

# Towards a bidirectional decoloniality in academic global health: insights from settler colonialism and racial capitalism

Bram Wispelwey, Chidinma Osuagwu, David Mills, Tinashe Goronga, Michelle Morse



This Viewpoint considers the implications of incorporating two interdisciplinary and burgeoning fields of study, settler colonialism and racial capitalism, as prominent frameworks within academic global health. We describe these two modes of domination and their historical and ongoing roles in creating accumulated advantage for some groups and disadvantage for others, highlighting their relevance for decolonial health approaches. We argue that widespread epistemic and material injustice, long noted by marginalised communities, is more apparent and challengeable with the consistent application of these two frameworks. With examples from the USA, Brazil, and Zimbabwe, we describe the health effects of settler colonial erasure and racial capitalist exploitation, also revealing the rich legacies of resistance that highlight potential paths towards health equity. Because much of the global health knowledge production is constructed from unregenerate contexts of settler colonialism and racial capitalism and yet focused transnationally, we offer instead an approach of bidirectional decoloniality. Recognising the broader colonial world system at work, bidirectional decoloniality entails a truly global health community that confronts Global North settler colonialism and racial injustice as forcefully as the various colonialisms perpetrated in the Global South.

## Introduction

Within the last 5 years, amidst a global reckoning with racism and deeply inequitable pandemic responses, a movement has emerged aimed at acknowledging and transforming the colonial nature and practice of global health. After a whirlwind of publications, conferences, webinars, and even the earning of its own acronym, by 2021, there were increasing calls to decolonise the decolonising global health (DGH) movement itself.<sup>1</sup> The range of decolonial focus areas included knowledge production and epistemology,<sup>2</sup> educational curricula, reforms to alleviate power imbalances,<sup>3</sup> efforts to include, centre, and follow Global South voices,<sup>4</sup> and at the more transformational end, calls to dismantle structures and accelerate a radical redistribution of power.<sup>5</sup> This last approach engages most directly with decolonial and anticolonial theories, and it also gets closest to Tuck and Yang's definition of decolonisation, which requires nothing less than "the repatriation of Indigenous land and life".<sup>6</sup>

Although increasingly well represented in the social sciences, two crucial fields of interdisciplinary scholarship have been largely absent from the DGH discourse: racial capitalism and settler colonial studies. Representing distinct modes of domination that are continually intertwining and constructing each other, settler colonialism and racial capitalism have made and continue to shape the modern world.<sup>7</sup> Both frameworks provide a material lens to understanding oppression, offering an advance from incomplete or performative analyses and actions. Centring these concepts within DGH efforts provides a strong foundation from which the movement can resist the elite capture that often threatens transformational potential.<sup>8</sup> Most importantly, in clarifying how and why health inequities exist, settler colonialism and racial capitalism help identify the targets that should be changed or dismantled to achieve the movement's decolonial aspirations.

While Global South and Global North literally reference a geographical divide, we use the terms to connote the division of states along lines of power, colonial history, and associated wealth. For the Global South, this roughly corresponds to Africa, south Asia, southeast Asia, east Asia, the Middle East, South America, and Central America. For the Global North, this roughly corresponds to North America, Europe, Australasia, central Asia, and Japan.

## Settler colonialism and global health

Although there is some debate on how strictly to define a settler colonial context, a considerable minority of the planet's landmass remains settler colonised to this day across a dozen or so geographical settings, including those known as the USA, Canada, Australia, New Zealand, Israel, occupied Palestinian territory, and at least some of Latin America. Settler colonialism is a common social formation whereby organised groups from elsewhere, typically Europe, live on and exercise sovereignty over land inhabited by Indigenous communities. Whereas franchise colonialism is categorised by an "extractive relationship between a colonizing metropole and a colonized periphery",<sup>9</sup> as in British India or the Dutch East Indies, settler colonialism seeks to eliminate Indigenous populations and societies to replace them, eventually collapsing the conceptual and physical distinction between metropole and periphery. Although revolutionary independence movements throughout the 20th century brought franchise colonialism to an end, or at least into neocolonial stages, settler colonialism has endured into the present. Because "settler colonizers come to stay", their invasion and subsequent occupation of Indigenous land is an enduring "structure not an event" with ongoing health effects.<sup>10</sup>

