O'NEILL-LANCET COMMISSION ON
RACISM, STRUCTURAL DISCRIMINATION
& GLOBAL HEALTH

Early findings from the

LANCET COMMISSION ON RACISM, STRUCTURAL DISCRIMINATION & GLOBAL HEALTH

Reimagining Global Health Lecture

Dr Ngozi Erondu, PhD, MPH
Co-Chair | Senior Scholar
11 June 2025

22 leaders in global equity, for health and beyond

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Commission Co-Chair
UN Special Rapporteur on the right to health

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Kevin Fenton

Camara Jones

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Osama Tanous

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The O'Neill-*Lancet* Commission on Racism, Structural Discrimination, and Global Health

The Commission seeks to **advance equity & improve health outcomes around the world** through **leveraging partnerships**, **engaging communities**, & **conducting empirical research** to understand racism & structural discrimination in global health.

Commission Charges (2022-2025):

- "**Diagnose the problem of racism in health** through literature reviews, community and expert consultations, and empirical research"
- "**Identify best practices and actionable antiracist strategies** through research of global health data and **related** policies, practices, and laws that have led to equitable results across population groups"
- "**Compile a report of its findings** by producing a 25,000-word Lancet report and additional accessible materials"
- "**Widely disseminate its findings** through various mediums"

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N ON
MINATION

WHY THIS?

IF YOU DON'T TRUST US KEEP YOUR MONEY!

I AM ALWAYS A **REBEL**

PROCESS NEEDS TO BE ANTI-RACIST

UNDERSTAND & CAPTURE THE NEW WAY

ARCHIVES & STORYTELLING

INTERVENTION — RESEARCH —

MULTIMEDIA

THE WORK HAS TO HAVE MEANING!

RACISM DIRECTLY IMPACTS HEALTH

WE ARE THE PEOPLE TRYING TO SOLVE THE PROBLEM... WHO ARE IN THE PROBLEM...

BELIEVE IN ONE ANOTHER

BE A TEAM

EXTEND GRACE

BUILD A COMMUNITY OF PRACTICE

GLOBAL PH IT IS A POISONED SYSTEM...

WE NEED TO DO REAL CHANGE

WHY NOW?

OPPORTUNITIES

RESTORATION

BECOME AWARE OF OUR PRIVILEDGES & STAY CONNECTED TO COMMUNITIES

WE ARE RIDING THE WAVE OF OPPORTUNITY & REFLECTION

HOPE

BRING THE VOICES IN NOT AS VICTIMS BUT AS POLICY MAKERS

DIG DEEPER INTO OURSELVES

TENSION BETWEEN THE GLOBAL & THE LOCAL

HOW DO WE TIE BOTH WITHOUT LOOSIN THE DIVERSE SPECIFICITIES?

FOUNDATIONS & PURPOSE | VISION & VALUES

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N ON
MINATION

190
1800
1700
CAPITALISM
EXCLUSION
RACISM
ENABLES
SEXISM
CLASSISM
COLONIAISM
COLORISM
CASTEISM
ETC..
STRUCTURAL
DISCRIMINATION
ANCESTRAL HERITAGE

IDENTIFIYING CRITICAL FRONTIERS

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Methods

Comment

Towards anti-racist policies and strategies to reduce poor health outcomes in racialised communities: introducing the O'Neill-Lancet Commission on Racism, Structural Discrimination, and Global Health

Approach: Multi-scalar, mixed-method; grounded in critical theory, community engagement, and historical inquiry.

Key Methods:

- Case study methodology (core)
- Historical and policy analysis
- Stakeholder interviews and consultations
- Literature reviews and secondary data (incl. GIS, grey literature)
- Qualitative coding (QualCoder 3.5 from May 2024)

Conceptual Lens: Race as a social construct interlocked with colonialism, shaping health systems globally.

Reflective Learning: Regular critical dialogue and webinars among Commissioners on Gaza, fear and silencing, extractivism, caste, and structural violence.

