United Nations University
International Institute for Global Health

Enabling Environments to Advance Gender Equality in Health

UNU-IIGH Meeting Report,
June 2023

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United Nations University – International Institute for Global Health (UNU-IIGH), Kuala Lumpur, Malaysia is the designated UN think tank on global health, serving as a policy translation hub for UN member states, agencies and programmes.

Preface

In early 2020, UNU-IIGH embarked on a journey to better understand the field of futures and foresight and to examine the potential value to be garnered from its integration into our work.

‘Futures’ is defined as “a broad academic and professional field”, and ‘foresight’ as an approach to thinking “systematically about the future to inform decision-making today”. Adopting a futures mindset and implementing foresight methodologies enable us to break free of the constraints of the "now" to collectively imagine what could come "next”. By revisiting the past through the lens of hindsight and using foresight to collectively envisage an array of potential futures, many of which are not explored in traditional planning processes, discussions can yield valuable insights that can in turn be used to inform decision-making in the present and contribute to the the development of agile and adaptive policy environments.

At the start of this process, we made three recommendations to underpin our journey and support sustained, critical, and holistic applications of futures thinking and foresight approaches. These were to:

1. Cultivate ‘pracademics’: build a futures and foresight practice that combines a familiarity with the existing literature documenting conceptual and methodological developments in adjacent fields, opportunities to learn from experienced practitioners, and hands-on practical exposure.
2. Implement futures and foresight critically: embed processes to document and reflect on the experiences of integrating a futures and foresight lens and ensure that approaches align with foundational values of the institution, including respect for a diversity of opinions, contextualised solutions, and the advancement of equity.
3. Integrate foresight as part of a ‘jigsaw’ puzzle approach: augment and enhance existing research capacities with futures and foresight, systems thinking, and design thinking to develop, deploy, and iterate research outputs and policy recommendations.

Held in June 2023, the ‘Enabling Environments to Advance Gender Equality in Health’ meeting provided an opportunity to embed a decolonial feminist futures approach throughout the design and delivery from conception to completion. Taking place in Kuala Lumpur, Malaysia, this three-day in-person meeting brought together 28 delegates from 17 countries and across the life course for the primary goal of exploring how a decolonial feminist approach to futures might inform long-term strategic thinking on and yield valuable policy insights to create, facilitate, and sustain enabling environments to advance health equity and gender equality in systems for health by 2050. The workshop was co-designed with Dr. Katindi Sivi Njonjo and supported by the Canadian International Development and Research Centre (IDRC).

Beyond geographic diversity, participants represented a variety of sectors, disciplines, and areas of expertise. Drawing on decolonial feminist principles, a curation guide was created to identify an inclusive list of experts embedded in research, activism, funding, policymaking, and health-adjacent spaces such as the climate change and humanitarian sectors.

This workshop:

- Provided an opportunity to further iterate a decolonial feminist approach to futures and foresight to envision and work towards health-equitable and gender-equal futures for all by generating insights, identifying policy recommendations, and developing a multisectoral, multidisciplinary community invested in change.
- Enabled the UNU-IIGH team to adapt and facilitate several commonly used foresight methodologies, such as looking back to look forward, identifying drivers of change, and generating narratives of desired and disowned futures, by anchoring all praxis in the central question of: futures by, with, and for whom?
- Raised questions about how a decolonial feminist approach to futures might offer an opportunity for greater overlap and collaboration between actors working across disciplines, sectors, and geographies by identifying shared challenges rooted in power inequities and desired outcomes centred around equity.

As this body of work continues to develop, UNU-IIGH will be looking to nurture and grow this network of allies working towards more equitable futures for all through the collective use of decolonial feminist principles to guide visions of desired futures and pathways of shared actions.

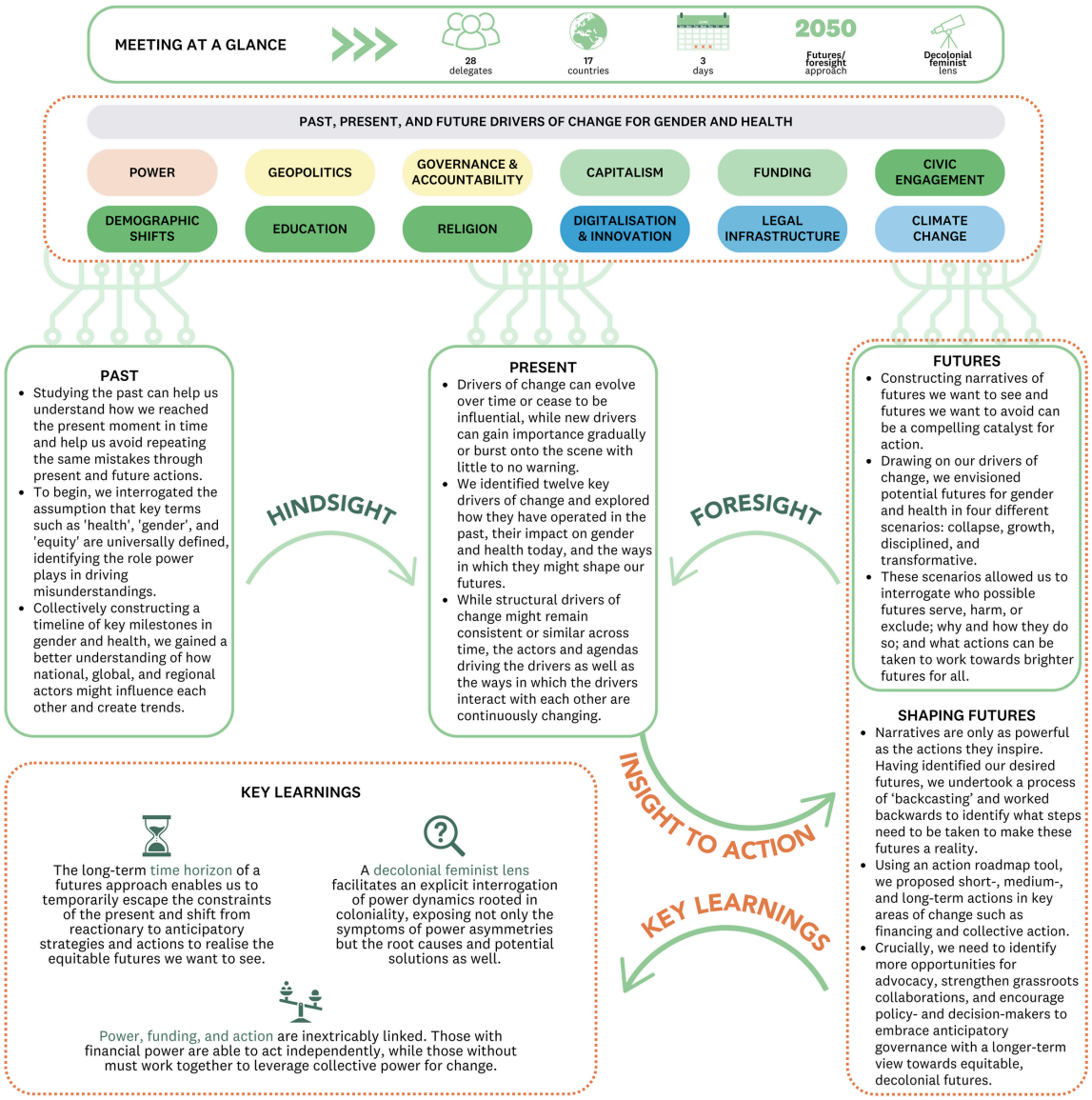
Other reports in this series include:

- Future Healthcare of Malaysia (2020)
- Futures and Foresight as Tools for Global Health (2021)
- Futures of Gender and Global Health 2030 (2022)

Table of contents

1. Executive summary

This report captures insights gleaned from a meeting convened by the United Nations University's International Institute for Global Health (UNU-IIGH), which took place on June 20-22. Across the three days, over two dozen delegates from 17 countries came together to envision, facilitate, and support "Enabling Environments to Advance Gender Equality in Health" through the use of a futures approach. A decolonial feminist lens informed the design and delivery of the meeting, guiding interpretations of our past, analyses of our present, and visions of our futures through an explicit interrogation of the ongoing impacts of coloniality as a racialised and gendered project. This visual summary highlights the ways in which power both drives and impedes change in gender and health, the value of constructing narratives of our futures, and how we can work backwards to realise our desired futures.



Our three key learnings centre around power: the power to break beyond the constraints of the present, the power to confront the root causes of inequities, and the power to leverage collective might for brighter futures. Moving forward, the UNU-IIGH team will be drawing on these learnings to identify potential next steps and avenues for change.