Settler colonialism is a shapeshifter with tools and technologies that evolve in conjunction with other oppressive structures (eg, heteropatriarchy and white

Lancet Glob Health 2023;  
11: e1469–74

FXB Center for Health and Human Rights, Harvard University, Boston, MA, USA (B Wispelwey MD, D Mills MD); Department of Medicine, Harvard Medical School, Boston, MA, USA (M Morse MD); Division of Global Health Equity, Brigham and Women's Hospital, Harvard Medical School, Boston, MA, USA (B Wispelwey); Department of Global Health and Population, Harvard TH Chan School of Public Health, Boston, MA, USA (B Wispelwey); Lewis Katz School of Medicine at Temple University, Philadelphia, PA, USA (C Osuagwu BA); Global Health Program, Boston Children's Hospital, Boston, MA, USA (D Mills); Department of Pediatrics, University of California San Diego, San Diego, CA, USA (D Mills); Centre for Health Equity Zimbabwe, Equal Health Global Campaign Against Racism, Harare, Harare, Zimbabwe (T Goronga MBCHB); New York City Department of Public Health and Mental Hygiene, New York, NY, USA (M Morse)

Correspondence to:  
Dr Bram Wispelwey, FXB Center for Health and Human Rights, Harvard University, Boston, MA 02115, USA  
bwispelwey@hsph.harvard.edu

supremacy) to further Indigenous dispossession.<sup>11</sup> These tools include direct frontier violence, land appropriation, forced displacement, sequestration into reservations or camps, various forms of assimilation, and weaponised legal strategies among others. The settler movement ultimately attempts to cover its tracks through the literal and discursive disappearing of Indigenous populations, often with claims to the symbolic and material inheritance of Native title or to a genetic ancestry without present Indigenous relationality.<sup>12–14</sup> Settler society then fabricates indigeneity as just another thread within the liberal multicultural tapestry: Indigenous sovereignty is renounced, their dispossession disavowed, and mention of colonialism ceases. The effect of these processes on the social determinants of health has been considerable: compared with non-Indigenous and settler peoples globally, Indigenous communities are more than three times as likely to live in extreme poverty, and they experience consistent health inequities across geographies.<sup>15</sup>

One particularly important insight from settler colonial theory for the DGH movement is an exploration of what underlies attempts, implicit in the movement's name, to metaphorise decolonisation—to make the term mean something other than the return of land and Indigenous authority over it. Tuck and Yang suggest that in settler colonial contexts, a form of settler anxiety underlies calls to decolonise, which, when not accompanied by bold anticolonial action, reflect premature attempts at reconciliation.<sup>6</sup> In efforts to avoid complicity and guilt, settlers attempt to transform other social justice causes into decolonial ones to avoid the Indigenous persistence that continues to haunt them. The over-representation of settler Global North voices in the DGH movement is, therefore, not just a matter of exploiting the spoils of coloniality (eg, access, language, time, and resources). It also reflects a deeper sociopsychological need to somehow evade or transcend participation in the continuing local usurpation of Indigenous land to secure a morally unburdened settler futurity.

### Settler colonialism and racialisation

In the global health sphere, the conception of settler colonialism as an ongoing driver of inequitable health outcomes for Indigenous populations has yet to permeate mainstream academic discourse. Pervasive explanations for Indigenous health disparities, such as native biological or cultural inferiority, have long shaped settler academic understandings of Indigenous health,<sup>16</sup> and only the persistence of Indigenous scholars has ensured the presence of structural and historical framings that capture the logic of elimination inherent to settler movements.<sup>17</sup> By clarifying the root cause of higher rates of Indigenous morbidity and mortality, settler colonial theory provides a path to causal clarity.<sup>18</sup> The framework also offers a starting point to challenge the epistemic and structural violence against Native populations by

identifying material health-promoting targets within decolonial agendas (panel).