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Select Webinars and Events (2023–2025)

- *The Violence of Gender Essentialism: How Law Determines the Health of Gender-Diverse People*
- *Racisme et Santé Mentale: Une Conversation avec Fatma Bouvet de la Maisonneuve*
- *Decolonial Feminism, Public Health, and Indigenous Justice*
- *Racism, Colonialism, and Climate Change: Uncovering Injustices in Impacts and Responses*
- *Decolonizing Harm Reduction*
- *Mental Health & Racism (FR)*
- *Gender Essentialism & Health*
- *US Antiracism (attempts)in Public Health Institutions*

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Decolonial & antiracist approaches to polycrises in health systems:

Perspectives from the O'Neill-*Lancet* Commission on Racism, Structural Discrimination & Global Health

November 21, 2024
11:40 a.m. - 1:10 p.m. JST

The 8th Global Symposium on Health Systems Research, Dejima Messe Conference Center, Room 101(c)

MODERATORS

Dr. Renzo Guinto

Dr. Walter Flores

SPEAKERS

Benilda Batzin

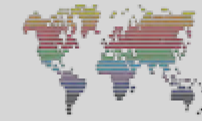
Dr. Chelsea Watego

Dr. Papaarangi Reid

Rosaura Medina

Case Studies

Countries / populations	Theme	Approach
Guatemala and Philippines Indigenous community/ formally colonized state	Health and healthcare systems in colonized settings and their legacy in contemporary times	interdisciplinary group of co-authors (historian, public health, anthropology, epidemiology) Community consultations
Roma communities across Europe and PLHIV and TB in South Africa	Analyzing health access and services at point of care for racialized groups.	Literature reviews Community consultations Key informant interviews
United States and United Kingdom National public health institutions	What are the factors that increase or reduce resistance of anti-racist and anti-discriminatory structures in Western NPHIs	Historical review Literature reviews Key informant interviews
Palestine Healthcare system	Settler colonialism, apartheid, state monopolizing violence & health care access	Systematic literature review and comparative analysis



A Selection of Findings

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The Commission's conceptual framework

The Commission agreed on a conceptual framework to guide its work in assessing the health effects of racism, colonialism and structural discrimination. The framework consists of five key pillars:

1. Intersecting forces of racism and structural discrimination have profound effects on health.
2. Race is a social, not a biological fact
3. Colonialism was decisive in the production of race
4. Racialization is a process, not just a manifestation of individual bias or prejudice
5. Global health must confront racism as a structuring force

High-level findings by focus area

1. The **international finance sy**stem perpetuates the colonial system of economic oppression and results in the under-financing of health services
2. Colonialism, racism, and structural determinants have birthed and shaped current **health systems** globally
3. Racialized health outcomes are a function of **State power, violence, and law-making**.
4. The **research, development, and distribution of life-saving products and technologies** represents systematic and wilful racism
5. Racism and colonialism permeate and distort the international community's responses to health and **humanitarian crises and emergencies**

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*The **international finance sy**stem perpetuates the colonial system of economic oppression and results in the under-financing of health services*

Racism & colonization

International tax laws set tax at home of corporation, ensuring revenue to the Global North instead of South

Lack of international regulation of the burden of debt for former colonies

Tax havens emerging after decolonization

Overemphasis on domestic resource mobilization

Overemphasis on aid as a solution for lack of global health funding

Credit rating agencies downcycle Black-led countries

Former colonies pay high rates for debt servicing

Post colonial & current capital flight

Domestic health expenditure constraint by international system barriers. Causes of insufficient funds cannot be fixed domestically

