Holst J. Broadening the decolonisation of global health beyond identity-based approaches toward structural transformation.JGPOH 2026, posted: 22.07.2026. DOI: 10.61034/JGPOH-2026-06. www.jgpoh.com

Review

Broadening the decolonisation of global health beyond identity-based approaches toward structural transformation

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Recommended citation:
Holst J. Broadening the decolonisation of global health beyond identity-based approaches toward structural transformation. JGPOH 2026. DOI: 10.61034/JGPOH-2026-06

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Abstract

Background: In recent years, the discourse surrounding the decolonisation of global health has gained significant traction, fuelled by a renewed interest in addressing historical inequities rooted in colonial legacies. Nevertheless, the present discourse on decolonisation evinces a certain degree of selectivity and conceptual reductionism, overlooking important structural and geopolitical dimensions.

Methods: An explorative narrative literature review was performed between January 2025, and April 2026, encompassing a comprehensive search strategy across relevant health sciences databases, including PubMed, Scopus and Web of Science. In addition, the review expanded beyond conventional health-related literature to include social science, history and other databases, along with grey literature sources, thereby ensuring a multifaceted exploration of the subject matter. The initial findings were supplemented using citation tracking and snowball searching, including publications in languages other than English, namely Spanish, Portuguese, German and French.

Results: The examination of the socio-political and economic dimensions of the colonial legacy points to several critical gaps in the current decolonisation discourse, particularly with regard to the relative marginalisation of perspectives from Latin America. Beyond rather technical challenges, three gaps emerge as essential for decolonising global health. Firstly, contemporary decolonisation efforts frequently reflect a Eurocentric perspective predominantly shaped by scholars from the Anglophone Global North, often neglecting the dynamics and implications of internal colonialism. While aiming to dismantle historical injustices and power imbalances, these approaches insufficiently address the role of domestic elites in sustaining neocolonial dependencies. Secondly, the decolonisation discourse in global health remains heavily Anglo-Saxon in orientation, marginalising diverse geographic regions, epistemologies, and ethnic perspectives. Thirdly, an examination of the intersection of race, capitalism and colonialism reveals insufficient attention being paid in the decolonisation debate and practice to the framework conditions. These are increasingly set by the neoliberal, increasingly feudalist global economic order and its role in reproducing and perpetuating health inequalities.

Conclusion: This review calls for a critical reassessment of dominant paradigms in global health decolonisation, emphasising the need for systemic transformation that takes account of the historical, geographic, ethnic and socio-political complexities. Greater attention to internal colonialism is imperative for decolonising global health, alongside the inclusion of marginalised voices and perspectives. Promoting a more equitable and comprehensive landscape requires a transformative approach that addresses the structural drivers of global health, including the economic and commercial determination of health, and challenges the broader conditions that sustain inherited inequality.

***Keywords**: Decolonisation, global health, coloniality, decolonising, internal colonialism, racism, capitalism, neoliberalism, refeudalisation*

Background

The international global-health discourse has undergone a notable shift in focus during the last few decades, with greater emphasis placed on the colonial legacy and patterns of health in low- and middle-income countries. A critical examination of the historical evolution of global health reveals the persistent presence of hierarchical structures, which have contributed to the perpetuation of Eurocentric conceptualisations. Addressing these issues is imperative to achieve equitable global health outcomes. There has been an evident surge of interest in the 'decolonisation' of global health, which has unquestionably become one of the most prominent phrases in global health (1-5) and beyond (6), particularly since 2020, as well as in humanitarian health (7).

The decolonisation process entails the dissolution of the political, economic, and cultural subjugation engendered by colonialism. The term is employed to denote both to the withdrawal of colonial powers from their colonies, thereby leaving them in a state of political or economic independence, and the process of liberating an institution, a sphere of activity, the mind, etc., from the various effects of colonisation (8). The call for decolonising global health is predicated on the objective of challenging and dismantling historical and ongoing power imbalances, injustices and colonial legacies in the field of global health. The focus is on redressing power imbalances between high-income and low-income societies and, concomitantly, challenging the ideas and values of some wealthy countries that shape the practice of global health (3,9,10).

Agenda-setting in global health research is predominantly initiated and controlled by universities and academic institutions in countries of the Global North (11,12). This accurately reflects the current balance of power and influence in the broader global health policy and actor landscape (13). Consequently, a growing number of scholars in the field are challenging the Global North's legacy of dominance in global health (14-20) and, to a lesser extent, the Anglophone prevalence in global health agenda-setting and publications (21-24). Concurrently, an emerging imperative to transcend the conventional dominance in global health research and associated scientific publications has been identified (11,25-30). These demands have been made in the context of a growing call for more contextual approaches that take into account diverse local realities and a critical analysis of power relations (29,31).

Colonialism can be defined as the systematic domination of peoples, assets, markets, countries, cultures and political institutions (32), involving the dispossession, exploitation and extraction of wealth and resources. The term refers to the subjugation of one ethnic or cultural group by another group and is typically, although not exclusively, associated with the historical exploitation of non-Europeans by Europeans. In recent decades, the term has also been employed to describe the domination of populations in low-income countries by Westerners. The concept of colonialism, defined as the domination of one group over another, can manifest itself in two different forms. Firstly, settler colonisation occurs through substantial individual migration, as evidenced in North America and Australia. Secondly, the displacement and

simultaneous exploitation of indigenous populations is a pertinent issue, as evidenced by occurrences primarily in Latin America, Africa and certain regions of Asia.

The term 'colonialism' is defined as the establishment of settlements of populations in distant and foreign lands and has been expanded to denote the economic domination by metropolitan states over other peoples (33). This phenomenon can be manifested in two distinct ways: firstly, as external colonisation, defined as the subjugation of a foreign territory and its population through the establishment of a colony in that territory, and secondly as internal colonisation through territorial expansion, settlement, and development within a foreign territory. In their traditional sense, the terms ‘decolonisation’ and ‘decoloniality’ primarily refer to external colonisation and the subsequent establishment of colonies outside an existing state. In contrast, the term 'colonialism' is rarely used to describe the rule over national minorities, as evidenced by the numerous ethno-political conflicts that have emerged in recent decades, including those involving the Kurds in Iran, Iraq, Syria and Turkey (34). Catalans and Basques in Spain, the Bretons in France, the Eritreans or Tigrayans in Ethiopia, and the Uighurs in China. Furthermore, citizens of Africa, Asia and Latin America would not choose to describe a government by fellow Africans, Asians or Latinos as 'colonialism', even in the context of despotic governance (35). However, it is crucial to acknowledge the role of indigenous elites in the establishment and perpetuation of actual neocolonial dependencies, which continue to exert a profound impact on people's health, social circumstances, and living conditions.

Objectives and Methodology

Against this backdrop, this article first analyses some key historical aspects of colonialism before examining the extent to which current decolonisation efforts in global health adequately address existing challenges and take their complexity sufficiently into account. The subsequent examination seeks to ascertain whether the present discourse on decolonisation in global health is adequately addressing geopolitically significant phenomena such as internal colonialism, the neoliberal global order and the current refeudalisation of capitalism and society. The hypothesis proposed is that the present decolonisation debate risks being one-sided in nature, with much of the influential literature produced within the Anglophone academic world focusing on Black identity. This phenomenon is exemplified by the decolonisation process in Latin America, which offers significant insights into the dynamics of internal colonialism and the oversight of this issue within the broader decolonisation discourse.