The primary goal of settler colonialism—land accumulation via Native elimination—can help us better understand how it achieves a means to an end, including by the crafting of races made in the targeting of peoples primarily for their land or for their labour.<sup>10</sup> Race in the modern era broadly operates such that distinction from whiteness, often imprecisely determined by origin or physical characteristics, implies group-based cultural, social, cognitive, or moral inferiority, but different forms of colonial targeting can generate divergent processes of racialisation. This differential racialisation is seen most prominently in the US case wherein Indigenous people have been racialised to disappear to appropriate more land, whereas Black Americans were historically racialised to multiply—infamously requiring just one drop of African ancestry—to maximise enslaved labour.<sup>6,10</sup> By land accumulation and labour exploitation, white supremacy is served in both forms of targeting, reinforced by western scientific rationalisation and embedded within the structures of settler governance, law, politics, health, education, and the criminal punishment system. Society then becomes structured into “a relatively secure or sedimented set of hierarchies that continue to facilitate the dispossession of Indigenous peoples of their lands and self-determining authority”,<sup>27</sup> while also extracting maximum wealth from the racialised labour regimes of racial capitalism.

### Racial capitalism and global health

Like settler colonialism, racial capitalism contributes to the formation and evolution of race because “violent dispossessions inherent to capital accumulation operate by creating, leveraging, and intensifying racial distinctions”.<sup>28</sup> Among the many important insights from racial capitalism is that there is, in fact, no other existing form of capitalism.<sup>29</sup> Race operates to normalise the capitalist method of producing and distributing resources unequally by naturalising social power and privilege. Borrowing the phrase and concept of racial capitalism from South African activists, Cedric Robinson argued that racialisation within Europe predates mercantile capitalism and the slave trade, but ultimately fused with them to constitute modern capitalism's racialised and gendered hierarchies.<sup>30</sup> Because the steep social hierarchies that capitalism requires for profit are difficult to maintain even with brute force, essentialising groups of peoples as inferior by racialisation serves to rationalise society's inequitable organisation.

The history of fusing race with labour in pursuit of extractive profit is most notoriously captured in transatlantic slavery, but racial capitalism also elucidates the highly racialised realms of environment, housing, education, and workforce that are perpetuated nowadays on a global scale. Race and racism are constantly mutating under pressure from capital to shore up

### Panel: Actionable priorities for a bidirectional decoloniality that confronts and resists settler colonialism and racial capitalism