Charity model cannot do the work of health equity & justice

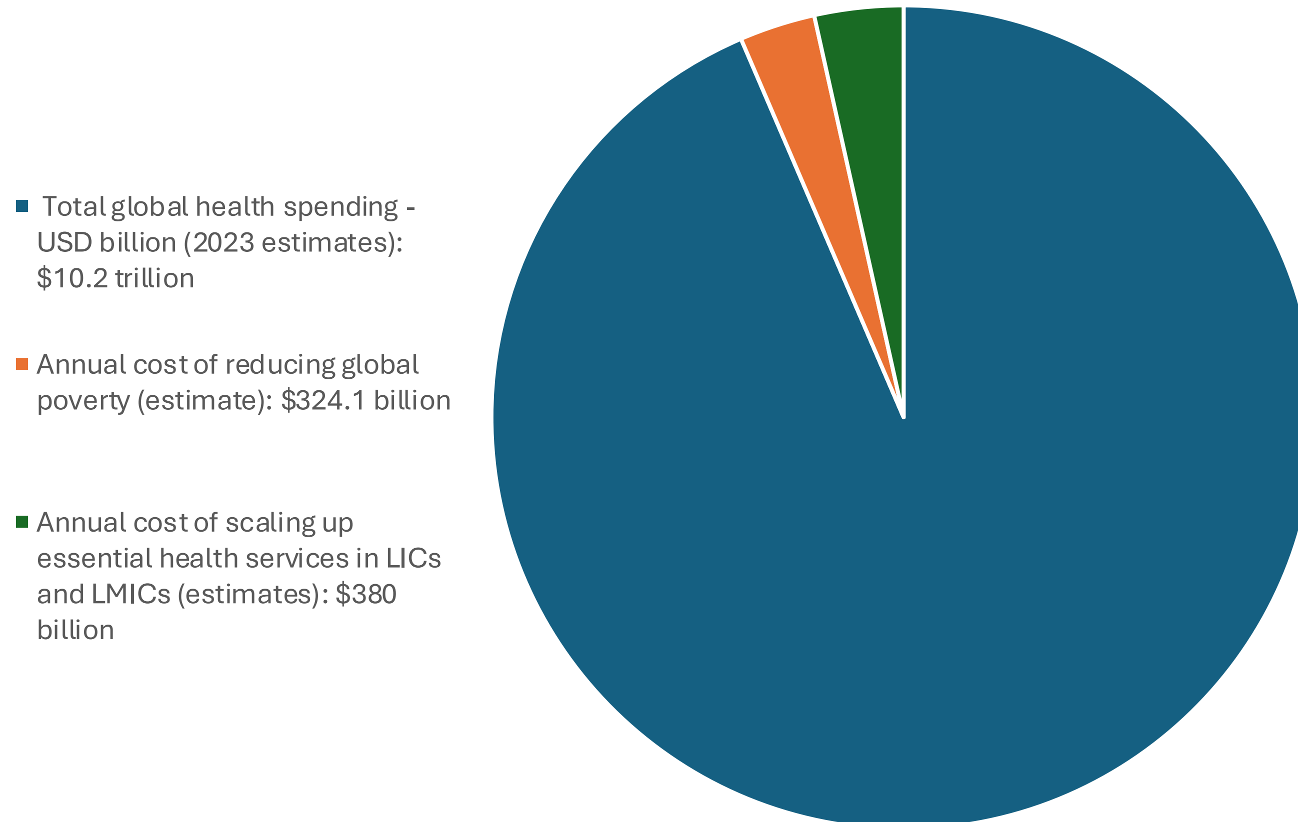
These resources are not sufficient by orders of magnitude

Abundant funds for health in the Global North

South loses massive capital to international finance facilities through tax havens & debt obligations