This paper is a critical review of other areas where the current discourse on decolonisation is subject to limitations. The analysis is grounded in a comprehensive examination of the regional and ethnological underpinnings of decolonisation in global health. The present study focuses on the experiences of Latin American countries, which have, at best, played a minor role in the existing international discourse on decolonisation. The potential reasons for this marginalisation are also considered. Finally, the close connection between race, racism and capitalism is analysed to provide the backdrop for a discussion of the current challenges to

achieving a sufficiently complex and realistic decolonisation debate in global health. As posited by Hindmarch and Hillier, the notion of 'indigenisation' may, at first glance, appear to be a compelling proposition (36). However, it is debatable whether it can offer any significant resistance to the prevailing capitalist world order and its associated stakeholders. It is imperative to concur with the assertion of Chaudhuri et al. that "decolonisation must address the pillars of colonialism, including White supremacy, racism, sexism and capitalism" (18). However, the hierarchical organisation of these fundamental aspects of decolonisation merits closer scrutiny. This paper puts forward the argument that greater attention should be paid to the role and impact of the capitalist system of production and exploitation, and in particular to re-feudalisation, within the process of decolonisation in global health.

In order to examine these questions and test the aforementioned hypothesis, this narrative study employs an exploratory approach. A literature review was initiated in January 2025, encompassing a comprehensive search strategy across relevant health science databases, including PubMed, Scopus and Web of Science. Moreover, the review expanded beyond health databases to encompass social science, history and other databases, as well as grey literature sources, thereby ensuring a multifaceted exploration of the subject matter. The initial findings were supplemented using the snowball sampling method, including publications in languages other than English, namely French, German, Portuguese and Spanish. The study adopts a transdisciplinary, systems-analytical approach to examine the interactions between political, social, and economic systems. In doing so, it establishes a connection between past and present with the aim of exploring the potential influence of historical developments on the current decolonisation debate.

Significance of transatlantic slave trade for decolonising global health

Colonialism was a significant catalyst for the slave trade, and its repercussions continue to resonate, manifesting in the enduring consequences of the mass enslavement of millions of individuals, predominantly of African descent (37). The transatlantic slave trade, widely seen as the most devastating and abhorrent expression of colonialism, can in turn be considered a crucial starting point for large-scale global trade, ultimately giving rise to the present-day global capitalist economy. Since the fifteenth century, the growth of transatlantic slavery linked different regions of the world, and has been particularly lucrative for European merchants who controlled trade. The transatlantic slave trade, predicated on the forced mass exodus of millions of people of African descent as an export commodity, stands as a seminal instance of capitalist profit maximisation irrespective of its profound human cost. A pernicious nexus of ruthless oppression, overexploitation and the negation of humanity, citizenship and sovereignty precipitated a surge and sustained growth in global trade (38).

The transatlantic slave trade, the emergence of the European capitalist system, and the rise of nation-state powers have been intricately intertwined (39). The global connections implemented and exploited by European colonial powers have had immense consequences for

the geographies of power, environmental history, wealth, and political subjectivities in the past and continue to do so today (38). The historical nexus between colonialism and the forces of emerging capitalism has been well documented, particularly with respect to the exploitation of people and natural resources, and the destruction of the environment. The repercussions of these practices have been found to be disastrous for local and indigenous communities (40), and they are of great pertinence to contemporary global health challenges.

Driven by nationalist agendas, European colonial powers perpetrated incessant population transfers across various regions of the globe. Driven by strong nationalistic sentiment, this phenomenon has been observed to encompass both the forced displacement of individuals of African descent through the historical slave trade, particularly during the 19th century, and the emigration of a significant number of Europeans from their home countries to the colonies. The colonial powers and their business enterprises have been instrumental in providing millions of contract labourers to both the colonial centres and peripheries, according to fluctuating workforce demands. It is important to note that the process of settling territorial gains in the context of colonialist expansion contributed to the destabilisation of native ethnic identities and the enforcement of adaptation to the conditions imposed by colonial rule (41).

A significant consequence of racialised slavery was the establishment of African diasporas in various locations across the Atlantic, particularly in the Americas, which were divided along racial lines (42,43). Moreover, the repercussions of the transatlantic slave trade persist in manifesting contemporaneously through racial, social and economic inequalities and marginalisation. This ultimately gives rise to the resurgence of Black political activism and the subsequent emergence of White supremacist movements, as well as phenomena such as human trafficking and illegalised migration (44,45). The ongoing quest of these diasporas for cultural and social recognition in their settlement states remains unfinished and is not automatically resolved by formal or political decolonisation (38).

The neglect of internal colonialism in the decolonisation discourse

The contemporary decolonisation discourse in the field of global health has frequently concentrated on the Anglophone countries of the United States of America (USA), Canada and Australia. These countries have experienced ongoing processes of colonisation of the indigenous population and the enslavement of millions of people of African descent persisted unabated following the attainment of independence from the British Empire. However, the process of decolonisation in Latin America commenced much earlier, following the attainment of formal independence from Spain and Portugal by the respective countries of the subcontinent, at the beginning of the 19th century. The relatively small minority of European settlers continued the alliances with indigenous groups that had developed during colonial rule. These alliances, in part, reflected the rivalries and conflicts between different ethnic groups and were fuelled during colonial rule by inter-ethnic agreements between ruling and ruled indigenous groups and elites (46). This enabled European settlers to maintain power in South

and Central America (47,48). Consequently, colonial domination and exploitation persisted within the borders of the newly created nation-states.

The transition from external to internal colonialism was marked by the seizure of power by local elites in former colonies. This transition occurred subsequent to a significant number of these elites having participated actively in colonial and imperial rule (49). This phenomenon first emerged in Latin America, where a new elite of American-born Spaniards (creoles) and subsequently mestizos, people of mixed ethnic or cultural heritage, assumed governmental power (50). This transition was a contributing factor to the perpetuation of colonial rule in Latin America following the formal conclusion of the colonial era (48). The endurance of local elites in formerly colonised regions, despite political upheavals instigated by renegading elements within these elites, has resulted in the ongoing subjection of indigenous or aboriginal peoples and other minority communities to unjust political and economic systems and oppressive and exploitative arrangements, thereby continuing until today colonialist extractivism (40).

A comparison of the transition from the colonial era to decolonisation in Africa and Asia with that experienced by Latin America reveals significant differences in terms of timing, pace, and character. While the former Spanish and Portuguese colonies in the Americas witnessed elite-led revolutions in the early 19th Century, decolonisation in Africa and Asia commenced after World War I and was accomplished after World War II due to the weakening of the former European colonial powers, who were confronted with mounting challenges in maintaining their vast empires. The transition in Africa and Asia was not uniform but rather involved diplomatic negotiations between colonial and anticolonial actors as well as a calculated process of military engagement between the two contending parties (49). A number of newly independent countries were able to establish stable governments almost immediately; however, others were subjected to dictatorship or military rule for extended periods, or experienced protracted civil wars.