#### Resisting settler colonialism

- Learn: start with the knowledge-based imperatives for non-Indigenous global health practitioners adapted from Smylie and colleagues<sup>19</sup> and other Indigenous calls to action.
- Understand: following Indigenous leadership and scholarship, learn the local histories of Indigenous peoples, their ongoing presence on the land where you live and work, and the manifestations of settler colonialism and their effect on health today.<sup>18</sup> Integrate this knowledge into a cycle of learning and disruptive action.
- Engage discomfort: move into responsibility and move away from immobilising shame, sorrow, or rationalisations towards innocence. Channel emotions into tangible actions that are accountable to Indigenous recommendations and community and embrace an identity as co-conspirator in the struggle for Indigenous land, justice, sovereignty, resurgence, and health.
- Research ethically: study the frameworks of Indigenous scholars, seek their guidance on collaborations and initiatives, and source Indigenous scholarship in your work. Familiarise yourself with Smith's *Decolonizing Methodologies*,<sup>20</sup> and follow the guidelines from Friedman and colleagues for preventing Indigenous data genocide and erasure.<sup>21</sup>
- Take action: whereas settler colonial projects share similarities across time and space, each project also exhibits specific health-affecting manifestations, making blanket recommendations for concrete actions unsuitable. The important step is to seek local Indigenous struggles and calls for support, talk with the people, and contribute in tangible ways (eg, magnifying Indigenous calls, educating fellow settlers, and contributing resources). One universal and pragmatic step for global health practitioners and scholars to promote health across settler colonised geographies is to join the struggle for Land Back. Land Back is the project of returning land to native stewardship and territorial jurisdiction, which additionally offers a tangible, proven means of combating climate change and its current and impending global health effects.<sup>22</sup> There are numerous successful examples of returned land, and ongoing efforts can benefit from pragmatic settler solidarity and activism. Join local efforts, and start with guides, such as the Land Reparations and Indigenous Solidarity Toolkit or Yellowhead Institute Community Tools and Resources.
- Understand: following the leadership and scholarship of racially marginalised groups, learn the histories of racial capitalism and white supremacy where you live and work, and their global interconnections. Seek praxis, a continuous cycle of learning and action, to both grasp and challenge how racial capitalism shapes the social determinants of health today.
- Engage discomfort: for White people, avoid responding to awareness of racial capitalism with defensiveness, hostility, or immobilising shame. Embrace responsibility and support tangible means of betraying your unethically dominant, if unchosen, social position to become a co-conspirator for racial justice and against capitalist exploitation.
- Research ethically: avoid health equity tourism, "parachuting into the field in response to timely and often temporary increases in public interest and resources".<sup>23</sup> Instead, support racially marginalised colleagues who have been toiling for years to document racial capitalism's health effects in an historically underfunded and under-recognised field.
- Take action: pragmatic actions should be housed within an abolitionist framework, which seeks to end all forms of systemic, racialised violence, and captivity. As theorised by Gilmore channelling Du Bois, abolition also goes beyond dismantling the existing racial capitalist and settler colonial order to become a "fleshly and material presence of social life lived differently", with the creation of crucial life-affirming systems of human support.<sup>24</sup> Whereas the centuries of harm cannot be undone, a tangible means of moving towards such a future begins with reparations, which requires joining and supporting mobilised and community-directed movements.
- Reparations are the responsibility of state governments and provide redress for the past and ongoing harms of slavery and colonial and state-sponsored racism, exploitation, and dispossession. Reparations, when modelled, improve health and extend life.<sup>25</sup> Efforts are ongoing in various global contexts, and the decolonising global health movement should organise in support of reparative state legislation (eg, HR 40 in the USA) and Global South debt cancellation. Whereas approaches to reparations often centre harm restitution or reconciliatory justice, Táíwò has recently put forward a constructive model that more directly challenges racial capitalism via a future-oriented project promoting a new social order of the kind suggested by Gilmore.<sup>26</sup>

#### Resisting racial capitalism

- Learn: start with knowledge-based imperatives for global health practitioners and scholars.

For HR 40 see <https://www.congress.gov/bill/117th-congress/house-bill/40/text>

For Land Reparations and Indigenous Solidarity Toolkit see <https://resourcegeneration.org/land-reparations-indigenous-solidarity-action-guide/>

For Yellowhead Institute Community Tools and Resources see <https://redpaper.yellowheadinstitute.org/>

incarcerated, trafficked, coerced, uncompensated, and poorly compensated labour that is also gendered. This labour regime maximises profit and functioning for the major players in global health via direct means, as with

the profit-seeking behaviours and racialised workforce hierarchies of pharmaceutical companies, multilaterals, hospitals, and universities, and by indirect means via non-governmental organisations that rely on donations

from those with wealth built on racialised extraction.<sup>31</sup> A crucial inquiry of racial capitalism raises the possibility that there can be no decolonial global health without new economic and organisational systems that do not demand ongoing dispossession and exploitation of group-based differences to flourish.