Forced scarcity of funds for health in the Global South

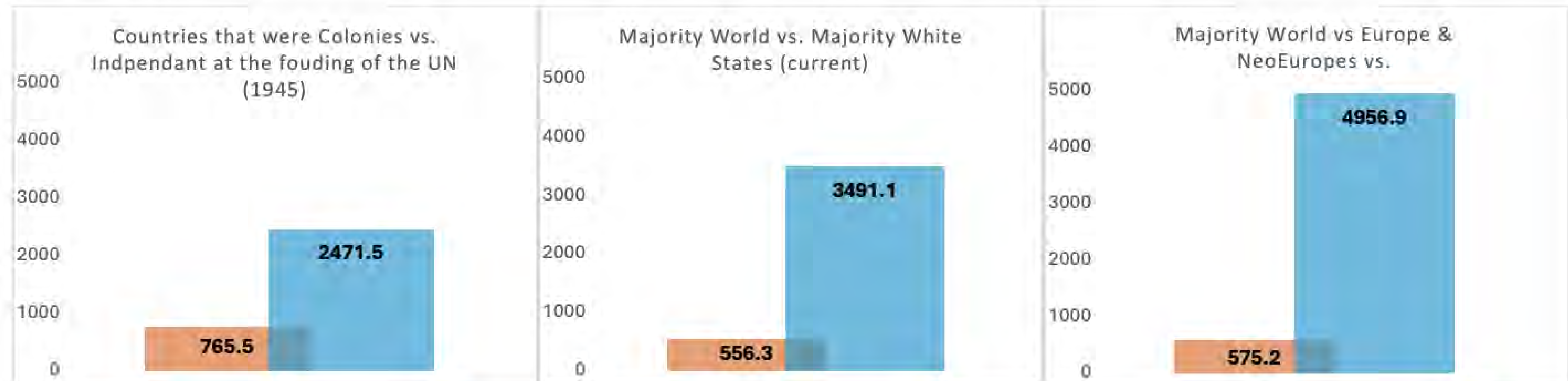
Disparate and racial health outcomes



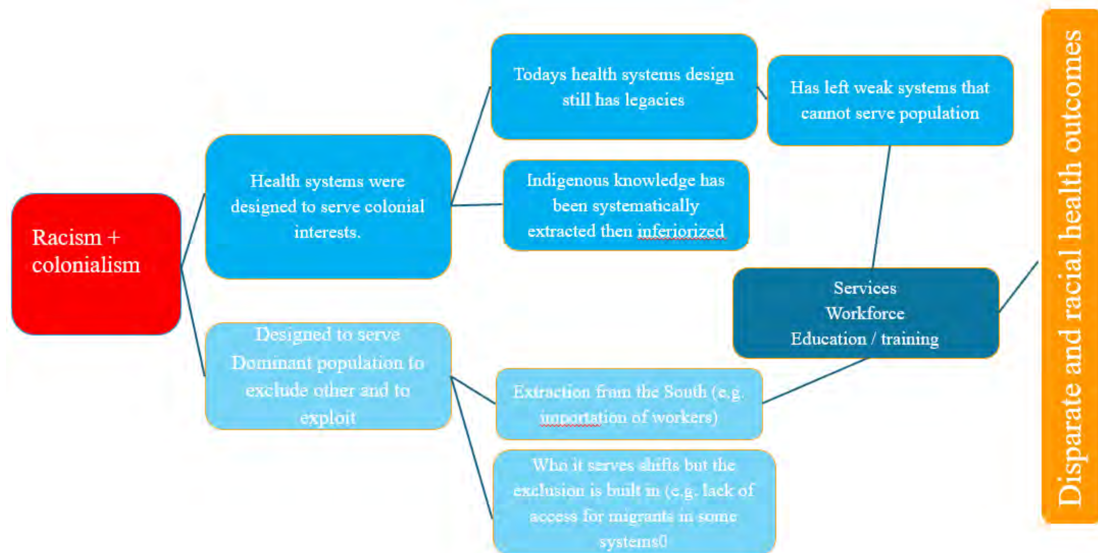
- Abundant money for health distributed along globally racialized lines
- The colonial roots of the global economy – and of global health spending
- International tax law reflects, imposes and reinforces racism and discrimination
- Colonial debt and today's neocolonial interest rates
- Illicit financial flows and their impact on health

Average National Per Capita Health Expenditure, Country Group Comparison

(Current USD, 2022)