2. Introduction

Systems of health have undergone significant improvements over the past 60 years, thanks in large part to new research that allows us to better understand drivers of ill health and advances in treatments that have led to the reduction or elimination of diseases that were once leading causes of death. There has also been a greater recognition of how good health and well-being touch on all aspects of our lives. However, large disparities in health outcomes persist, with health inequities often exerting and experiencing a compounding effect with gender inequalities.

Power asymmetries lie at the heart of much of this inequity. To truly effect change and reduce health inequities and gender inequalities, a thorough interrogation of power structures and dynamics is necessary. Those interrogations must be intersectional, examining the diverse ways in which race, gender, class, sexuality, ethnicity, ability, age, and other social factors interact to shape the power of individuals, communities, and systems.

In recent years, well-coordinated and highly funded[1] anti-gender movements have won a string of victories in support of their agenda at national and global levels, one which weakens existing safeguards against both health inequity and gender inequalities, attacking everything from long-enshrined abortion rights to the provision of gender-affirming care to the interrogation of harmful gender norms which drive premature death. The interconnected nature of our modern world is such that changes in one country has ripple effects at the regional and even global level. Social justice movements advocating for gender equality with an intersectional lens face the risk of not merely stalling but moving backwards in the face of multi-pronged and multisectoral attacks on gender-equitable policies, programmes, and practices.

Against this backdrop, UNU-IIGH brought together over two dozen delegates from 17 countries to counter this tide by envisioning, facilitating, and supporting "Enabling Environments to Advance Gender Equality in Health". Through a process of collective visioning, enriched by the diverse experiences and expertise of our delegates, we imagined a range of futures from the desired to the dystopian and identified actions that are required in the short-, medium-, and long-term to realise our desired futures. We set out to explore:

- What do enabling environments look like at the national, regional, and multinational levels?
- Where are the opportunities for cross-sectoral learning and collaboration?
- What actions can (global health and other) actors take now to positively influence the development of gender-equitable systems for health in the immediate post-SDG era and beyond?

This report captures valuable learnings from our journeys into the past, present, and future, guided by decolonial feminist principles and values. It highlights the assumptions we bring into our work and how they might double as barriers, identifies the underlying factors that drove, drive, and might continue to drive the trajectory of gender and health, and draws out opportunities for action and coalition as we work towards the futures we want to see.

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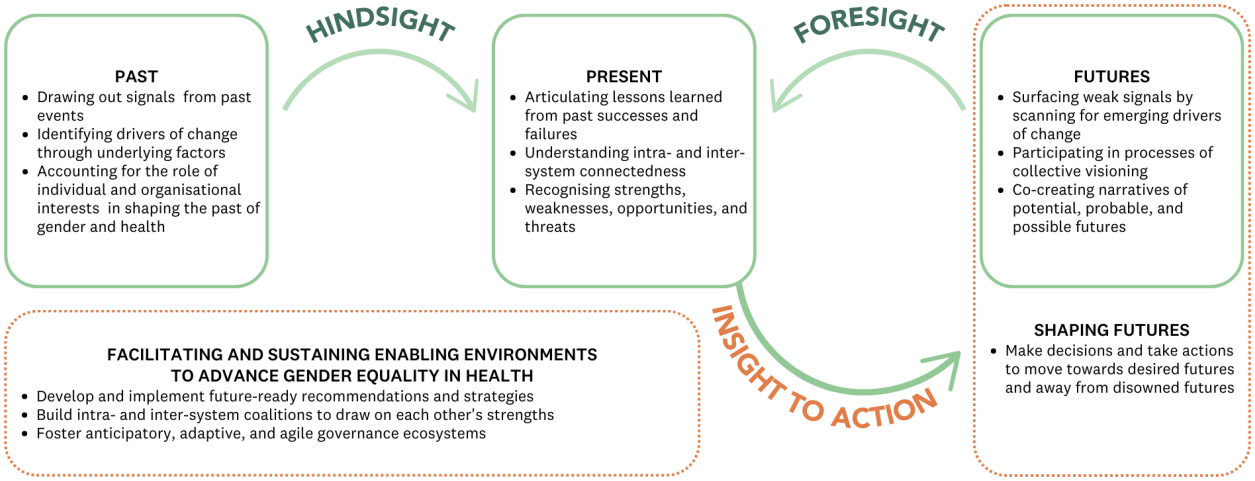
[1] Datta, N. (2021). "Tip of the iceberg: Religious extremist funders against human rights for sexuality & reproductive health in Europe". European Parliamentary Forum for Sexual & Reproductive Rights report. Brussels: European Parliamentary Forum.

Why and how did we use a futures approach and bring a decolonial feminist lens to bear on gender inequality and health inequity?

At the heart of our exploration sits the imperative to drive our own agendas in this continually shifting landscape, understanding the need to be more proactive than reactive. A futures approach[2] to advancing gender equality in health enables us to break free of the constraints of the "now" to collectively imagine what could come "next" and begin planning in the present for the future. By revisiting the past through the lens of hindsight and exploring potential futures with the aid of foresight, discussions can yield valuable insights and inform decision-making in the present[3] (Figure 1). This approach reminds us that as unyielding as the tides of (negative) change can sometimes appear, futures are never set in stone, and the actions we take now can shape futures that are more inclusive and equitable for all.

Figure 1: The conceptual underpinning of this meeting, adapted from UNDP's Choosing Your Tomorrows[4].



Disciplines and methodologies are not neutral vessels, carrying within their blueprint the visions, aims, and curiosities of their founders and designers; however, they may also be imbued with the misconceptions, shortcomings, and biases of those very founders. Contemporary foresight approaches have been shaped by their roots in Western militaries and corporate establishments, reflecting predominantly Western concepts and methodologies. An uncritical application of these methodologies risks imposing exclusionary processes and practices, perpetuating the harmful power systems and structures we aim to transform.

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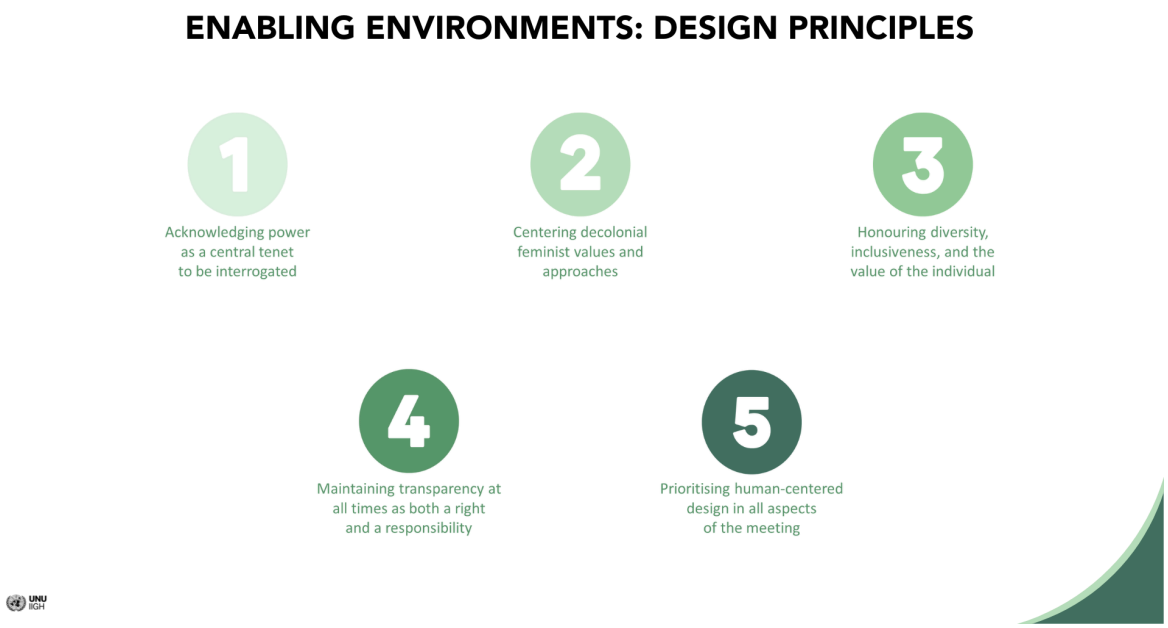
[2] 'Futures' is defined as "a broad academic and professional field", and 'Foresight' as an approach to thinking "systematically about the future to inform decision-making today". We use 'Futures' in the plural to emphasise that there are many possible and alternative futures.
[3] United Nations University - International Institute for Global Health (2021). "Futures and foresight as tools for global health". DOI: 10.37941/RR/2021/5
[4] UNDP (2023). "Choosing your tomorrows: Using foresight and anticipatory governance to explore multiple futures in support of risk-informed development".