### Epistemic injustice and global health praxis

In 1998, two centuries after the revolutionary removal of the colony of Saint-Domingue and its tens of thousands of White settlers, a community of people living with HIV in rural Haiti declared that it is “we who take the responsibility to declare our suffering, our misery, and our pain, as well as our hope. We hear many poignant statements about our circumstances, but we feel compelled to say something more categorical and more resounding than what we have heard”.<sup>32</sup> Among the Cange Declaration’s demands to an audience of wealth and power was an injunction to stop the propagation of “erroneous assumptions about our right to health and our unconditional right to life”.<sup>32</sup> In correcting these erroneous assumptions, the declaration highlights the importance of the reconstitution of Global South and Indigenous narratives and epistemologies in the struggle against the naturalised epistemic dominance in academic global health and beyond.

This epistemic reconstitution—the resurgence of knowledge and narratives that have been repressed, denigrated, and marginalised in building colonial modernity—is under way. With the health effects of racial capitalism and settler colonialism increasingly theorised and investigated,<sup>38</sup> knowledge production pathways are readily available for global health scholars interested in challenging the epistemic violence inherent to many mainstream frameworks of public health. Beyond the global health facts being recorded and described, the theory, causal assumptions, and frameworks are essential to adequately explain observations and to design productive interventions.<sup>33</sup> The question of which frameworks a DGH movement embraces, therefore, could not be more important.

An example of the type of reframing afforded by a settler colonial analytic is instructive. The use of data to generate a popular narrative of White American disadvantage in deaths of despair has recently been recharacterised as a form of Indigenous data genocide.<sup>21</sup> Deaths of despair, which include mortality from suicide, drug overdose, and alcohol-associated diseases, are those related to the conviction that one’s life prospects are bleak. In the 21st century, deaths of despair were far higher and increased more considerably among American Indians than White Americans, but American Indians were entirely excluded from the original analysis.<sup>34</sup> Summarising their recent reappraisal of this data, Gone notes that “The entire narrative about deaths of despair among White Americans depended on the invisibility, or, we might say, the erasure of

indigenous presence in those datasets.”<sup>35</sup> This erasure “is not merely an act of passive, neutral omission; such neglect constitutes an active re-inscription—and therefore legitimation—of global health inequities along colonial lines”.<sup>36</sup>

In the Global South, ongoing displacements generated by economic extraction highlight how racial capitalism and settler colonialism work in tandem to negatively affect human and environmental health. In Brazil, compared with non-displaced Indigenous people whose livelihoods are relatively unscathed by settler colonialism, Indigenous people enduring forest habitat destruction and displacement to urban areas experience rapid increases in hypertension, obesity, and cardiovascular mortality.<sup>37</sup> Even previous to urban displacement, incremental changes in death rates occur with the onset of deforestation, highlighting the multiple layers of dispossession that link both settler colonialism and racial capitalism to human and environmental health outcomes. Resistance is crucial, as Indigenous legal victories against deforestation in Brazil resulted in a dramatic 20-fold reduction in forest losses within 5 years, mirroring the effect of North American Indigenous success in halting up to a quarter of annual greenhouse gas emissions from the USA and Canada.<sup>22</sup>

Resistance to settler colonialism has also informed a strong health justice legacy in African nations, wherein Indigenous peoples are often overlooked within settler colonial studies.<sup>38</sup> 4 years after securing independence and successfully dissolving the possibility of Rhodesia as a racialised settler colonial nation–state, the newly established Government of Zimbabwe released a 1984 white paper detailing its plan to transform the colonial health system into one that was socialised and designed for racial equity.<sup>39</sup> Informed by the Alma-Ata Declaration’s commitment to primary health care as the key to attaining Health for All, Zimbabwe had for a time one of the highest performing health systems in Africa.<sup>40</sup> While acknowledging the importance of local political and governance challenges, this health system success was ultimately derailed by neoliberal austerity measures operating within the racial capitalist logic of Global North-enforced structural adjustment programming.<sup>41</sup> Instead of capitalising on such unjust circumstances with Global North and settler job creation initiatives that reify and strengthen existing hierarchies in global health, a DGH movement could instead centre Global South and Indigenous narratives and initiatives within an understanding of our world as shaped continually—but not inevitably—by settler colonialism and racial capitalism.