The geographical boundaries of African nations were often delineated by the colonial powers through artificial often arbitrary lines, disregarding pre-existing ethnic and tribal divisions and, in some cases, antagonisms. In an effort to overcome the fragmentation caused by colonial borders and ethnic/religious divisions, governments have placed a significant focus on forging national unity, a practice that is especially evident on the African continent. Furthermore, the numerous African territories were regarded by European powers as mere "resource pits", a situation that was compounded by the absence of institutional frameworks capable of facilitating sustainable development. In contrast, many Asian nations had older, more cohesive political institutions in place, and the colonial powers often used bureaucratic management rather than direct, intense exploitation (50). The decolonisation processes in Africa and Asia were shaped by a number of factors, including twentieth-century global politics, nationalist movements that were frequently fuelled by mass mobilisation, and the rise of local elites. In the postcolonial contexts of Africa and Asia, emerging elites - often Western-educated and

nationalist in orientation - frequently utilised the administrative mechanisms established by the former colonial powers, to the greatest extent possible. In numerous instances, these emergent elites encountered difficulties in the management of heterogeneous populations, resulting in political instability, encompassing military coups and social inequities, as evidenced in various regions of the African continent (51).

In the context of formerly colonised regions that have achieved independence, the local elites have often been effectively co-opted by the colonisers, resulting in the conferral of property rights over land, resources, and populations (52). This process has also entailed the implicit right to engage in mining and exploitation activities (2). In other cases, new elites emerged from the independence wars and uprisings, or from protracted armed conflicts. Irrespective of the nature of elite formation, the misidentification of elites in low-income countries with those in affluent nations rather than with their respective domestic populations can be observed. This perpetuates the historical process of linking imperial power with local or regional elites (53). Postcolonial domestic elites utilised their international contacts to pursue their own personal agendas, facilitated by essential links to the globalised world of culture, diplomacy, banking and finance. The historical tendency of colonial elites to establish strong connections with metropolitan centres and to engage in or benefit from the process of colonisation is being continued (54). It is therefore essential to acknowledge the significance and repercussions of internal colonialism in the discourse on decolonising global health. A fundamental principle that must be upheld is the rigorous examination of the manner in which colonial powers engage with domestic elites and the subsequent consequences of these interactions, particularly with respect to the public's health and well-being (55).

It is important not to disregard the fact that, despite the pervasive call for decolonisation to be considered in any discourse on global health, the prevailing theory and praxis of decolonising global health is predominantly an Anglo-American phenomenon. This phenomenon is mainly driven by scholars working in and from institutions of the Global North who may or may not have roots in countries of the Global South, mostly in Africa (9,56,31). Evidence suggests that both global health and decolonialism in this field are spearheaded by elite Global North organisations and institutions, including the Johns Hopkins School of Public Health and the Bill and Melinda Gates Foundation (BMGF) (29). In a similar vein, the boards of global health institutions and organisations remain predominantly male and from high-income countries (57). As is evident in the discourse surrounding decolonisation, there appears to be a phenomenon of elite capture of this process, whereby a cadre of professionals from countries of the Global South has been empowered by the Global North and its institutions with a view to decolonising global health (58).

When considering this issue, it is imperative to give due consideration to postcolonial power dynamics and particularly to the phenomenon of internal colonialism in former colonies. Some scholars hypothesise that 'double agent' academics from the Global South who are currently

trained or employed in global health institutions in the Global North may 'serve as dual citizen scientists' and thereby play a crucial role in decolonising global health (59). The efficacy of this assumed potential remains to be ascertained (60), as remaining in the host country and the corresponding process of assimilation may prove to be more appealing than maintaining a critical perspective rooted in an upbringing in a low-income country. Scholars originating from such environments may erroneously perceive themselves as representatives of the Global South (61), neglecting their actual socioeconomic position and role as representatives of the local elite.

The pervasive and significant social inequality that characterises the majority of former colonies often renders it particularly challenging, and in some cases unfeasible, for individuals from lower social strata to access higher education and pursue a career at an institution in the Global North. It is reasonable to hypothesise that members of the domestic elite are the primary beneficiaries of educational, training and labour opportunities at academic institutions in the Global North. Should they opt to utilise the knowledge and experience they have acquired for the benefit of their home countries in the Global South, it is reasonable to assume that those who stand to gain the most from this will be members of their own social class – that is, the better-off socioeconomic groups and, ultimately, the domestic elites. This transfer of power and influence, given its primary reservation to the upper class, is likely to result in the further entrenchment of existing internal colonisation. This will contribute to the further strengthening of local elites and thereby ultimately reinforce the phenomenon of internal colonialism. The aforementioned factors may exert a counteracting effect on the demand for equity, a concept that is profoundly entrenched within the overarching call to decolonise global health (58).

Reductionist approaches to decolonising global health

While the concept of decolonisation is dominated by the Global North (58), scholars tend to reflect an identity rather than a political conceptualisation (53,62). The decolonisation debate in global health and related fields frequently exhibits an exclusive nature, perpetuating a form of racism through the neglect of other populations that do not conform to the same ethnic or regional identity (63,64). In this context, the critique of universalism and humanity as inextricably linked to the Eurocentric conception of the (hu)man itself (65) is problematic as it tends to promote a primarily identity-based understanding that neglects the universal nature of human exploitation under capitalism. The narrowing of the scope of decolonisation and the exclusion of other victims of colonialism represents a hazardous course of action that could easily lead to a dead end if the existing crossings are closed rather than upgraded.

While it is imperative to thoroughly assess and acknowledge the historical exploitation of the African continent and its peoples by colonial powers, it is equally crucial to recognise the postcolonial legacy in other regions of the world (66).The analysis of the Cameroonian historian and political theorist Achille Mbembe (*1957) of racial differences as a “result of a process of abstraction, classification, division and exclusion - a process of power which is then

internalised and reproduced in everyday actions, including by the excluded themselves“ applies to humans and peoples around the globe (67). In order to achieve a truly global perspective, it is essential to embrace the relatively recent emergence of studies of racism that tend to move away from the prevailing presumption of a dichotomy between Whites and “Others”. Nevertheless, the focus remains on White people racialising others, irrespective of their ethnic or religious affiliation (68).

Consequently, the prevailing emphasis on blackness and ethnicity cannot claim to represent more than a fraction of the human colonialism and the history of racism. This has the potential to jeopardise not only the inclusion of significant aspects of colonialism but particularly its manifold and intricate challenges in the contemporary globalised world. For instance, the historical legacy of colonialism in Latin America manifests in the form of significant disparities in the distribution of resources and means at the expense of the indigenous population, which continues to exert a substantial influence of racism on the health and well-being of individuals in the region (69). A comparable phenomenon pertains to the social construct of skin colour in Asia, where racialised social groups have assimilated hegemonic conceptions of colour, nation and belonging, where whiteness is beyond the reach of most coloured people (70). The Chinese Communist party employs a racialised discourse of ‘Chineseness’ or national identity to reinforce both domestic cohesion and patriotism in the country’s endeavour to ensure domestic control and gain international influence (68).