From conception, this meeting was intentional in centring decolonial feminist principles across all elements of its design and delivery, asking at every step: Who are futures created by, with, and for? A decolonial feminist lens helped guide analysis of the past and present by helping us explicitly interrogate the ongoing impacts of coloniality as a racialised and gendered project and guide plans of action and agents of change to avoid replicating these power asymmetries. This lens was brought to bear on both the organisation of the meeting, as well as the design and delivery (Figure 2).

Figure 2: The design principles developed for this meeting, drawing on decolonial feminist values.

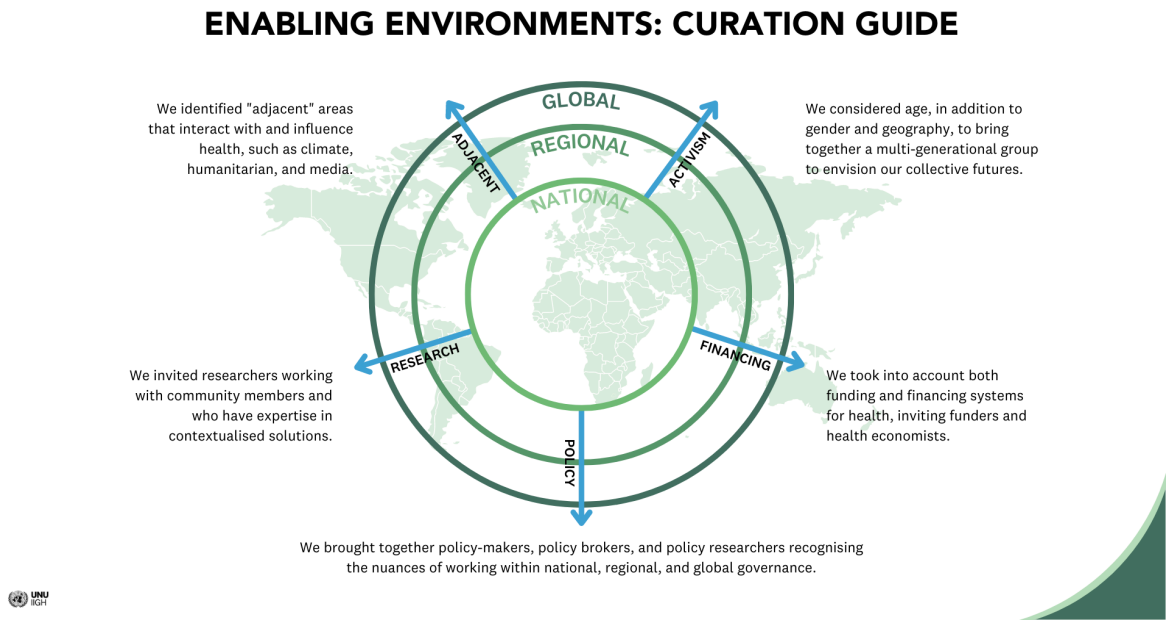


Questions about voice, representation, participation, and decision-making were interrogated through the lens of historical and contemporary power asymmetries perpetuated by coloniality, with particular emphasis on how worldviews and hierarchies imposed by colonial forces continue to suppress and devalue certain individuals, cultures, and epistemologies. In an effort to counter this trend, we very intentionally selected invitees to bring together a group of experts who are not only positioned in geographically diverse contexts but are also situated across the life course and working in different sectors related to gender, health, and health-adjacent spaces. Experts were also selected to represent the three systemic levels – national, regional, and global – which must be addressed in tandem to effect the changes required to create enabling environments (Figure 3).

BOX 1. Bringing a decolonial feminist lens to bear on discussions of our past, present, and futures.

Drawing on decolonial feminist ideas of knowledge, we wanted to ensure that we created space for all participants to share not just their technical expertise but also to provide to glimpses into the diverse range of geographies, disciplines, and contexts they occupy. At the beginning of each meeting session, designated 'conversation starters' were invited to initiate discussion and prompt reflection, fostering an environment that prioritised knowledge and expertise gained from lived experiences.

Figure 3: The curation guide developed to identify experts for this meeting, drawing on decolonial feminist principles.



Discussions across the three-day meeting were significantly enriched by the diverse range of voices in the room. An interrogation of assumptions and biases, both those held by ourselves and those frequently encountered in our communities and contexts, identified the differences in understanding and operationalisation that create barriers to advancing gender equality in health. A collective activity to generate a timeline of key milestones in the history of gender and health surfaced events, frameworks, policies, and other moments in time. It illustrated how the national, regional, and global levels might exert a ripple effect at some points in time yet experience significant divergences at others. Drawing on the multidisciplinary, multisectoral expertise in the room, the group was able to identify emerging signs and forces of change and envision how these might play out in four different scenarios, generating possible futures for our mission of advancing gender-equitable systems for health. Finally, these scenarios of the futures we want to work towards and the futures we want to avoid were used to work backwards and identify what changes are necessary in the short-, medium-, and long-term, as well as how we might be able to achieve these changes by building partnerships and coalitions across our wide range of contexts, disciplines, and sectors.

3. Looking back to look forward

What relics and lessons from the past do we take with us as we journey into the future?

Our past has many lessons to offer those looking to chart possible, probable, and potential futures. As such, we began with a journey through time, reflecting on past events and present conceptualisations to better understand the trajectory of gender and health thus far. Positionality was a key element of this discussion, as the range of lived experiences shaped by life course, geographic location, and sociocultural settings allowed the group to share different perspectives.

3.1. Unpacking health, gender, and equity

Decolonial feminist principles call for an interrogation of 'universal' definitions. Concepts vary by context and community; the ability to impose a single definition at the expense of holding space for a variety of world views is an exercise of epistemic power, which is the ability of dominant actors to position themselves as the utmost authority on a given subject. We asked our experts to reflect on the terms' health', 'gender', and 'equity' using three prompt questions:

- What assumptions are made about these concepts, by us and by others?
- What disruptions are occurring in these spaces?
- What questions do people outside of (y)our immediate community have about these topics?

BOX 2. Using a decolonial feminist lens to surface assumptions and create space for contextual understandings.

To initiate this discussion, we invited a short reflection on the nature of decolonial feminism as a reflexive and ongoing process of (un)learning which requires us to interrogate the claim to universality perpetuated by Western definitions and interpretations. By establishing from the outset that there is no one ‘correct’ way of understanding these concepts, the discussion created space for experts to surface and hold multiple meanings, each equally valid and rooted in their local contexts, thus challenging the coloniality of knowledge.

Through lively discussions, the group observed that those working on issues related to gender and health equity often take for granted that all parties involved have a "shared understanding" of what these terms mean. On the contrary, we heard how the same term can mean different things to different people in different contexts. This further emphasises the value/importance of bringing together a diversity of experiences and expertise to expand our collective understandings of gender, health, and equity.

Health

The conversation on health revealed significant pushback to a foundational assumption of those working in the health sector: that all individuals have a right to good health. Experts reported that in some communities, "many people believe health is a women's issue," and "some believe they cannot be infected by certain viruses" based on their gender, youth, or other attributes. While the group identified skewed funding and limited services as a factor in perpetuating these beliefs, they noted that attempts to expand the availability of and access to services are challenged by non-health actors who question why the goal of "good health and well-being for all" is "considered a priority when we are yet to meet other facets of equality" and view "demands for health equity [as] unreasonable – health is not a right, it is something that is earned".

The global health endeavour is also viewed with scepticism by some who cite the Global Gag Rule and PEPFAR as examples of health being weaponised or otherwise used by external forces as a tool for influence and control through a combination of soft (e.g., social norms) and hard (e.g., economic assistance) power; the increasing calls to decolonise global health were highlighted as one result of this. Crucially, experts rang the alarm on the continually expanding role of commercial actors in systems for health as well as a pattern of shifting responsibilities from governments and commercial actors to individuals; one participant noted that "there is an assumption that lifestyles are a major determinant of health" while another called out the misconception that "health is separate from our socio-economic conditions".

Some questions on health that experts shared from their communities and constituents include:

- "What do we mean by health? Is it limited to physical well-being? Are we including traditional and indigenous ideas of health?"
- "Whose health are we talking about? Is health-seeking behaviour gendered? How does the messaging speak to different people?"
- "Is healthcare the responsibility of the government? Is health an individual choice?"

Gender

The discussion on gender was a study in contradictions. Experts reported that community understandings of gender ranged from ones rooted firmly in the binary to those that assume gender is concerned only with trans, intersex, and non-binary individuals. Common reactions to gender equality initiatives and projects run the gamut from "Is this even a problem?" and "There are no gender issues because of the delusion of inclusion" to "What is the point of fixating on gender?" and "Enough has been done". Gender was discussed in close relation to power, with the patriarchy defined by one participant as "a system that cuts across various spheres and needs to be contextualised"; failure to localise and contextualise has led and can lead to hesitation and hostility as reported by those who have been told gender is the domain of "Western feminists", a "foreign concept" which is incompatible with local cultures and religions and might even be "a colonial agenda".