*Colonialism, racism, and structural determinants have birthed and shaped current **health systems** globally*

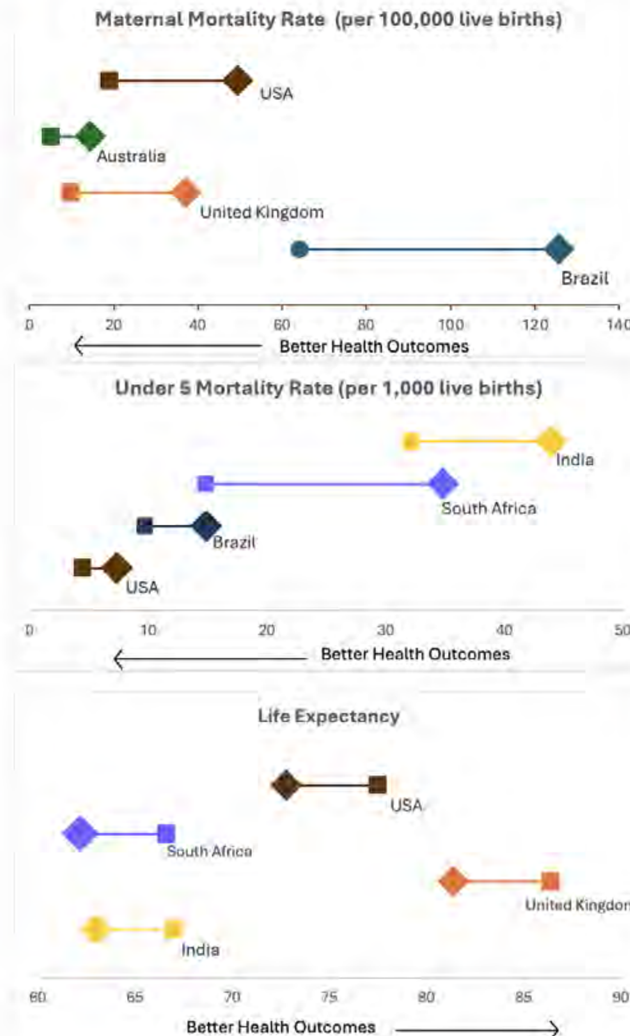


- Inequities, exclusion, neglect: Features, not bugs, of health care systems
- Marginalization of indigenous health care knowledge and practices
- The impact of colonialism on the (mal)distribution of health services
- The continuing effects of colonialism on the health workforce
- Neocolonialism, neoliberalism and health promotion
- Recreating structural discrimination and racialized exploitation through the 'financialization' of health care

It’s a feature not a bug

Dominant and non-dominant groups: The ‘through line’ across diverse countries

Across and within diverse societies and regions, intersecting lines of inequality are apparent (Figure 1), with significant disparities between dominant groups and communities facing marginalization along lines of race, caste, ethnicity, gender, and sexuality in countries around the world, at all income levels. In former colonial powers such as France and the United Kingdom, white people experience markedly superior health outcomes and health service access compared to Black and other minoritized populations. A similar pattern is apparent in the United States of America, a settler colonial society where extensive enslavement of African people formed a pillar of national prosperity. In Australia, another example of settler colonialism, substantial disparities in health outcomes are apparent between the indigenous and non-indigenous populations.



The effects of racism on the health and wellbeing of Roma people

The history of enslavement and exclusion of Roma people, enforced by violence
hierarchies premised on white supremacy, follows a history that is familiar to rac
and the broader European colonial project. After Romani people departed from t
homelands almost a millennium ago, empires and peripheral and semi-peripher
peaceful Roma migrants to oppression and disdain across Europe.[82] Systematic
can be traced to the Middle Ages[83], resulting in enslavement, denial of settleme
and exploitation. [84] [85] [86]