### Towards a bidirectional decoloniality

Although building transnational solidarity with the expert leadership of those who were formerly colonised provides a desirable programme, solidarity from the Global North that is solely outward facing can reiterate settler colonial logics. Tuck and Yang note that “The anti-

colonial turn towards the transnational can sometimes involve ignoring the settler colonial context where one resides, in order to establish ‘global’ solidarities that presumably suffer fewer complicities and complications”.<sup>6</sup> This simplified form of solidarity is further implicated in Byrd’s contention that modern US imperialism is an expansion of North American settler colonialism via global reiterations of pioneer logics that were honed in confrontation with the Indian.<sup>42</sup> Byrd’s point confirms that any meaningful global decolonising from settler colonial contexts can only emerge alongside local decolonising processes led by presently colonised peoples.

Similarly, a decolonial global health landscape cannot materialise from those whose social positions are settler, White, or wielders of power and influence within untransformed Global North institutions, even with extensive DGH efforts aimed at re-education and mobilisation. The colonised people will struggle to secure their own decolonial agendas whereas co-conspirators from groups with settler or other dominant positions might be invited to collaborate as self-identified traitors to their social locations. Bringing settler colonialism and racial capitalism forward could be one pathway for Global South communities to expand and redirect attention generated and received from the DGH movement back towards the settler colonial metropolises, such as the USA, that command a solely outward-facing discourse while maintaining colonial domination of native nations and other racialised populations.

What happens when the global health gaze is reversed, reflected at powerful settler states, such as the USA by the native peoples (eg, those of Zimbabwe, Kenya, Namibia, Libya, Algeria, etc) who have successfully thwarted European attempts at sovereign settler colonial societies? Or when it becomes more widely acknowledged that health inequities in Global North states, such as the USA eclipse many of the disparities between high-income and low-income countries when assessed along the colonial axes of Black–White and native–settler? A decolonial global health landscape requires something more than the end of North-to-South neocolonial formations in academic and pragmatic engagement. A transformative movement will instead show a bidirectional decoloniality, aimed at colonisation within the Global North as much as that perpetrated in the Global South, refusing inherited academic and geographical siloes. Such a decoloniality entails a disruption of the extractive, exploitative, and eliminatory logics that naturalise the health inequity-generating hierarchies between and within colonising and colonised societies. Wherever we find ourselves, the urgent need for practical decolonial solidarities is, literally, all around us.

#### Contributors

BW conceived and wrote the original draft. CO and DM wrote additional sections. All authors contributed to conceptualisation and extensively

revised the article. This is a multinational team of physicians with a medical student, each working at the intersections of health and racism and colonialism across a geographical range of settler colonial contexts. Regarding our positionality within the triad frameworks from Indigenous scholars Eve Tuck (Unangax), Jody Byrd (Chickasaw), and Aileen Moreton-Robinson (Goenpul), among others, our author team includes Indigenous (TG), settler (BW and DM), and arrivant (CO and MM) coauthors. In terms of racial positionality, we are Black (CO, TG, and MM) and White (BW and DM). With one exception (TG from Zimbabwe), we are currently university-based in the settler colonial USA (BW, CO, DM, and MM), living and working on unceded Massachusetts and Lenape land. In the apt words of Corey Snelgrove, Rita Dhamoon, and Jeff Cornstassel, a writing team with similarly diverse positionality, “we seek to explore possible lines of solidarity, accountability, and relationality to one another and to decolonization struggles both locally and globally”.<sup>43</sup>

#### Declaration of interests

We declare no competing interests.

#### Acknowledgments

We are grateful to Mary Bassett for her helpful comments on an earlier manuscript draft and for ongoing conversations on these topics. BW would also like to thank Artair Rogers for highlighting a couple of key references and for topical discussions during the editing stage.