Some questions on gender that experts shared from their communities and constituents include:

- “How is gender related to public health?”
- “How can we tackle gender issues with existing power imbalances?”
- “How are gendered divisions unnatural?”

Equity

Experts reported encountering confusion and contestation related to the term equity. On the one hand, it is often used interchangeably with equality; on the other, some people have expressed that "equity does not matter if equality exists" and questioned whether equity presents "a challenge to equality" by "treating people based on differences". It was argued that we have failed to make a sufficiently strong case for equity, as evidenced by experts being asked questions such as "Why is it important to be 'fair'?" and "Where is the proof of concept?". Power is a key consideration as some communities view equity as "taking away from those who have," and others believe that "equity is part of the neoliberal agenda". Equity was highlighted as a key component in building "decolonial systems for health", yet the concept itself seems in need of decolonisation by way of interrogating its intent and impact.

Some questions on equity that experts shared from their communities and constituents include:

- “What does equity mean in an unfair world? Why is it important to be ‘fair’ or have a ‘fair society’? Is health equity possible in unequal and undemocratic states?”
- “If we all have the same rights, why do we need to talk about equity?”
- “Why is equity more of a priority in some spaces and why not others? What underlies these differences in perspective? Are they informed of lived experience or theoretical concepts?”

Common threads can be found across the three conversations, with power consistently highlighted as a factor driving misunderstandings and contention. From questions about the "prioritisation" of health and equity over other items on the development agenda to claims that those working towards gender equality are "[going] against divine design", many shared experiences of hostility in response to perceived attempts to shift or (re)balance power. Attempts at misdirection or fragmentation were also noted, with one participant asking, "What happened to the big pushes for basic income and tax avoidance?" while discussing equity and another noting the increasingly polemical and non-constructive nature of conversations on gender, which often "end in conflict because of differing views".

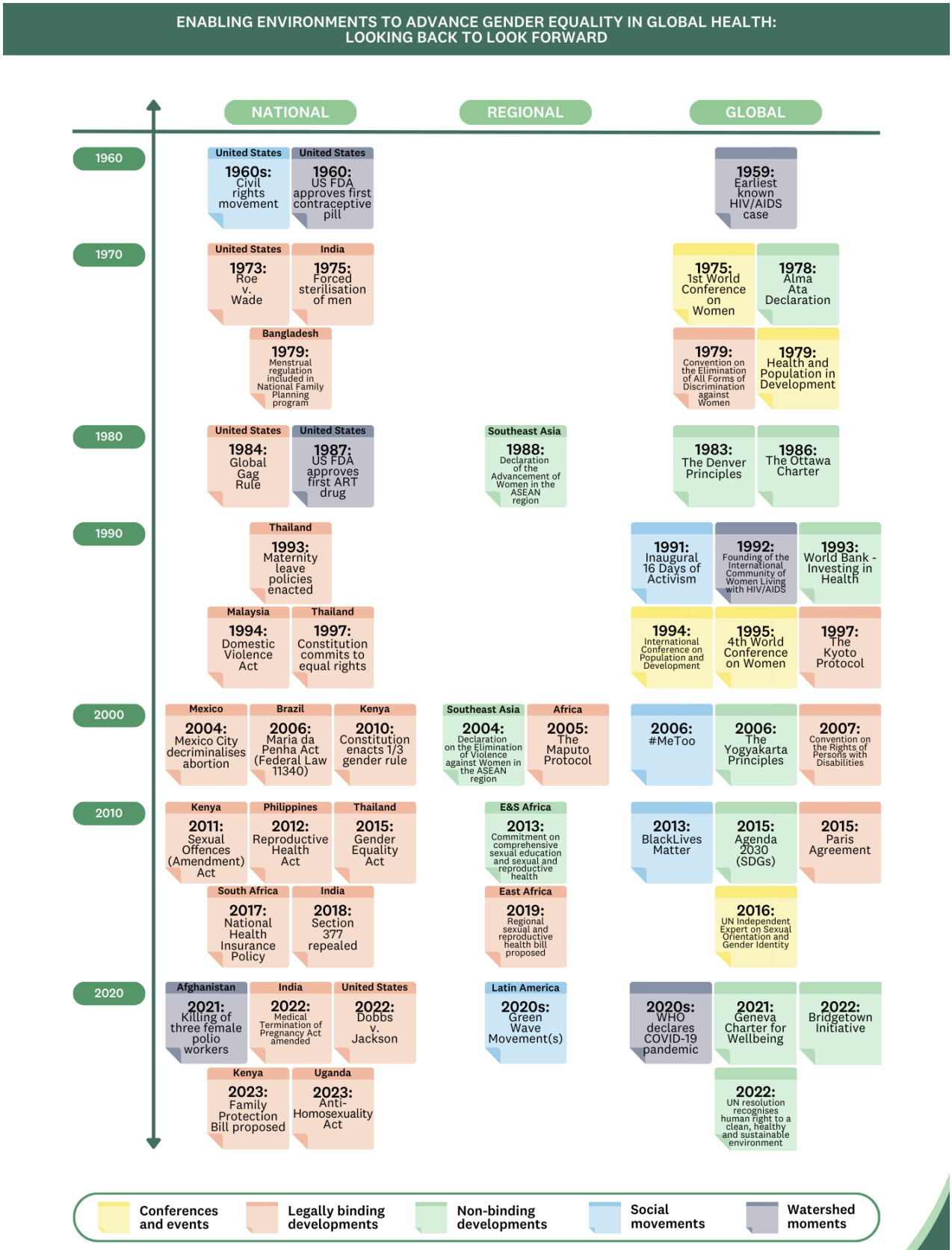
Finally, the conversations interrogated how those working within these spaces wield power themselves and whether discourses on gender, health, and equity are "meaningfully engaging" all relevant parties; men, boys, and individuals beyond the gender spectrum or confines of heterosexuality were identified as lacking in representation while women and girls are often "assumed to be in 'weakened positions'" or reduced to the subjects of interventions.

Assumptions, beliefs, and biases, such as the ones surfaced in this discussion, can both shape and be shaped by critical moments in time. As such, experts were next asked to co-create a timeline of key moments in the history of gender and health at the national, regional, and global levels that they believe have been instrumental in shaping contemporary systems of health.

3.2. An incomplete history of gender and health

Hindsight exercises, which involve studying data and reflecting on learnings from past events, can be used to understand how we reached the present moment and help us avoid repeating the same mistakes with present and future actions. Through piecing together a timeline of key moments in the history of gender and health (Figure 4), the group began to identify the signals that heralded past instances of change. Signals can be studied for patterns or trends over time, and drivers of change can be identified from these patterns. Whilst trends may wax and wane over space and time, drivers are deep, structural forces that persist and have obvious impacts at various scales and across a wide range of geographies and contexts. For instance, the timeline identifies legislation as one of the most prominent tools of change at the national level. In contrast, non-legally binding frameworks and instruments are more commonly seen at the regional and global levels.

Figure 4: A timeline of key moments in the history of gender and health, pieced together by our experts.



Collectively constructing a "bigger picture" of gender and health also allows for a better understanding of how national, global, and regional actors might influence each other or diverge entirely. For instance, in 2004, ASEAN, the Association of Southeast Asian Nations, put forward its Declaration on the Elimination of Violence against Women[5]. Announced 25 years after the UN General Assembly adopted the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)[6], which all ASEAN members have ratified at the national level, it outlined a commitment to 'strengthening regional cooperation, collaboration and coordination for the purpose of eliminating violence against women in the region'. On a less encouraging note, Kenya's parliament has recently put forward a Family Protection Bill seeking to prohibit homosexuality just weeks after neighbouring Uganda passed its Anti-Homosexuality in May 2023. The Kenyan bill stands in opposition to a proposed East African Community Sexual and Reproductive Health Bill, first proposed in 2019 and continuously advocated for by feminist activists in the region, including Kenya. Another point of divergence is illustrated by the successes of the Green Wave movements across Latin America to decriminalise and legalise abortion and the United States Supreme Court's 2022 ruling on Dobbs v. Jackson, which has led to a wave of anti-abortion legislation across the country.

Who can influence and effect change is as/almost as important as the underlying structural forces. As such, in addition to discussing what happened, groups all explored which actors – individuals, organisations, coalitions, and movements –have been particularly influential in driving change. Whilst this varies in nature between contexts, there were common themes, including national policymakers that champion a particular issue, grassroots movements that come together to create momentum for change, and media powerhouses that can shape popular opinion on any given issue.

What has driven, is driving, and might continue to drive the actors and agendas behind these milestones in gender and health? Using this timeline as a starting point and drawing from their respective areas of expertise and experiences, meeting attendees identified the driving forces of gender and health.

