoid 'lens fatigue'.[71]

Drawing on the findings of this analysis, we also call for broader social justice movements to more explicitly integrate a decolonial gender analysis in applications of intersectional feminist approaches which identify, examine and challenge the roots of power asymmetries. Decolonial thinking draws clear lines between the past and the present, allowing those who incorporate it to treat

not only the symptoms of contemporary power asymmetries but to confront the historical causes which remain embedded in systems and structures. These systems and structures work in tandem to ensure the continued exploitation and oppression of various communities and populations, necessitating initiatives and movements for justice and equality to also work together in confronting the many faces and forms of power. We call for an alliance of movements to address the shared colonial roots of racism, sexism, classism, ableism and other markers of marginalisation, breaking free from the yoke of shared oppression to find shared strength instead.

To that end, we offer three recommendations:

1. Movements advocating for the decolonisation of global health must integrate a gender lens and feminist perspectives into their analyses and actions if their aim is to uncover and dislodge the myriad manifestations of colonial influences on global health. Failing to do so will limit movements to partial and temporary success.
2. Opportunities for alliances must be identified and acted on. Power imbalances lie at the heart of all inequities; we must work with and not against each other to confront the primary cause of our shared struggles. In the absence of allyship, we leave space for mistrust and rivalry to fester in this time of increasingly limited resources for justice-centred movements.
3. Our answers to coloniality must not be neocolonial in design and implementation. Both within global health and among allied movements, we must ensure that the voices of the oppressed shape our agendas, approaches and actions. In short, we must ensure that decolonising movements are not themselves colonised[74] or sanitised.

The manifestations of power asymmetries and other ongoing impacts of coloniality presented in this analysis are not exclusive to global health, providing an opportunity for global health actors intent on effecting change to learn from and share with other sectors. Thus, in closing, we stress once more the need for the integration of a gender analysis and feminist perspective into decolonial discourses, the prioritisation of collective action and alliances both within and beyond global health, and a constant process of reflexivity[75] to ensure that we do not perpetuate that which we seek to dismantle. Ultimately, we argue that coloniality remains one of the root causes[69] of many of the symptoms of our ailing world—confronting it requires a shift from focusing on competing goals to advancing shared visions for change.

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Acknowledgements We'd like to thank Dr Pascale Allotey, former Director of UNU-IIGH, for her critical input during the initiation of the decolonising global health work at the institute and for continually pushing us to consider the gender aspects. We'd also like to thank the many UNU-IIGH colleagues both past and present, with whom we've explored and discussed these ideas. In particular, we would like to thank Dr Johanna Riha for her extensive feedback on earlier versions of this manuscript, Dr Rifqah Roomaney who contributed to the larger dataset of which this analysis forms a part and Mr Rajat Khosla, Director of UNU-IIGH, and Dr Sagri Singh, Chief of Gender and Health, for their feedback and guidance. Finally, we extend our thanks to an anonymous reviewer for feedback on an earlier version of this manuscript.

Contributors TN-A and ELMR contributed equally to the conceptualisation and design of this work, data collection and analysis, and preparation of the initial manuscript as well as subsequent revisions. Both authors approved the final version of this manuscript for publication and agree to be held accountable for the accuracy and integrity of this work. ELMR is the guarantor responsible for the overall content of this review.

Funding This work was partially supported by the Ford Foundation (grant number: 137700).

Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement All data relevant to the study are included in the article or uploaded as supplementary information. Not applicable.

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