The narrowing of both regional and phenotypic characteristics can be explained as a result of the prevailing decolonisation debate in global health, which focuses mainly on the second wave of colonisation in the 19th century, whereas the earlier centuries' colonial history and subjugation of contemporary Latin America are widely disregarded (71,72). This ahistorical reductionism is derived from the observation that the decolonisation debate is almost exclusively focused on Anglophone countries, particularly North America, the UK, India, the Middle East and certain regions of Africa that were part of the former British Empire (and only to a lesser extent to former French and Belgian colonies). The discourse is predominantly shaped by scholars from North American and European universities. Concurrently, the prevailing postcolonial discourse in global health, which is centred on the consequences of the second wave of colonisation in the 19th century, largely disregards the colonialist subjugation of contemporary Latin America, which has occurred to a greater extent in the past (71). This oversight cannot be ascribed solely to the restricted familiarity with Spanish and Portuguese among the academic constituents, but also to the influence of North American and Northwestern European dominance, within which Anglo-Saxon predominance underwent continuous reinforcement.

It is important to acknowledge that the second wave of colonisation cannot be comprehensively understood without the first, as the two waves are inextricably intertwined, particularly with respect to the origins of the capitalist economic order. The process of internal colonisation can

be defined as the establishment of new power structures and relations within territories that had previously been colonised by external powers. These territories underwent a transformation into sites of internal domination, subsequently evolving into nation-states. The process unfolded uninterruptedly, giving rise to an external colonisation of peoples who possessed a distinct identity from that of the colonisers. Furthermore, these peoples inhabited territories that had not previously been considered part of the colonisers' sphere of influence (73). In this context, Mexico, with its dualistic society, can be considered a prime example of internal colonisation, as a privileged and dominant minority of European descent managed to dominate the indigenous majority and enforce their assimilation towards a process of cultural mixing known as 'mestizaje'. The subjugation and utilisation of one ethnic group by another has been established as a form of 'internal colonialism' in the country (74).

It is imperative to emphasise that the discourse on decolonisation in Latin America commenced well in advance, encompassing all countries from Mexico to Argentina. A particularly salient observation is that the discourse on colonialism in former Spanish and Portuguese overseas territories in the Americas went beyond a mere discussion on the effects of colonialism on the conditions and realities in previously colonised countries (75). Indeed, the contemporary understanding of internal colonialism can be attributed to the resurgence and rejuvenation of the concept during the 1960s, which was spearheaded by a group of Latin American researchers under the leadership of the Mexican sociologist Gonzalez-Casanova (1922-2023). The notion of internal colonialism, as initially theorised, encompassed the continuation of external colonisation through alternative means and actors, namely the local or regional dominant class (76). This notion encapsulates the intricate structure of political, economic and cultural inequalities between groups and regions within a nation-state (77).

The concept of internal colonialism, which can be defined as the transposition of metropolitan social structures to a domestic context, does not mitigate the repercussions and magnitude of external colonialism. Instead, it underscores the assertion that colonial forces also function within postcolonial states. Indigenous communities, within the geographical confines of a nation, manifest the characteristics of a colonised society. Consequently, these communities can be regarded as internal colonies (74). Latin American scholars have long focused on the relatively interchangeable nature of the terms 'colonialism' and 'colonial structure', as well as the transnationality of internal colonialism, as a common challenge to the development of the new nations of Africa, Asia and Latin America (78). However, with the exception of sporadic cases in other scientific disciplines (79), the findings and analyses from Latin America have only been incorporated into the English-speaking academic milieu only to a limited extent, and even less so into the present decolonisation debate in global health.

Biased endeavour to decolonise global health

The apparent neglect of non-Anglo-Saxon research may seem surprising at first glance; however, closer inspection reveals that the marginalisation of Latin America in the discourse on the decolonisation of global health was and is also likely to be politically motivated. Indeed, the theoretical and practical approach to public health in Latin America over the past decades had the potential to contribute to the field of public and global health by facilitating a more comprehensive understanding of health as a public good significantly shaped by social determination. However, the regional emphasis on social epidemiology, social medicine and collective health did not fully align with the predominant global health trend that has emerged during the last three decades (80). The underattention paid to Latin American approaches and positions can be attributed to two main reasons. Firstly, the prevailing biomedical reductionism in global health (81) is further exacerbated by the narrow focus on quantifiable data, which has been shown to lead to the suppression of social and political perspectives. Secondly, the growing prominence and agenda-setting of multibillion-dollar philanthrocapitalistic endeavours and government programmes in the (anglophone) Global North is evident, as demonstrated by prominent philanthropic institutions such as the BMGF or PEPFAR (72).

Latin American authors have long observed and described global health as characterised by fundamental conflicts between the globalised neoliberal capitalist system and its inherent financial and political interests and universal access to health as a human right and requirement of social justice (82,83). Consequently, endeavours to decolonise global health must acknowledge this existing experience and evidence and consequently address these immanent conflicts in all their breadth and complexity and even place them at the centre of the postcolonial debate and the struggle to decolonise global health. In this context, the call for Latin America to strengthen its global leadership in health (84) has emerged as a significant and necessary contribution to the global discourse on decolonising global health.

It has been a considerable time since Latin America has assumed a more prominent leadership role in global health, with a particular focus on decolonisation. The region stands to benefit from the theoretical and practical insights inherent in the subcontinent's experience, which have the potential to catalyse a fundamental shift towards a more comprehensive consideration of social, economic and commercial factors that are pertinent to global health. There are encouraging developments, for example, in Brazil, where the concept of "racial democracy" was introduced into the political discourse during the first populist dictatorship of Getúlio Vargas (1930-1945) (85). Whilst the question of whether and to which extent racial democracy is a myth or has the potential to become a reality remains unresolved (86), contemporary health policy debates are inextricably linked to the concept of ‘racial democracy’. It has been incorporated into the healthcare system, explicitly addressing racism (87, 88), and may contribute to and enrich the global debate about decolonising health worldwide (89).

Latin American authors and institutions have long taken a counterhegemonic perspective in global health (90) and emphasised the paramount importance of the social, economic,

commercial, and political determination of health that must be placed at the centre of global health (91). The implementation and practice of health-in-all policies must be prioritised in both national and international health policy, constituting a fundamental aspect of global health and the process of decolonising global health. In this context, the claims of Brazil and other countries for decolonising the health sector merit further investigation as potential cornerstones for decolonising global health (89).

Lessons for decolonising (global) health to be learned from Latin American

The Brazilian Unified Health System (SUS) has engaged with decolonial perspectives primarily through critical academic analysis and targeted policy initiatives, rather than a comprehensive system-wide transformation. In the field of academic research, scholars have examined the Health Care Reform through the lenses of decolonial and Black feminist thought. This examination has enabled the identification of persistent colonial structures that the original movement failed to fully address. However, these scholars have also argued that despite these limitations, the reform "is assuredly not a 'denatured movement'" and remains open to epistemological reorientation (92). Research on Integrative Health Practices in the Federal District has documented how Afro-Brazilian healing traditions remain marginalised within the policy framework. Analysts have called for integration with the National Comprehensive Health Policy for the Black Population (Política de Saúde Integral da População Negra) to advance anti-racist implementation (93). The case of the Xavante Indigenous community illustrates the broader challenge: despite administrative reforms and some mortality reductions, a systematic review found that overall Indigenous health status has "significantly deteriorated" over time, revealing how colonial legacies continue to shape health outcomes even within a nominally universal system (94). Moreover, the Family Health Strategy, as the largest community-based public health programme, functions as a decolonial instrument by utilising over 278,000 community health workers to deliver accessible care tailored to regional and popular needs. This approach is in direct opposition to the Global North models of privatisation and austerity, and positions the SUS as a model of health sovereignty (89). The findings suggest that, whilst SUS provides a constitutional and institutional foundation for equitable care, meaningful decolonisation of health in Brazil remains an ongoing and incomplete project requiring deeper structural engagement with racial and epistemic inequities.