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[5] Association of Southeast Asian Nations (ASEAN) (2012), Declaration on the Elimination of Violence Against Women in the ASEAN Region

[6] UN General Assembly (1979), Convention on the Elimination of All Forms of Discrimination Against Women, United Nations, Treaty Series, vol. 1249

4. Drivers of change for gender and health

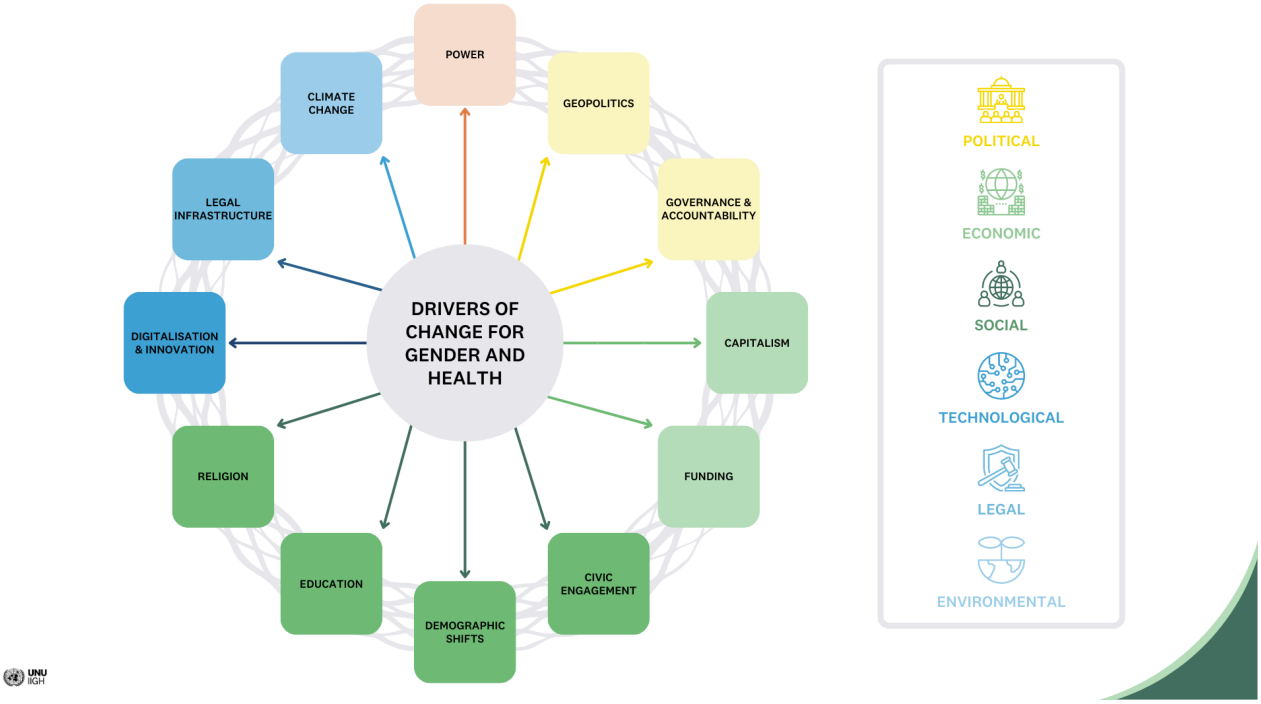
What and who drove, drives, and will continue to drive developments in gender and health?

Understanding past drivers of change provides an entry point to consider what factors may influence potential futures. However, the past is not a predictor of our futures - trends can be cyclical, some drivers may cease to be important, and new ones can emerge, sometimes with a speed that catches us off-guard. Therefore, in interrogating potential drivers of systems for health in 2050, experts were asked to consider the following:

1. How has this driver been influential in the past?
2. What has been its impact on gender equality and health equity?
3. What role may it play as we consider 2050 futures?

The PESTLE framework, an acronym for Political, Economic, Social, Technological, Legal, and Environmental factors, was used to ensure a wide range of drivers and their ability to influence enabling or restrictive environments was considered. More than 50 themes and sub-themes were identified, which were then categorised into 12 overarching drivers of change (Figure 5). An overview of those drivers follows.

Figure 5: A collection of 12 overarching drivers influencing change in gender and health identified by our experts.



4.1. Power

Power structures and asymmetries shaped by colonial architects and perpetuated by neocolonial influences remain driving forces of gender and health, determining who gets a say in decision-making, research agendas, service provision, funding flows, and more. As such, power runs as a thread through all the other drivers identified.

The persistence of patriarchal systems of relationships, beliefs, and values that are embedded in the broader environment - political, social, and economic – within which systems for health operate contributes to structural inequity. Patriarchy resists attempts and calls for more gender equality, manifesting as power differentials between different gender identities and across the gender spectrum, for instance, between men and women or between cis-gender and transgender individuals. Gender norms and stereotypes can hinder access to resources, limit agency, and impact decision-making, including when it comes to the provision of and access to quality healthcare.

Looking to the future, power asymmetries between countries, and in particular the imposition of standards by (mostly) former colonial powers that they themselves do not meet, are contributing to scepticism of 'Western agendas', including gender equity and human rights. This risks further fragmentation of global health systems and greater health inequity. Contemporary discourses on decoloniality show promise in their pursuit of shifting power but are themselves susceptible to perpetuating coloniality and inequity within systems of health.

4.2. Political

Geopolitics
Multilateralism, particularly post-WWI, has helped nations work collaboratively to confront complex global challenges. However, the current architecture of much of the multilateral system is inherently colonial, with a paternalistic approach to cooperation, which has led to a 'Global North vs. Global South' dichotomy. When higher-income countries fail to engage and equitably cooperate with lower-income countries, it increases the poverty gap, limits knowledge sharing, and has downstream impacts on innovation and health.

Current increases in nationalist rhetoric are promoting a shift away from common agendas, including for gender equality and human rights. It has the chilling effect of limiting access to health care services for those deemed 'unworthy', especially by the global public health system, impacting millions of people who live in the Global South, especially vulnerable populations such as refugees and displaced people, through the denial of services.

To foster decolonial, enabling environments in which systems of health that promote gender equality and health equity can thrive, it will be imperative to shift power and agency to support local ownership and leadership. Doing so will require greater recognition of the Global South's expertise, knowledge, and capacity to lead in shaping global health policies, allocating resources more equitably, and addressing their unique health challenges with cultural sensitivity. This transition to a more balanced global (health) landscape of the future will require reevaluating traditional multilateral approaches as powerful actors grapple with relinquishing their dominant positions in decision-making processes and ensure that power asymmetries are not reproduced.

Governance and Accountability

Many existing governance structures, whether at the national, regional, or global level, have led to a centralisation of power. Within global health, this has led to the dominance of male leaders, particularly individuals from high-income countries; 7 in 10 global health leaders are male, whilst 83% of global health leaders are from high-income countries[7]. The low representation of women, as well as trans- and gender non-conforming individuals, in political leadership and the top leadership of the civil service, means their concerns are under-represented and needs unmet.

There are concerns about an absence of accountability across systems for health, especially with respect to the private sector, which plays an increasingly prominent role in the health sector. Lack of accountability in international funding and governance can derail the development of systems for health that promote gender equality and health equity, for instance, due to poor health budgets or skewed funding. With scant independent accountability mechanisms, governments and corporations are not forced to comply with commitments nor subjected to sanctions for lack of gender equality.

Mechanisms of accountability that transcend power imbalances are needed. The current trajectory of accountability from a 'right' to something that we must actively fight to preserve, especially in the face of increasing concentrations of power within public and private actors in the global health sector, does not bode well. Independent governance and enforceable accountability mechanisms will be crucial to ensure that decision-making processes are transparent, inclusive, and unbiased. To do so will require being clear about who is holding whom to account, the positionality of those arbitrators of accountability, and that there are lines of reporting back to beneficiaries. Social accountability mechanisms are growing in popularity and provide a foundation for future approaches.

4.3. Economic

Capitalism

Capitalism and associated competitive market economies were promoted as a vehicle to prevent monopolies and spur innovation. In reality, it is a colonial legacy that has contributed to power asymmetries and systems that privilege profits over people. The theory of 'trickle-down economics' that sits at the heart of much of the neoliberal economic agenda has led to the creation of dual healthcare systems (public plus private) that operate under the assumption that financialisation in some areas would lead to structural improvements that would 'trickle down'. Instead, it has resulted in a market approach to health care, contributing to inequitable provision and access.

Within systems for health, the concentration of market power gives some entities a disproportionate ability to shape health agendas that do not necessarily align with the needs surfaced by affected populations or disease burden. Simultaneously, the prioritisation of intellectual property rights hinders the ability to equitably reap benefits from public goods.