Colonisation, racism and health in practice:
A case study of Guatemala

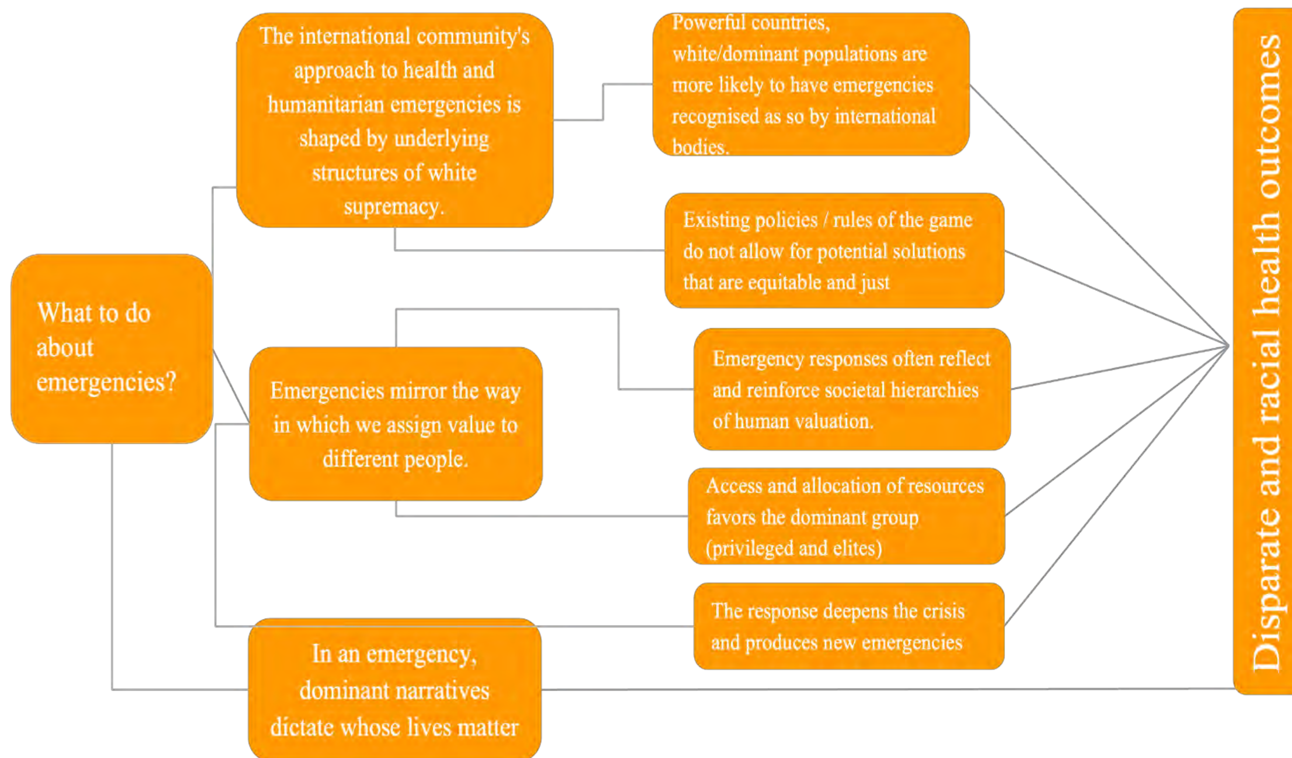
Beginning in the 16th century, colonial conquest inaugurated a syst
political and military subjugation and contempt for the humanity, b
populations of Mesoamerica. As a study of the history of Guatema
resulted in devastating and continuing health consequences for in

Health systems and human health

A health system "consists of all the organisations, institutions, reso
purpose is to improve health"[102], including both state and non-stat
preventive, promotive, curative and rehabilitative interventions, as
determinants of health. Using the WHO framework for health syste
examined how racism operates within the structures, policies, prac
WHO's health system building blocks: service delivery, workforce, I
medical products, leadership and governance.