Recent Colombian health policy frameworks have evolved to incorporate a more nuanced understanding of plural systems of care, intercultural approaches and monitoring mechanisms. These frameworks demonstrate a shift towards acknowledging the interlocking structures of oppression that influence health outcomes and access (95). The new frameworks emphasise equity, territorialisation and the social determinants of health. They prioritise the right to health, intercultural recognition and participatory governance as mechanisms to redistribute power and resources in health systems. This focus is particularly notable in historically excluded regions and groups (96). The decolonisation of healthcare has been pursued through the implementation of a formal intercultural approach, which aims to recognise, integrate and

institutionally support the health systems, worldviews and traditional practices of Indigenous, Afro-descendant and other ethnically distinct communities. This approach is predicated on the recognition that these communities should not be subordinated to a singular biomedical norm. This commitment is embodied in the 'Sistema Indígena de Salud Propio e Intercultural' (SISPI), a legally reinforced initiative that has been formalised as a national public policy. The SISPI enables Indigenous health systems to operate alongside and in articulation with the general health system, on the basis of cultural autonomy, ancestral knowledge and collective wellbeing (97). In practice, initiatives such as culturally competent health services for Afro-Colombian communities (e.g., kilombo ethno-medical units) illustrate localised successes in bridging gaps between national health services and community-rooted care models (98).

In Mexico, intercultural health policy has sought to move beyond purely biomedical models by acknowledging the validity of diverse health beliefs and traditional practices. This has been done in an attempt to reduce barriers to access for indigenous populations and improve equity. However, critiques have noted that implementation often replicates cultural essentialism without sufficiently shifting power to communities themselves (99). Examples of community-based, culturally competent care include the 'Casas de la Mujer Indígena' model, which was evaluated favourably for its linguistic and cultural congruence with Indigenous women's needs, increased reporting and referrals for health problems, and facilitated local ownership of health services. This outcome is aligned with decolonial aims of empowering marginalised users (100). In addition, the incorporation of traditional medicine and biomedical services within state health infrastructure has been demonstrated to be a viable prospect by intercultural hospitals such as the Integral Hospital in Cuetzalan in Puebla. This provides a practical precedent that such hybrid models can function within national systems when supported by policy and indigenous movements (101). Despite these advances, current research indicates that many state-led initiatives still frame interculturality as a cultural add-on rather than achieving structural transformation, underscoring ongoing challenges in fully realising a decolonised health system in Mexico that authentically redistributes authority and prioritises indigenous self-determination in health governance (99).

A few countries in Latin America have demonstrated some progress towards decolonising their health systems through intercultural, rights-based policies and institutional reforms (102,103). However, scholarly evaluations consistently note that systemic barriers remain—such as persistent dominance of biomedical paradigms, weak multilevel governance of intercultural programmes, insufficient professional training in Indigenous health, and an uneven epistemic recognition of Indigenous health systems—which constrain the transformative potential of these policies and limit measurable impacts on health inequities (92,104,105).

However, the universal human right to health (and social protection) can be adequately realised only if the full spectrum of determining factors and underlying conditions that adversely impact people's health are addressed (81). In the context of neoliberal capitalism and the viability of

its "business model", both global health and its decolonisation demand an interpretation of human rights that does not perceive health as a commodity but as an inherent right of all individuals. The primary objective of decolonising global health must be the enforcement of the universal right to health, with a view to addressing global power imbalances that impede the implementation of this right (40).

It is imperative to diverge from the prevailing biomedical reductionism in global health and the resulting decolonisation focus on medicine, disease control and socio-biomedical research (72,106,107). This should not be regarded as merely an intellectual endeavour but rather as a global health and political praxis. A series of changes must be implemented, including active recognition of oppressive forces; more equitable leadership patterns that include more women - especially women of colour - and minorities; and the transformation of the unidirectional flow of knowledge between LMICs and HICs into a bidirectional flow, as suggested by Büyüm and colleagues (15). However, any seminal and sustainable path towards new paradigms and epistemic approaches in global health will require social and political movement building, more radical imagination and, ultimately, more utopian thinking. The attainment of absolute equality may not be feasible, but this is not impossible. Colonialism and domination are extant, and equal opportunities and the common interests of global citizens are directed towards a better and fairer society. The term ‘utopian’ must not be assumed to signify unrealistic; rather, utopian thinking must be based on the given realities. It is imperative that the prevailing conditions are given due consideration, with particular emphasis on the dynamics of power relations. The analysis should be free from the influence of potentially beneficial activities and policies that might obscure the fundamental issues under scrutiny.

Indeed, global health strategies that are supported and dominated by the Global North reliably reproduce the conditions that have led to the prosperity of high-income countries and populations and thus to the extremely unequal global distribution of opportunities and resources (81). In their critique of the prevailing concept of global health, which they claim is inadequately prepared to address determinants such as structural violence and Western “White” dominance, Büyüm and colleagues (15) assert that “global health needs integrated, decolonised approaches - advanced by individuals and institutions - that address the complex interdependence between histories of imperialism with health, economic development, governance and human rights”.

The role of race, racism and capitalism in the decolonisation of global health

The term 'global' in global health, with its dual meaning of ‘all-encompassing’ and ‘worldwide’ inherently challenges any form of ethnocentrism. However, it is less clear whether and to what extent global health also challenges contemporary power relations beyond the rather simplistic Global North/Global South divide. It is an irrefutable fact that the ‘decolonial‘ perspective in global health and global health research should raise awareness and sensitivity to racial inequalities. However, the tendency to view colonialism primarily, or even exclusively, from

an ethnic and racial perspective (63) carries the risk of reducing decolonisation to an identity-based concept that would fail to adequately address the complex global challenges of our time posed by multiple crises and the ongoing syndemic (106,108).

It is an irrefutable fact that race constitutes an essential building block of colonialism. Consequently, it is impossible to envisage the decolonisation of global health without acknowledging racism as an inherent and perpetuated crucial part of it. However, it is important to note that race is not merely an identitarian social construct based on physiognomic or phenotypical characteristics of humans used to categorise seemingly distinct population groups. In a similar vein, the notion of 'blackness' should not be regarded exclusively as a literal attribute of skin colour. Instead, it should be regarded as the preeminent figure of racialised subordination within the dominant global regime characterised by white supremacy (109). The origins of this regime can be traced back to the European colonisation of the Americas and, subsequently, the colonisation of other continents. During this period, the transatlantic slave trade from Africa to the Americas and slavery in general played a prominent and thus eponymous role (38). Instead, the concept of race functions to normalise the unequal production and distribution of resources inherent in capitalism by rationalising these disparities through the utilisation of social power and privilege, on the basis of the presumed human nature of 'others' (110).