In pursuing more equitable health systems, it is crucial to tackle the downstream negative impacts of capitalism, including wealth disparity, labour exploitation, and the commodification of basic rights. Moving forward, we must confront capitalism's role in promoting and perpetuating the narrative that 'individual lifestyle choices' drive adverse health outcomes, distracting from the detrimental impacts of commercial determinants of health at the population level.

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[7] Global Health 50/50. (2019). "Power, privilege and priorities". London: University College London.

Funding

Financial capital is an undeniable form of power, granting funders an outsized ability to drive agendas. One of the ways in which funders do so is through conditionalities, such as the imposition of restrictions on geographies for which funding is available, diseases and issues they will support work on, constituencies they will serve, and the types of strategies they believe are valuable. Such conditions impact all aspects of systems for health as organisations and communities become compelled by a need to 'follow the money'.

On a larger scale, the consistent dwindling of public money available to global health actors has created a window of opportunity for private actors, such as philanthrocapitalists, and single agenda entities, such as vertical funds, to increase their influence over global health agenda-setting. This has exacerbated issues of fragmentation, siloing, and duplication, as an ever-larger proportion of global health activities and programmes are now dictated by individual actors rather than multilateral institutions such as WHO.

Funding pools and modalities that recognise health as a public good will be required to make meaningful progress towards a more equitable global health. Funding sources must also be changed to equitably shift the power granted by financial capital; one promising model is that of Global Public Investment[8], which is premised on three core features: all contribute, all benefit, all decide. Shared ownership over, and sustainability of, resources are vital to supporting longer-term initiatives to enact the structural changes required to reform the underlying architecture of global health.

4.4. Social

Demographic Shifts

Demographic shifts over the past 50 years, both in terms of size and age structure, have been a major driver of economic and social transition. These have driven wide-ranging policy responses, from education to migration and labour.

For health, demographic shifts have led to policies that variously promote or control population growth, with broader impacts on sexual and reproductive rights that are disproportionately experienced by cis-gendered women as well as queer individuals. For cis-gendered women, violations of bodily autonomy manifest as either limitations on or imposition of contraception and abortion. For queer individuals, "pro-family" arguments serve as a guise to further pathologise, criminalise, and penalise people based on their perceived inability to reproduce in 'conventional' ways.

Future demographic shifts will continue to have strong implications for systems for health, for instance, in driving both the supply and demand of healthcare services. Ageing populations with insufficient caregiving capacity will likely lead to increased burdens for women, both within and outside of the formal economy, due to the highly gendered nature of caregiving. Whilst countries with more resources will be able to alleviate such challenges by leveraging their economic power to attract healthcare providers from countries with younger populations, this risks leaving those countries with a depleted workforce, likely to the detriment of local populations. Without dedicated, long-term planning, for instance, in recruiting and training the next generation of the health workforce, this may lead to a collapse of the health system.

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[8] McCoy, D. (2022, August 8). Global Public Investment: Time to build the movement now. UNU-IIGH. https://iigh.unu.edu/publications/articles/global-public-investment-report-released-time-to-now-build-the-movement.html

Education

Global literacy rates have doubled since 1960[9], contributing to a more highly educated population, economic growth, and better health outcomes. Increased global sharing of knowledge reduces barriers to international collaboration, facilitates cross-context learning, and contributes to the development of innovative solutions for global problems.

However, improvements are not distributed equally; globally, disparities exist between groups on the basis of gender, race, and geography. Deliberate omissions from curricula, exclusionary policies and processes targeted at learners on the grounds of race and/or gender, and the decreasing space for government oversight over for-profit educators force us to ask: Are the education systems that are nurturing future generations promoting equality or exacerbating inequalities?

For many, education is the key to socio-economic mobility, which can lead to improved access to health services and health outcomes. What are the longer-term health impacts of a failure to safeguard inclusive and quality education for future generations? A systems for health approach that emphasises the interconnectedness of different sectors is necessary to attain good health and well-being for all.

Religion

Over the past sixty years, the centrality of religion and its influence on social norms have waxed and waned, both over time and across geographies. The perpetuation of regressive perceptions of reproductive health is particularly challenging for the advancement of health equity and gender equality.

Experts noted difficulties operating within contexts where religious systems dictate that wives must gain permission from their husbands for health-related issues including, but not limited to, vaccinating herself and their children or using contraceptive methods, and where sex education, abortion, and other reproductive services are viewed as a sin.

Efforts to engage religious organisations and communities and identify areas of commonality must be stepped up to counter the increasingly polarising narrative that assumes gender equality and religion are inherently oppositional. As a first step towards strengthening collective action, religious organisations working to promote gender equality and health equity within the frameworks of religious texts should be approached as potential allies.

Civic Engagement

Civic engagement is vital to achieve societal shifts through allyship and collective action and has been leveraged by feminists to attain broader sexual and reproductive health rights. With deep expertise in the contexts in which they work, and the communities they are representatives of, civil society actors have been able to ensure that the voices of the least represented are heard.

Community participation in systems for health has contributed to ongoing efforts to address health inequities, whilst collaborative action, both within and between movements, has enabled more effective influencing of and negotiation about health policy, both locally and at scale. For example, the formation of coalitions by AIDS activists and universal health coverage (UHC) advocacy groups has enabled them to more effectively negotiate and influence health policy.

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[9] Roser, M. and Ortiz-Ospina, E. (2018, September 20). Literacy. Our World in Data. https://ourworldindata.org/literacy

At present, civic engagement is imperilled by decreased funding for and prioritisation of civic participation and the associated shrinking of civic spaces, the weaponisation of civic engagement by anti-gender movements, and active attempts to drive wedges between movements and hinder allyship. Combined with a crackdown on civil society by authoritarian governments, these raise concerns about the future of "bottom-up" and "community-led" change within the gender and health space.

4.5. Technological

Digitalisation and Innovation
The rapid pace of technological change over the past 60 years, particularly the growth of digital technologies post-2000, has altered almost every facet of life as we know it. Within health, telemedicine services have increased access to health care, provided platforms for targeted treatment, and facilitated self-management. Digital communication platforms have also been used to raise awareness of important gender and health issues.

However, the ubiquitous nature of mis- and dis-information poses an increasingly larger challenge, leading to decreased trust in science and acceptance of healthcare, increased occurrences of violence against health workers, and cascading disruptions of/to health systems. Technological platforms have also provided a space for the anti-gender movement to amplify their rhetoric, grow their ranks, and scale up attacks against their counterparts.

The digital divide, built-in biases, and privacy issues can worsen health equity and impact the attainment of gender equality. These concerns are particularly prominent in discourses surrounding Artificial Intelligence, which risks perpetuating or exacerbating biases and inequities. With exponential growth in technological advancements, governance in this space must be reformed to match the speed of innovation; anticipatory, agile, and adaptive governance serves as one potential model forward.

4.6. Legal

Legal Infrastructure
At the global level, several notable legal frameworks have set out rights related to the attainment of health equity and greater gender equality and contribute to an enabling environment for legal and social change. At the national level, this has supported the creation of instruments that address gender pay gaps, promote gender-responsive budgeting, and ensure the provision of gender-responsive services.

However, gaps in national legal infrastructures have led to an increase in the use of strategic litigation by the anti-gender movement. Originally used by civil rights activists to expand service provision, strategic litigation is now being used to further anti-gender agendas, especially in relation to sexual and reproductive health. This is leading to an increase in discriminatory laws that challenge women's rights, LGBTQIA communities, and other minoritised groups.

Such gaps must be proactively identified and addressed to prevent further attacks on the legal rights of targeted groups. Beyond the anti-gender movement, legal infrastructure must also be strengthened to hold governments and private actors accountable to the commitments made as part of national, regional, and international agreements.

4.7. Environmental

Climate Change

Global heating and other long-term changes in global climate patterns have accelerated discourse on and developments of solutions that encompass mitigation, adaptation, and resilience strategies. Climate change interacts with a broad range of determinants of health, both directly and indirectly, to adversely affect health outcomes, with the impacts disproportionately borne by marginalised and vulnerable communities.

BOX 3. Drawing on decolonial feminist principles to expand our conceptualisations of health.

Coloniality perpetuates a primarily biomedical understanding of health, rooted in Western epistomologies which stand in opposition to Indigenous conceptualisations of wellbeing. Guided by decolonial feminist principles, we challenged the anthropocentrism of this definition of health and invited a climate specialist to begin our discussion on drivers of health by drawing explicit links between our health and that of the environment.

The negative impacts of climate change are frequently gendered due to strained systems and increased vulnerabilities. In overwhelmed health systems, issues affecting sexual and reproductive health are unlikely to be a priority or even forgotten; in times of crisis, this is exacerbated by the increased vulnerability to sexual violence faced by displaced women[10].