Using this framework is valuable, as strengthening health systems
and constraints in each of these six areas. However, in the view of t

*Racism and colonialism permeate and distort the international community's responses to **health and humanitarian crises and emergencies***



- The racialized politics of declaring an emergency
- The racialized politics of responding to an emergency
- How emergency responses reflect differential valuations placed on human lives
- Emergency responses and pre-existing narratives and disparities
- How non-existent or inadequate emergency responses deepen health crises and give rise to new emergencies

Academia, medical journals and research funders:
The silencing and marginalization of researchers from the global South

Global health discourse is primarily controlled by voices from the global North. N
have noted that this discourse is animated by a 'white savior' syndrome, whereby
is understood naturally to reside in the global North and is occasionally, paternal
take care of the global South.[312]

Haiti, cholera and the legacy of colonisation

Haiti's long history of colonisation has left it among the world's poorest
capita GDP in the western hemisphere.[322] The country's vulnerabilities
exacerbated in recent years by the world's racialized approach to healt

Once the world's most profitable colony[323], Haiti was the second Europ
gain independence and the first to abolish slavery. Rather than applauc
achievements, global powers opted instead for an official policy of opp
U.S. President Thomas Jefferson referring to the Haitian revolution as a
isolated.[324] Haiti's former coloniser, France, agreed to recognize Haitiar
on the condition of maintaining commercial colonisation, extracting co
plantation owners that was five times France's annual budget[325] and 10
paid Napoleon for the Louisiana Purchase of 1803.[326] These payments
GDP[327]) plunged Haiti into a cycle of debt that prevented it from investir

How the inadequate response is worsening the climate crisis

Although climate change poses an existential threat to planetary health, with n
harms visited on the least vulnerable people, the world has yet to mount a cred
commensurate with the immensity of the crisis. Indeed, climate-related actior
countries are making the climate crisis worse. From 2010 to 2022, rich countri
more to subsidize fossil fuels at home . . . than what they committed in interna
to support climate-vulnerable countries."[368] The parsimony of the global North
especially striking, given that the global North, comprising 14% of the world's p
92% of excess carbon dioxide emissions from 1850 to 2022.[369]

Both the climate crisis, and the way it is (not) being effectively tackled, is both
perpetuation of colonial structures. The fossil fuels burned by rich countries ov
centuries derive in large measure from the extraction of resources from the glo

Palestine: A case study on the right to health

The International Court of Justice confirmed in 2024 what had long bee
prolonged occupation of Palestinian territory, including forced displace
and deprivation of the rights of the Palestinian people to self-determin
international laws, including but not limited to international human rig

Defining when an emergency or crisis triggers an international response

A threshold challenge encountered by the Commission in its exploration of internati
responses has to do with the varying definitions used by lead UN organizations for h
humanitarian and environmental/disaster emergencies. In addition to inconsistenci
definitions, the Commission found that these definitions often exclude emergencies
income countries, especially those that are prolonged and that disproportionately a
populations, such as women, girls, children and people living with HIV.

WHO's International Health Regulations (2005)[286] covered extraordinary events dete
constitute a public health risk to other States through the international spread of dis
potentially require a coordinated international response." However, the IHR proved u
a robust, coordinated response" to COVID-19, primarily due to the "inequality in res
and power between high-income countries and low-income and middle-income cou

Overview of the writing process

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Commissioner workstreams ⇄ **Drafting committee** ⇄ **Commission**

Commissioner workstreams	Drafting committee	Commission
Plan activity	Compile outputs from different workstreams	Convene & discuss v1
Consultation/ data collection	Analyze	Revise v1 to incorporate feedback & draft v2
Collate arguments & findings	Synthesize & frame	Convene & discuss v2
Share output with secretariat	Draft report v1	Revise v2 to incorporate feedback & finalize

Final edits

Submit to *The Lancet* for peer-review

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<Up to ~July 2024> <Mar-Aug 2024> <Aug 2024 – Apr 2025> <May - Aug 2025>

Thank you!