A significant challenge to the process of decolonising global health is the legacy of subjugation and the subsequent establishment of a racial hierarchy in which White nations occupy a dominant position and Black nations are relegated to a subordinate status. Whilst the economic and political subjugation of the Global South by the Global North, and the challenges facing the Black diaspora are most visible and prominent in sub-Saharan Africa, it should be noted that racial discrimination and subjugation are also prevalent in other regions of the world. The pervasiveness of racism is evidenced by its profound social and societal impact in Latin America (111,112), Asia (68,70,113), Arabic countries (114), and northern Africa (115). It is crucial to acknowledge that the subjugation of racial groups is not exclusive to Black individuals but extends to non-Black communities on a global scale. Despite the pervasiveness of racism worldwide, the global discourse on racism and decolonisation is being predominantly shaped by scholars and activists addressing the experiences of racism and colonialism affecting Black communities. This is arguably due to the fact that the emergence of the capitalist system was fundamentally predicated on exploitative strategies such as forced labour and institutionalised racialised slavery, which has long been a pervasive economic practice (83). It is imperative to acknowledge that, in conjunction with the direct exploitation of the colonies, the transatlantic slave trade – characterised by the brutal exploitation of Black Africans – was a pivotal propelling force behind the Industrial Revolution in Europe (38).

Since the advent of the contemporary capitalist system in the aftermath of intercontinental slave trading and European colonisation, capitalism has inherently exhibited a fundamental racist

component (38). In the context of the profound connections between racist politics and capitalist reproduction, the term ‘racial capitalism’ has recently become popular (116). It refers to a concept defined as "the process of deriving social and economic value from the racial identity of another person" (176). The term 'racial capitalism' is typically attributed to Cedric Robinson; however, it appears to have been utilised earlier in a South African liberation journal (118). The term's consistent theme is the assertion that capitalism is inherently racial or racist, with racialism pervasive across all facets of capitalism. In contrast, Stuart Hall challenges the notion that capitalism requires racialism to function, emphasising South Africa as an exceptional case of “an industrial capitalist social formation, where race is an articulating principle” (119). Hall's theoretical framework posits that the evolution of racism is contingent on contextual factors and shaped by the prevailing balance of class forces.

In contrast, the Marxist approach examines social and political circumstances from a class perspective (116). Accordingly, the hallmark of racial capitalism is the creation of dense social divisions, a phenomenon that has been evident since Karl Marx's analysis of the development of colonialism and the credit system. According to Marx, capital accumulated through the expropriation of resources, whether through colonial expansion or credit systems, flows into the other system in a symbiotic relationship (116). If labour is regarded as the antithesis of capital in Marx's sense and blackness is interpreted as the ultimate condition of labour's subordination and subjection to capital, then all labour under capital is driven towards a socio-political condition of blackness.

As racism consolidates and entrenches the inequalities necessary for capitalism to function (120), racial capitalism reinforces commodification by reducing identity to a marketable good. This has resulted in increased racialised marginalisation and exploitation, leading to resentment among members of less powerful races towards those perceived as superior, mostly non-White people who feel exploited by White people. However, critiques of racial disparities and the commodification of identity as a source of exploitation and alienation, along with calls for an end to racial capitalism, remain embedded within the framework of capitalist thinking. Consequently, these critiques accept the underlying principles of capitalism proposing forms of 'social capital' that promote inclusivity (109,121).

Drawing upon Indian experiences, Contractor and Dasgupta contend that the endeavour to decolonise global health is inadequate without addressing the antihierarchical movements that have emerged in former colonies following the retreat of the European or Western powers (55). Indeed, as has been demonstrated, “European colonisers manoeuvred existing social hierarchies in colonised nations into varying types of feudal structures to sustain imperialism” (2). In the context of internal colonisation, the process of indigenous capitalist development was initiated by the colonial powers in collaboration with metropolitan capital by establishing the necessary conditions for the capitalist development and the establishment of a bourgeois (colonial) state (122). The field of tropical medicine, which can be regarded as the progenitor

of global health, was oriented towards the prevention, diagnosis and treatment of diseases that had the potential to afflict expatriates or reduce the efficiency of the local workforce. It is important to note that this remains accurate under the system of globalised capitalism, albeit tempered by the contemporary and progressive views of research funding agencies from donor nations and the influence of private philanthropic entities, including the BMGF, Rockefeller and Ford Foundation, and the Wellcome Trust (123).

Decolonising global health in a neoliberal neocolonialist context

In consideration of the close linkage between postcolonialism and the global capitalist economic order, the decolonisation movement and its advocates have thus far neglected to allocate sufficient attention to the historical origins and consequences of neocolonialism. This term was initially coined by Jean-Paul Sartre (1905 - 1980) and subsequently introduced into the political discourse by the former President of Ghana, Kwame Nkrumah (1909-1972). The term neocolonialism refers to the dominance of one nation by another following formal decolonisation, highlighting unequal power relations and often emphasising economic dependence, typically with the collaboration of local elites (109). Despite the growing clarity of neocolonial geopolitics in the second half of the 20th century, the decolonisation discourse within global health has only recently - and, it must be noted, in an insufficient manner – recognised this transition in global political relations from classical colonialism to neocolonialism (124). This phenomenon can be attributed, at least in part, to the overarching emphasis on the redress of postcolonial injustices and the adoption of an identity-driven approach to decolonisation. Furthermore, a rather simplistic understanding of the "Global North versus Global South" dichotomy was evident. The philanthropic commitment to the decolonisation of global health further blurred the distinction between technical improvements and fundamental structural changes.

While the decolonisation debate in global health was already lagging behind the changing circumstances in the early phase of neocolonialism, the further development of neocolonialism has left it even further behind. Contemporary examples demonstrate that, with a few exceptions, foreign territories are no longer under the direct control and exploitation of nation-states and their rulers. In contemporary practice, the primary agent of neocolonialism has transitioned from nation-states to transnational corporations (TNCs) and their ‘rulers”, i.e. individuals or groups of individuals, frequently categorised as billionaires or oligarchs and classified as transnational capitalist class (125,126). In the period following the process of globalisation, a transnational capitalist class – whose material basis rests on the transnational exploitation of resources and globalised production processes – has increasingly captured the state and its institutions over the past decades. The displacement of the preceding capitalist class, particularly by techno-rentier oligarchs, bears a resemblance to the replacement of the traditional aristocracy by the early commercial capitalists during the transition from feudalism to capitalism (127,128). The present study is predicated on the premise that the contemporary shift in power is, in contrast, engendering a refeudalisation of the global economy and

international relations, thereby establishing a neofeudal system. The concept of refeudalisation, as expounded by certain scholars in the field of sociology, offers a theoretical framework for elucidating how capitalism can engender social hierarchies and power imbalances that bear resemblance to feudal estates, without suggesting a return to a society governed by feudal laws or serfdom (129).