Looking ahead, systems for health need to be prepared to deal with the increased strain they are likely to be under as countries grapple with an increased frequency of natural disasters, the greater risk of zoonoses-driven pandemics, and the many other consequences of climate change. At present, there is a lack of climate financing for resilience and sustainability in health service delivery that will have to be rectified. Finally, in thinking about efforts to mitigate the effects of climate change, we must think about just transitions that centre those most affected by the crisis and the associated mitigation efforts in a given society.

These political, economic, social, technological, legal, and environmental drivers have been instrumental in shaping contemporary systems for health. Whilst the importance of any individual driver varies over time and between contexts, their interconnected nature means that we must consider how they can interact with and influence each other when we think about potential futures. In the next part of the meeting, experts worked in four groups to collectively imagine scenarios of the future.

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[10] OHCHR (2022, July 12). Climate change exacerbates violence against women and girls . https://www.ohchr.org/en/stories/2022/07/climate-change-exacerbates-violence-against-women-and-girls

5. Envisioning futures of gender-equitable systems for health

What might gender-equitable systems for health look like in our futures?

There is power in collectively co-creating visions of potential futures, in constructing narratives about futures we want to see and futures we want to avoid, and in turning abstract data and drivers into compelling snapshots of what might lie ahead. As such, storytelling, in the form of scenarios, is a popular of futures approaches. Not to be mistaken as an attempt to predict the future, scenario development is a structured process of narrative development, drawing on previously identified drivers of change to explore how those drivers could play out in different future environments. Once developed, scenarios help us identify and challenge assumptions embedded in current strategies and consider and action the adaptions required to move towards desired outcomes.

Pulling together past, present, and potential future drivers of change, experts worked in groups to envision four possible futures of gender-equitable systems for health. Each group was assigned one of the four following scenarios:

- Growth: A world in which humanity continues on our current path, with all the attendant progress and pitfalls that might bring.
- Collapse: A world in which the system has reached its limit and society as we know it disintegrates.
- Disciplined: A world in which order is imposed to avoid collapse and sustainability is prized over growth.
- Transformative: A world in which a radical shift has occurred – typically for the better, but not necessarily.

These scenarios are rooted in the 'Four Futures of Jim Dator'[11], who argued that these four narrative archetypes encapsulate all 'types' of stories we tell ourselves about the future. This framework is built on two core truths about the future:

1. We can never know for sure what lies ahead, so we need to cover our bases by exploring as many possible futures as we can envision.
2. We make sense of the future in the same way that we do the past: by telling ourselves stories about it.

BOX 4. Integrating decolonial feminist values into a collective visioning exercise.

To centre our goal of envisioning more inclusive futures, we prefaced the collective visioning exercise with a conversation starter on the humanitarian crises facing us today and the voices often left out from conversations of our futures. Decolonial feminist values of inclusion and equity drive us to interrogate who we design for and with and remind us to be explicit and intentional in considering those who are relegated to the margins by existing power structures and struggles.

Constructing stories also allows us to explore who these futures serve, who they harm, and who they exclude; anchoring scenarios in decolonial feminist values necessitated that our experts interrogate who the architects of our futures might be and practice more collective and inclusive visioning processes. Here, we share a summary of the four futures envisioned by our experts.

[9] Dator, J. Alternatives futures at the Manoa school. Journal of Future Studies. 2009;14(2):1-18.

5.1. Four visions of 2050

ENABLING ENVIRONMENTS TO ADVANCE GENDER EQUALITY IN GLOBAL HEALTH: VISIONS OF OUR FUTURES

GROWTH

This is the story of Skylar, who was gestated in a Petri dish and identifies as a distinct gender they chose at puberty through genetic modification. Their gender is immaterial to both this story and their society, which is concerned only with extracting resources from everyone. In this future, technology and intellectual property rule supreme. Anchored in key superpower countries, tech companies have amassed extraordinary power, enabled by a hyper-connected Internet-of-Things. Many people in urban areas are housebound, with work largely replaced by AI and all goods delivered by autonomous vehicles. Friends 'visit' each other via hologram and gather through social media, where the Internet-of-Things convinces depressed and isolated individuals like Skylar to buy things as the antidote to their depression.

Skylar suffers from genetically engineered diabetes introduced by the company which grew them – the same company that controls access to and the price of vital drugs. While Skylar has personalised at-home, fee-for-service, healthcare thanks to insurance, they are only able to afford the exorbitant cost due to royalties generated from a piece of software they developed as a teen.

Not all is lost, however. Beyond the cities, in the hinterlands, there are societies free of technology's control. Communities of native-born 'hinterlanders' and urban escapees live in cooperatives that prioritise human connection and circular economies based on wellbeing. Though life is very hard, these places offer holistic care and support, nutritious food, and traditional/spiritual healers who support the wellbeing of those who want it. Like many before them, Skylar dreams of escaping to the hinterlands.

COLLAPSE

This is the story of Alice, who lives in a future where the world as we know it has collapsed. From the idyllic dome-like 'Bubbles' in which they live, the 'One Percent' rule over an extractive, neo-imperial world and control everything from the military to the media, from food production to financial flows. The UN has been dissolved, elected governments are no more, and the 'One Percent' have placed faith-based fundamentalists in positions of power in the world beyond the 'Bubbles'. Alice is part of the 99% left to live in this dystopia, constantly struggling to make it into a 'Bubble' where people have clean air, potable water, abundant food, and free healthcare.

Displaced from her native Maldives by a series of climate change-induced tsunamis, Alice lives in a refugee camp in India where food and water are extremely limited. Separated from her partner Anett, with whom she had dreamed of living in a society that was respectful of people's differences and accepting of LGBTQ+ individuals, she is now accompanied by her 8-month-old daughter, conceived when she was raped by a camp soldier. Desperate to meet the health needs of her malnourished daughter, Alice is forced to turn to sex work in a camp rife with disease, where the few private health services available are owned by the 'One Percent'.

With no healthcare system to speak of and the cost of subsistence increasing exponentially, Alice finds herself in increasingly dire straits and is even considering selling her blood and organs to make ends meet. She also starts bartering with one client, an Army General, for him to take her and her daughter inside a 'Bubble'. The path to a brighter future is treacherous and uncertain, but Alice refuses to surrender.

TRANSFORMATIVE

This is the story of Indigo, a 25-year-old gender-fluid individual who lives in a future where all voices contribute to vibrant national societies and all fundamental needs are met. This world is made possible by strong global solidarity for an inclusive, equitable, and gender-just world. There is a guaranteed universal basic income, systems for health address the needs of all people, and the planet has been protected for future generations.

Indigo can access people-centered health services through a portable device infused at birth with their genetic information. In this world, every individual has access to this primarily virtual, cloud-hosted medical service provided by Digi-Med, regardless of gender, race, and socio-economic status. Biometrically accessed, a simple finger tap is sufficient to swiftly analyse data, diagnose illness, and prescribe the most effective remedies. When greater intervention is needed, users can select healthcare providers from anywhere in the world to either visit a health kiosk or have a medical team come to them. Digi-Med's underlying technology was developed by North-South partnerships, supported by unrestricted, unconditional funding and strengthened by co-ownership of research and benefits.

In this world where healthcare is available to all, Indigo aims to ensure their fellow citizens access services and experience the best possible standard of health. They serve as a Digi-Med ambassador on the popular platform ACCESS POINT, encouraging young people to protect their wellbeing and supporting those who experience challenges interfacing with the system. Leveraging their platform as an influencer, Indigo works to ensure that availability translates into accessibility.

DISCIPLINED

This is the story of Mapenzi and her non-binary child, Uno. They live in a future characterised by sustainability, equilibrium, and equal opportunities for all. Mombasa, the coastal and cosmopolitan city they call home, has progressive legislative frameworks for greater public investment directed towards healthcare and prioritises gender-responsive services, research, and policy development.

Aged 17, Uno wants to access abortion information; Mapenzi arranges an appointment with Dr. Anwar, their primary care physician. However, Dr. Anwar struggles to provide the requested information given his cultural, religious, and gender beliefs. Furthermore, there is a conflict between the age of consent to access abortion services and the best interests of the child. Dr. Anwar consults with fellow medics to find a solution, mindful of provisions which recognise the evolving capacities of adolescents, especially with regard to sexual and reproductive health and rights. While Dr. Anwar chooses to exercise his right to object to providing this information, he also refers Uno to a colleague within the same facility as he supports gender equity in health systems and the right to information.

After seeing how difficult it was for Uno to access this information even within a system that prioritises health equity and gender-responsive services, Mapenzi is compelled to lead the conversation on access to abortion information. She becomes a leader for acceptance of gender diversity and access to information despite some pushback, using social media to promote human rights and progressive legal frameworks that support the diverse needs of adolescents and young people.

