Time to take critical race theory seriously: moving beyond a colour-blind gender lens in global health

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In 2020, as worldwide protests demanded racial justice, the COVID-19 pandemic shed a stark light on racial inequities in global health: one need look no further than the disproportionate burden shouldered by Black and other racial minority groups in the Americas and Europe.[1] Yet, despite the purported racial reckoning of the moment, the global health community has been slow to consciously centre race in our work. This seeming racial inertia persists despite fervent advocacy and conceptual rigour around addressing gender inequity, even in the face of ample awareness of the intertwined disadvantages faced worldwide by women who are racial minorities.[2,3] As women of colour scholars, practitioners, and educators whose work addresses race, gender, and class inequity, we recognise that it is vitally important to take a gender lens to addressing health inequities. But this gendered perspective must not be unidimensional. We now call upon our colleagues, particularly influencers in high-income countries, to meaningfully engage with critical race theory, a transdisciplinary intellectual movement to understand and disrupt systemic racism. Of particular relevance to these efforts is the concept of intersectionality, a central tenet of critical race theory coined by Kimberlé Crenshaw to describe how multiple social categorisations—such as race and gender—interact and confer interlocking oppressions and privileges.[4] This intentional centring of race in global health will help to achieve the mutually reinforcing goals of eradicating both racial and gender inequity. As a point of departure, we articulate the multiple racial contexts of the global health sector, with the aim of moving beyond a colour-blind gender lens.

We are pleased that scholars and advocates of global health and gender now acknowledge the importance of explicating the interlocking oppressions of gender inequity and racism, among other "-isms".[2,5] For decades, the concept of intersectionality has been foundational to scholarship addressing systemic racism, most prominently in the USA with respect to simultaneous oppressions due to race and gender.[4,6] Nowadays, concepts such as intersectionality are also applied to other social categories, such as religion, nationality, and socioeconomic status.[3] However, the concept of intersectionality is a relatively new addition to the global health gender lexicon. The deep wellspring of learnings it affords remains underused in mainstream initiatives on gender and global health. For example, little attention is given to ethnoracial imbalances in discussions about the dearth of women in global health leadership. Consider the ambitious Global Health 50/50 workforce analysis, which revealed that women comprise 70% of global health workers, but less than 5% of leadership positions.[7] The finding that 84% of global health organisations are headquartered in the USA or Europe[7] invites further questions about ethnoracial disparities within headquarters and across their international offices. Which women of which nationalities are in senior management? And where are American or European women of colour situated in the organigrams of headquarters staff?

As delineated in Ford and Airhihenbuwa's Public Health Critical Race Praxis,[6] we must first develop a consciousness about the intersecting racial contexts of global health work. The notion of racial consciousness should ring familiar to those who use a gender lens to understand how health is influenced by gendered biases and norms. Like gender's problematic binary of male versus female, race is a complex social construct with biological implications, the classifications of which vary across history and geography.[8] Globally, many societies—particularly racially homogeneous ones—do not regard race as the predominant societal fault line along which health disparities fall. But it bears

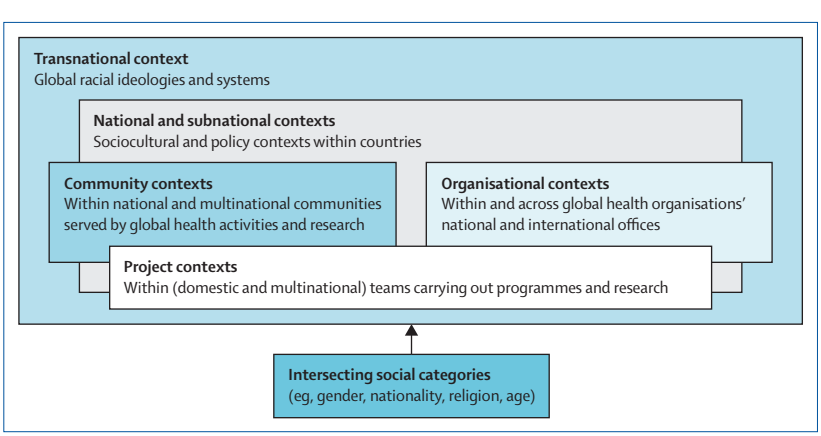

Figure: **Multilayered and intersecting racial contexts in global health**

reminding that global health research and practice take place in multiple, interlocking racial contexts (figure).

At a transnational level, the preponderance of resources and decision making lie in the hands of male executives, editors, and donors in majority-White, high-income countries—an entrenched legacy of the colonial antecedents of foreign aid writ large. In their cogent reflection on recent, invigorated calls to decolonise global health, Abimbola and Pai note that global health practice "emerged as an enabler of European colonization of much of the rest of the world."[9] A sober appreciation of our sector's history is essential for any global health professional. We see this dynamic playing out in the global roll-out of COVID-19 vaccines: less-resourced countries are far from the front of the queue.[10] At national, subnational, and community levels, systemic racism is often embedded in policies and hegemonic Euro-American sociocultural frameworks. That racism so frequently undergirds health and other social disparities across and within countries is a fact seldom prioritised in global health initiatives. Last, within organisations and programmes—often comprising multinational colleagues spread across countries—there are racialised hierarchies interacting along several axes. Multiple racial dynamics are at play in an HIV prevention project in Nigeria funded by a European donor, managed by European and Nigerian non-governmental organisation staff, in partnership with Nigerian adolescent girls. And, cutting across these racial contexts, power is unevenly distributed, with race intersecting with other societal privileges and oppressions, such as gender or nationality. Within each context, acknowledgement and redress of racialised, gendered power imbalances are long overdue.

Current impassioned conversations about systemic racism present an opportunity to embrace race as an omnipresent factor influencing global health practice, research, and outcomes. This racial consciousness needs to be part and parcel of our efforts to address gender inequity worldwide. Now, more than ever, we must centre our work on people at the racial margins, in each of the intersecting racial contexts of the global health sector. Only then will we develop an essential sense of humility and self-awareness to be antiracist in our work.

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