The transition to neofeudal capitalism, a phenomenon described since the late 20th century, has resulted in the emergence of a new class of aristocrats, comprising primarily the transnational corporate elites that are globally interconnected (130). Despite the pivotal role of this emergent financial 'aristocracy' spearheaded by super-rich tech feudalists, in the realm of neocolonialism, as delineated in the ensuing sections, their influence has hitherto evaded the purview of decolonising global health initiatives. This issue is of particular pertinence, given that the corporate elite, has been identified as a key driver of climate breakdown (131,132). The contemporary resurgence of neofeudal power, exercised not by the historical nobility but by today's financial aristocrats, has significant ramifications for global health. It is noteworthy that a considerable proportion of billionaires on a global scale have a vested interest in the control, financial gain and exploitation of processes that contribute to carbon pollution (133). This is in direct opposition to the efforts aimed at facilitating a just transition to renewable energy sources. Consequently, the global financial capital has exerted a substantial ecological influence and has contributed significantly to global warming. The lifestyles and business practices of the billionaire corporate elite have a considerable impact on health and pose a major threat to global health (134), with the populations of low-income countries bearing the greatest burden despite contributing the least to climate change (135). The ongoing climate crisis has been demonstrated to exacerbate existing inequalities, burdening Black, Indigenous, and people of colour, women, and lower-income groups disproportionately (136).

The decolonisation movement in global health has thus far neglected two key aspects. Firstly, the role of the financially extremely powerful transnational corporations is being overlooked. Secondly, the underlying structural conditions of global capitalism have been neglected, particularly with regard to its further development into the contemporary neofeudalism. This is surprising given that the neo-feudal world order is ultimately the successor to formerly direct territorial rule because it exerts similar pressure on political and social systems worldwide to impose economic priorities and interests. In the contemporary era, the implementation of neocolonial control over middle- and low-income countries is predominantly facilitated through the medium of economic, financial, and trade policies, as opposed to the exercise of direct political rule. In this context, TNCs play a significant role. The governance relationship between TNCs and capitalist states (137) has been shown to make them a kind of "double" in the colonial project. Yeros & Jha observed that the withdrawal of direct control over peripheral regions has been facilitated by the economic strategies of TNCs to ensure access to tropical agricultural produce, natural resources and inexpensive labour (138).

It has been established that the intricate relationship between TNCs and capitalist states has historically been identified as the primary agent and recipient of knowledge concerning imperial governance (139). In contrast to the actions of other colonising powers, the British initiated a private-sector strategy from the outset in order to develop and exploit the wealth of their Asian colonies through the East India Company. This approach bears a resemblance to that employed by the Dutch East India Company and Hudson's Bay Company in Canada, and may be regarded as an early manifestation of an industrial model of an enterprise primarily acting in the interests of shareholders and an early expression of international corporations (140,141). A considerable proportion of TNCs are headquartered in the USA and, to a lesser extent, in Western and Northern Europe, despite a growing number of their headquarters being based in BRICS member states and other countries.

The role of TNCs in this context is a salient factor that warrants consideration (139), precisely because it had a strong impact on neocolonialism and is therefore so relevant for a consistent decolonisation of global health. The utilisation of natural resources and inexpensive labour in the pursuit of profit is facilitated by investment, thereby perpetuating a form of colonial-like exploitation that is not subject to direct governance. The displacement of domestic workers with less expensive foreign labour is achieved through two mechanisms. Firstly, production is relocated (or ‘outsourced’) to overseas markets. Secondly, workers are migrate to economic hubs in high-income countries. From the outset, this approach aims to enrich a select group while keeping the wider population in a state of dependency (140).

Inadequate approaches to decolonisation within the context of the global economic order

The failure to acknowledge these aspects in the decolonisation debate may result in the concealment and normalisation of the unequal and asymmetrical economic and political relations between capitalist and neocolonial states. In the context of global health, it would be unwise to disregard the pivotal role played by transnational corporations (TNCs) in the processes of globalisation and neo-colonialism. TNCs exert a substantial influence on population health at both national and international levels (142), a phenomenon shaped by their social, political and economic power (143). TNCs play a pivotal role in the commercial determination of health (144,145). At the same time, they have a major influence on worldwide research activities, including health-related industries (146).

The structures of colonialism that were inherited have been built upon by TNCs, which exploit workers in the Global, albeit not exclusively in the geographic South, on behalf of wealthy shareholders in the Global, but not exclusively in the geographic North. The exacerbation of racial inequalities by TNCs can be attributed to the integration of global supply chains and export-oriented industries within the prevailing colonial system of wealth extraction. These industries have utilised global labour markets, thus perpetuating systemic injustices and further entrenching racial inequalities. The outsourcing of production to the Global South by TNCs, driven by the pursuit of low-cost labour, serves to reinforce neo-colonial or even neo-

imperialist power dynamics. The consequences of this phenomenon for workers in global supply chains are manifold, with frequently substandard working conditions, an absence of collective bargaining rights, and inadequate social protection. Marginalised communities, notably Indigenous, Black, and other racialised groups, shoulder the burden of low wages, hazardous working conditions, and environmental degradation (147).

A significant legacy of colonialism that has contributed to global inequalities and endangered global health is the issue of debt. The demand for the repayment of international debt, presented as a rationale for governance in the interest of global finance capitalism, results in the ongoing seizure of land and public goods, including water (120). The debt trap exerts a significant influence on the economic policies of poorer countries, compelling them to engage in the exploitation of their own natural resources, labour forces, and domestic economies. This, in turn, serves to expedite the systematic dispossession of local populations in favour of TNCs and the global financial elite. This process frequently occurs with a flagrant disregard for fundamental human, labour, and environmental rights. A substantial body of research has demonstrated the adverse consequences of debt repayment for the health and social services of individuals in the Global South (147-150). The global financial system is characterised by its profoundly unjust nature, favouring the Global North at the expense of the Global South. This perpetuates the historical process of colonisation through alternative means, resulting in the marginalisation and exploitation of disadvantaged nations. The inherent unfairness of the capitalist financial system, with its involvement of local elites, has garnered increasing attention in public policy discourse, particularly in heavily indebted countries. This issue has also come to the fore on the international stage, as evidenced by the recent attention it has received in publications (151,152).

In the domain of global health, transnational pharmaceutical industries leverage their monopoly privileges to influence the research and development of medicines, prioritising their own profit opportunities over global health needs (153). It has been asserted that major pharmaceutical companies perpetuate colonialist dependencies and adopt a neocolonial approach by conducting medical experimentation in the Global South without consideration for the health and wellbeing of the populations involved (154). The COVID-19 pandemic has dramatically brought to the fore the pressing need to address the legacies of colonialism in industrial development and business activities. The pharmaceutical sector in the Global South remains inextricably linked to the neocolonial political economy of trade, global labour division and hierarchy, and the disadvantages experienced by the Global South (155).

Of particular concern is the exacerbation of racial and gender inequalities by corporate power, a phenomenon that is facilitated by privatisation. The policy of privatisation has been demonstrated to drive and reinforce such inequalities, particularly in relation to race, class, caste and gender. Privatisation has been demonstrated to engender the commodification of

essential services, including healthcare and education, resulting in the exclusion and impoverishment of those lacking the financial means to pay for them (156-158).