#### References

- 1 Opara I. It’s time to decolonize the decolonization movement. July 29, 2021. <https://speakingofmedicine.plos.org/2021/07/29/its-time-to-decolonize-the-decolonization-movement/> (accessed Jan 9, 2023).
- 2 Bhakuni H, Abimbola S. Epistemic injustice in academic global health. *Lancet Glob Health* 2021; **9**: e1465–70.
- 3 Khan M, Abimbola S, Aloudat T, Capobianco E, Hawkes S, Rahman-Shepherd A. Decolonising global health in 2021: a roadmap to move from rhetoric to reform. *BMJ Glob Health* 2021; **6**: e005604.
- 4 Oti SO, Ncayiyana J. Decolonising global health: where are the Southern voices? *BMJ Glob Health* 2021; **6**: e006576.
- 5 Chaudhuri MM, Mkumba L, Raveendran Y, Smith RD. Decolonising global health: beyond ‘reformativ’ roadmaps and towards decolonial thought. *BMJ Glob Health* 2021; **6**: e006371.
- 6 Tuck E, Yang KW. Decolonization is not a metaphor. *Decolonization Indig Educ Soc* 2012; **1**: 1–40.
- 7 Koshy S, Cacho LM, Byrd JA, Jefferson BJ, eds. Colonial racial capitalism. Durham: Duke University Press, 2022.
- 8 Táiwó OO. Elite capture: how the powerful took over identity politics (and everything else). Chicago, IL: Pluto Press, 2022.
- 9 Sylvestre P, Castleden H, Denis J, Martin D, Bombay A. The tools at their fingertips: how settler colonial geographies shape medical educators’ strategies for grappling with anti-Indigenous racism. *Soc Sci Med* 2019; **237**: 112363.
- 10 Wolfe P. Settler colonialism and the elimination of the Native. *J Genocide Res* 2006; **8**: 387–409.
- 11 Ray L, Wylie L, Corrado AM. Shapeshifters, systems thinking and settler colonial logic: expanding the framework of analysis of Indigenous health equity. *Soc Sci Med* 2022; **300**: 114422.
- 12 O’Brien JM. Firsting and lasting: writing Indians out of existence in New England. London, OH: University of Minnesota Press, 2010.
- 13 Veracini L. Introducing: settler colonial studies. *Settl Colon Stud* 2011; **1**: 1–12.
- 14 TallBear K. Native American DNA: tribal belonging and the false promise of genetic science. Minneapolis, MN: University of Minnesota Press, 2013.
- 15 Anderson I, Robson B, Connolly M, et al. Indigenous and tribal peoples’ health (The Lancet–Lowitja Institute Global Collaboration): a population study. *Lancet* 2016; **388**: 131–57.
- 16 Hay T. Commentary: The invention of aboriginal diabetes: the role of the thrifty gene hypothesis in Canadian health care provision. *Ethn Dis* 2018; **28** (suppl 1): 247–52.
- 17 Walters KL, Mohammed SA, Evans-Campbell T, Beltrán RE, Chae DH, Duran B. Bodies don’t just tell stories, they tell histories: embodiment of historical trauma among American Indians and Alaska natives. *Du Bois Rev* 2011; **8**: 179–89.

- 18 Wispelwey B, Tanous O, Asi Y, Hammoudeh W, Mills D. Because its power remains naturalized: introducing the settler colonial determinants of health. *Front Public Health* 2023; **11**: 1137428.
- 19 Smylie J, Harris R, Paine S-J, Velásquez IA, Nimatuj, Lovett R. Beyond shame, sorrow, and apologies—action to address indigenous health inequities. *BMJ* 2022; **378**: o1688.
- 20 Smith LT. Decolonizing methodologies: research and indigenous peoples, 3rd edn. London: Bloomsbury Publishing, 2021.
- 21 Friedman J, Hansen H, Gone JP. Deaths of despair and Indigenous data genocide. *Lancet* 2023; **401**: 874–76.
- 22 Hernandez J, Meisner J, Bardosh K, Rabinowitz P. Prevent pandemics and halt climate change? Strengthen land rights for Indigenous peoples. *Lancet Planet Health* 2022; **6**: e381–82.
- 23 Lett E, Adekunle D, McMurray P, et al. Health equity tourism: ravaging the justice landscape. *J Med Syst* 2022; **46**: 17.
- 24 Gilmore RW. Abolition geography: essays towards liberation. London, New York, NY: Verso, 2022.
- 25 Himmelstein KEW, Lawrence JA, Jahn JL, et al. Association between racial wealth inequities and racial disparities in longevity among US adults and role of reparations payments, 1992 to 2018. *JAMA Netw Open* 2022; **5**: e2240519.
- 26 Táiwò OO. Reconsidering reparations. New York, NY: Oxford University Press, 2022.
- 27 Coulthard GS. Red skin, white masks: rejecting the colonial politics of recognition. Minneapolis, MN: University of Minnesota Press, 2014.
- 28 Jenkins D, Leroy J. Histories of racial capitalism. In: Jenkins D, Leroy J, eds. Histories of racial capitalism. New York, NY: Columbia University Press, 2021.
- 29 Melamed J. Racial capitalism. *Crit Ethn Stud* 2015; **1**: 76–85.
- 30 Robinson CJ. Black Marxism: the making of the Black radical tradition. Chapel Hill, NC: University of North Carolina Press, 2000.
- 31 Giridharadas A. Winners take all: the elite charade of changing the world, First Vint. New York, NY: Vintage Books, 2019.
- 32 Partners In Health. Cange Declaration: PIH's first HIV patients advocate for equal access to treatment. Dec 1, 2013. <https://www.pih.org/article/cange-declaration-pih-first-hiv-patients-advocate-for-equity-in-access-to> (accessed March 13, 2023).
- 33 Krieger N. Ecosocial theory, embodied truths, and the people's health. New York, NY: Oxford University Press, 2021.
- 34 Case A, Deaton A. Rising morbidity and mortality in midlife among white non-Hispanic Americans in the 21st century. *Proc Natl Acad Sci USA* 2015; **112**: 15078–83.
- 35 Chatterjee R. Native Americans hit hard by 'deaths of despair' but were left out of the data. 2023. <https://www.npr.org/sections/health-shots/2023/02/01/1152222968/native-americans-left-out-of-deaths-of-despair-research> (accessed March 13, 2023).
- 36 Richardson ET, McGinnis T, Frankfurter R. Ebola and the narrative of mistrust. *BMJ Glob Health* 2019; **4**: e001932.
- 37 Kramer CK, Leitão CB, Viana LV. The impact of urbanisation on the cardiometabolic health of Indigenous Brazilian peoples: a systematic review and meta-analysis, and data from the Brazilian Health registry. *Lancet* 2022; **400**: 2074–83.
- 38 Kelley RDG. The rest of us: rethinking settler and native. *Am Q* 2017; **69**: 267–76.
- 39 Manga P. The transformation of Zimbabwe's health care system: a review of the white paper on health. *Soc Sci Med* 1988; **27**: 1131–38.
- 40 Alcorn T. Harlem to Harare. Feb 28, 2023. <https://www.thinkglobalhealth.org/article/harlem-harare> (accessed June 6, 2023).
- 41 Mukherjee J. An introduction to global health delivery: practice, equity, human rights. New York, NY: Oxford University Press, 2021.
- 42 Byrd JA. The transit of empire: Indigenous critiques of colonialism. Minneapolis, MN: University of Minnesota Press, 2011.
- 43 Snelgrove C, Dhamoon R, Corntassel J. Unsettling settler colonialism: the discourse and politics of settlers, and solidarity with Indigenous nations. *Decolonization Indig Educ Soc* 2014; **3**: 1–32.

Copyright © 2023 The Author(s). Published by Elsevier Ltd. This is an Open Access article under the CC BY 4.0 license.