In the context of the pervasive biomedical reductionism that characterises the dominant global health discourse, there is a conspicuous absence of adequate scrutiny pertaining to the profoundly neocolonial undertones of transnational pharmaceutical corporations (159,160). The issue of the path dependency of biomedical research into diseases prevalent in the Global South, a phenomenon that can be traced back to colonial tropical medicine, has rarely been addressed to date (161). A comparable oversight is evident in the context of the globally active and dominant pharmaceutical industry, which not only harbours inherent universal hazards to peoples' health but also constitutes a substantial impediment to the decolonisation of global health. The process of decolonising global health necessitates the interrogation of pharmaceutical monopolies, the intellectual property privileges accorded to them, and the unwarranted defence of their profit interests by philanthropic foundations. This can result in the occurrence of perilous shortages, as evidenced during pandemic crises (18). The decolonisation of global health will remain wishful thinking as long as the commodification of health persists and the power of transnational pharmaceutical and other corporations cannot be effectively limited.

Discussion

There is broad consensus that the decolonisation of global health requires a multifaceted strategy that addresses not only policies, practices, institutions, and education but also power dynamics and imperialistic drivers. A systemic approach is imperative for dismantling colonial legacies and advancing towards equitable and inclusive global health (162). It is imperative that any critical evaluation or transformative decolonising initiative within the global health sector comprehensively considers the racial, social, political, technological and commercial determination of health. It is evident that any endeavour to decolonise global health policy which fails to take into account the historical and contemporary manifestations of colonialism, along with their ramifications, is likely to prove futile. Moreover, it is essential that decolonisation efforts and discourses in the context of global health also accord due consideration to the phenomenon of internal colonialism, whilst not eschewing engagement with established perspectives, such as those predicated on identity-based approaches.

A review of the extant literature on the decolonisation of global health reveals that, in most cases, the prevailing decolonisation discourse addresses questions of the internal or immanent reorganisation of companies, reform of institutions, the role of philanthropies, governance issues and higher-level education. It is evident that scholars tend to advocate for reforms that do not fundamentally challenge the upstream social, geopolitical and economic conditions, such as imperial power relations, neoliberal capitalism or its refeudalisation. The call for decolonisation frequently functions within the established geopolitical and economic framework, rather than systematically addressing the conditions that enable neocolonialism.

Consequently, the academic discourse on decolonisation risks contributing to the perpetuation of neocolonial conditions and coloniality, as opposed to facilitating their elimination.

While personal experience is an irrefutable motivator, it can also result in a certain lack of perspective. A merely identitarian focus on Black people, particularly in or with links to North America, as a strategy for decolonising global health, does not reflect the broad spectrum of the worldwide colonial legacy and is therefore insufficient to adequately address the challenges of decolonisation (19,53). This approach is particularly problematic in terms of its ability to contribute to the resolution of fundamental conflicts, as well as the upstream causes of colonialism in global health and its social, political, ecological and commercial determination. The decolonisation of global health will undoubtedly necessitate a significantly more pronounced emphasis than heretofore on the decolonisation of the social determination of health (80,163) and the fight against all forms of neocolonialism.

Evidence has been presented which indicates that neo-colonialism in the domain of global health serves to reinforce prevailing power structures, thereby impeding the development of a more equitable global health system. In order to combat this, it is essential to implement health initiatives that are more inclusive, locally driven, decentralised and diverse, and that prioritise the voices and needs of marginalised populations. Concurrently, the decolonisation of global health policy must acknowledge contemporary and emerging neocolonial practices as inextricably associated with the tendency to generalise the situation of Black individuals. This tendency is characterised by three events: slavery, colonisation, and apartheid (67). The argument that anti-colonial struggles should persistently challenge the dominant economic ideologies and narratives used to legitimise and perpetuate the oppressive practices of contemporary globalised neocolonialism remains significant (40). Concurrently, the mounting menace from nationalist, anti-globalisation and revanchist movements reinforces the imperative for expanding the quest for decolonising global health to encompass impending economic, social and societal challenges. Any conceptual narrowing of focus, as well as insufficient consideration of the political, economic and commercial determinants of global health in the decolonisation process, will reduce its chances of success.

It is imperative to underscore the assertion that the global health of humanity is imperilled by the persistent degradation of the planet engendered by a global economy predicated on the unrelenting extraction and the relentless pursuit of profit (164). However, it is the same powerful postcolonial drivers of neoliberal capitalism (i.e., wealth extraction, land expropriation, control over production and trade, exploitation of natural resources, financial outflows, and limited social and economic development on the one hand and white supremacy, patriarchy and ableism on the other) that are simultaneously responsible for both health inequalities and climate catastrophe. Consequently, in the era of the Anthropocene, any comprehensive and promising approach to decolonisation must incorporate an ecological dimension (40).

The threat that neoliberal capitalism poses to public and global health is more real and fundamental than has hitherto been reflected in the decolonisation debate. While the public health consequences of neoliberal neocolonialism (165) have been addressed on occasion (166-168), the academic literature has yet to provide a critical assessment of the growing rise of libertarian authoritarianism on global health and its decolonisation. This oversight can be attributed, at least in part, to the tendency of many decolonisation advocates to prioritise critiquing colonialism through the lens of identitarian criteria, often overlooking more intricate contexts and contemporary imperatives (19,86).

The contemporary emergence of the new authoritarian-libertarian global order, characterised by a blend of stringent societal government control and free-market capitalism, has been propelled by the inherent contradictions within the global north, or the political West, which have challenged and ultimately questioned the governance concept of Western liberal democracies (169). From a global health perspective, there is little reason to oppose the so-called Western values of democracy and human rights. The recent revelation of Western countries' apparent double standards and hypocrisy in the application of these values is a cause for concern. The claim for multilateralism in the 'international community', invoked and until more or less recently led by the USA and the EU, together with other Western allies, is increasingly lacking in credibility. The prevailing sentiment that underpins this discourse is one of disillusionment with the rule of law, human rights and democratic liberalism. These principles have been rendered seemingly hollow in the face of widespread acquiescence to flagrant injustices and overt endorsement of colonialist violence. Consequently, this is likely to result in heightened resistance from affluent and influential nations towards decolonisation initiatives that have previously been at least tolerated, and in certain instances, actively endorsed.

The present global emergence of a new authoritarian-libertarian world order poses particular challenges to the decolonisation of global health. However, the development of appropriate responses to these challenges remains an ongoing process. Concurrently, the erstwhile commitment to the rule of law, human rights, and democratic liberalism within the 'international community' has ultimately devolved into a farce. Whilst this assertion has always been deemed implausible, given the tolerance of widespread injustices and endorsement of neo-colonialist violence, a neo-colonialist policy is now witnessing a triumphant resurgence. The ramifications for global health extend far beyond the present intense debate surrounding the reduction of health development aid. Instead, this policy serves to re-establish and solidify colonial geopolitical relations, thereby posing novel challenges to the ongoing process of decolonising global health. In such circumstances, it would be imprudent, and potentially hazardous, for the discourse and praxis of decolonisation to address the contemporary and emerging geopolitical and economic challenges of our era with undue delay and inadequacy.

Abbreviations

BMGF	Bill and Melinda Gates Foundation
BRICS	Brazil, Russia, India, China, South Africa
EU	European Union
PEPFAR	The United States President's Emergency Plan for AIDS Relief
TNC	Transnational corporation
SUS	Sistema Único de Saúde [Unified Health System]
UK	United Kingdom
USA	United States of America

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