5.2. What can we learn from these scenarios?

Whilst divergent, each of these scenarios takes our current reality as a common starting point. In studying them individually and as a set, we can extrapolate learnings that can inform how we work towards desired futures and walk away from disowned ones.

Growth:

- Strategies and tools can be double-edged swords. We must be vigilant to the co-optation of progressive agendas, such as gender equality, by corporations and other self-motivated actors. The scenario presented shows how the language of "gender equality" might be misused to result in equal experiences of oppression and exploitation for all genders.
- Collective action remains the key to resistance. It is essential to build, join, and sustain movements for change that can share resources, provide support, and work together either defensively or offensively as the situation calls for it.
- Environmental health must be understood beyond ensuring the availability of resources such as clean air and adequate water. The preservation of non-urbanised, green spaces is vital for nurturing the overall well-being of individuals, serving as a buffer against rising temperatures, facilitating mental and emotional rejuvenation, and fostering resilient communities capable of adapting to a changing world.

Collapse:

- Health as a common good and a human right must be protected. The commodification of good health as a 'product' rather than a right further widens the gap between the rich and the poor and must not be normalised. Active steps must be taken to preserve the attainment of good health as an inalienable right to which all have a claim rather than something to be 'earned' by the 'deserving' few.
- Accountability mechanisms must be strengthened in the face of increasingly unchecked influence, greed, and self-interest. As new actors and structures enter the playing field, how can we embed and enforce accountability mechanisms within systems for health that not only address the issues of today but also safeguard against the challenges of tomorrow?
- Knowledge is power, regardless of the context in which one might operate. It is crucial that knowledge of the rights and standards that are owed to all, but enjoyed by the select few, continues to be passed down to all generations and shared amongst all populations to serve as the foundation to demand the realisation of rights and struggles for change.

Disciplined:

- Long-term gains must be prioritised over short-term wins. In a disciplined future, moderation, sustainability, and equity are prioritised to ensure long-term stability for all rather than short-term gains for the few. A sustainable approach to systems for health emphasises the need for equitable access to healthcare, the recognition of diverse health needs, and the reduction of gender-based disparities.
- Global challenges require global solidarity to make solutions a reality. Multilateralism must be strengthened to enable global buy-in to ensure concerted and collaborative action on a global scale. Actions and reactions have ripple effects; working together will allow for swift identification and response.
- Global solidarity must not come at the cost of local ownership. In working towards shared goals, space must be maintained for context-specific tactics and tools that recognise the nuances of individual contexts and needs and that prioritise the adaptation of interventions over wholesale adoption.

Transformative:

- Health is a cross-cutting issue which requires coordination action across systems for health. Goals such as universal basic income and universal health care cannot be achieved by working within health systems alone. In a transformative future, these visions are brought to life through recognition of the value of and need for cross-sectoral collaboration.
- Technological advancements will only lead to societal progress if they are made available to all of society. Beyond availability, accessibility, and affordability, equitable and ethical technological advancements must also preserve bodily autonomy and the right to privacy.
- Supply and demand must be equally considered when designing systems-level interventions. Accessibility must consider both the ability and the desire to access services. Past experiences, both individual and communal, impact a person's desire to access services – how can the 'human' element be addressed in the quest for universal healthcare?

As we moved into the final phase of the meeting, attention shifted to how reflections about and insights from the scenarios could inform action.

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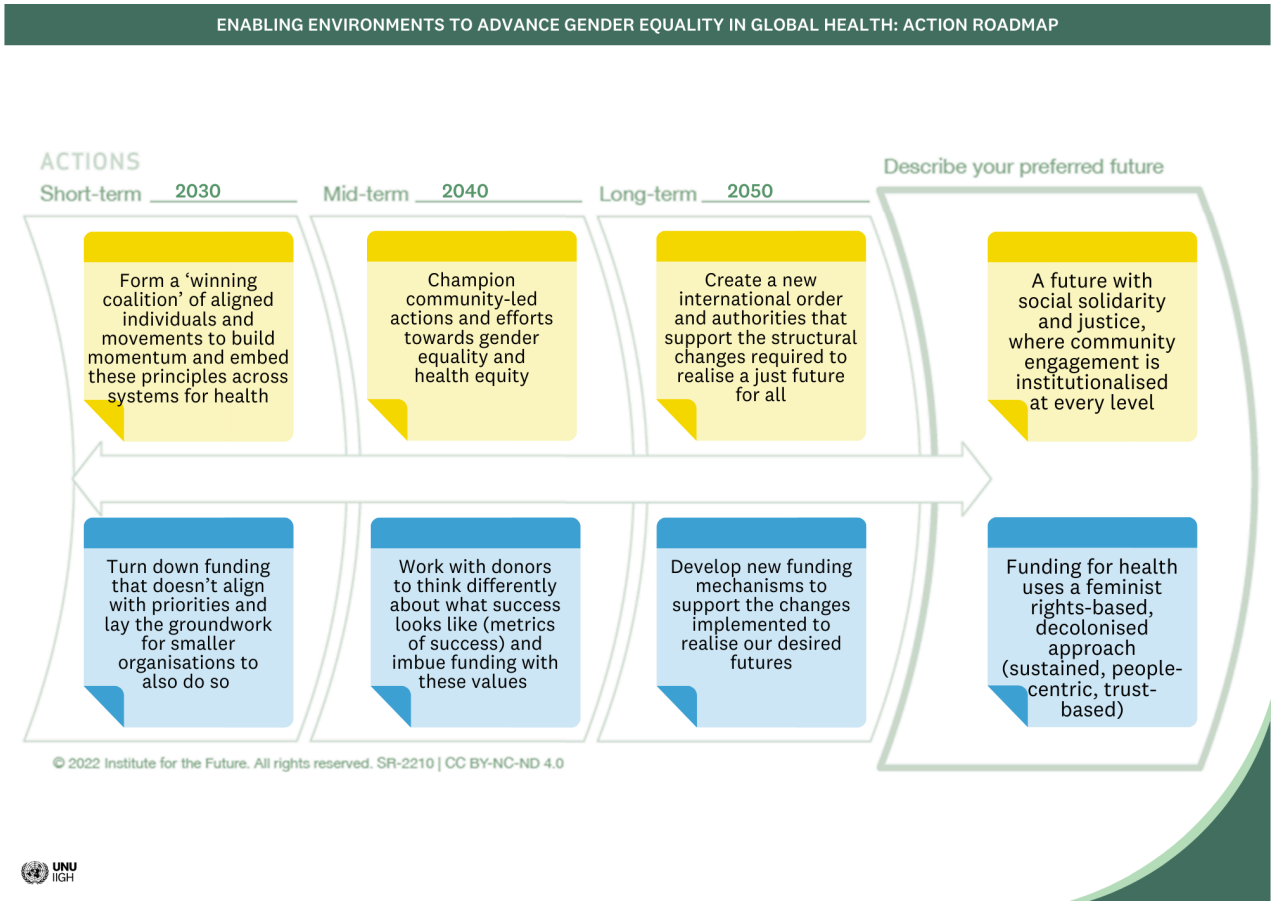
6. From insight to action

What are some actions we can take towards realising our desired futures?

While scenarios can help us flesh out rich snapshots of potential futures, their value ultimately lies in the catalytic potential of these visions to spur action. 'Backcasting' is an approach used to work backwards from scenarios to identify what steps, for example, design and implementation of policies and programs, need to be taken to make that potential future a reality. Having reflected on the four futures to identify key takeaways, discussions then moved on to identifying which scenario elements to make a reality or avoid.

Below are elements of two major pathways to change - financing and collective action - are presented (Figure 6). Financing appeared as a key area of focus repeatedly over the three-day meeting, with experts exploring both different models of funding and new trends in what is funded. Similarly, the need for inclusive and equitable action towards our desired futures was a recurrent topic of discussion. Other elements of preferred futures that were highlighted were a world in which mental health disorders are not considered a "burden" and futures in which there was a more effectively regulated private sector with diminished power, whilst capitalist healthcare solutions disguised as people-centred and individuals being denied health care on the grounds of gender, race, or socio-economic status were futures to be avoided.

Figure 6: Actions that could be taken in the short-, medium-, and long-term to realise our desired futures.



Moving forward

Over the course of three days, we surfaced lessons from past victories and failures, explored current strengths and weaknesses, and envisioned a range of possible futures in search of insights to inform future-ready recommendations for policy- and decision-makers. Moving beyond the reactionary rut and very real constraints of the present moment, we identified proactive next steps to reform and strengthen systems for health through a decolonial feminist lens.

In the final session of the meeting, experts discussed ways to both build and act on this work. Some suggestions included: virtual discussions to further flesh out the scenarios, particularly for disciplined and transformative futures; regional consultations to adapt this approach to local contexts and needs; outputs such as briefing papers and a manifesto for change to draw increased attention to the ideas that thinking longer term can inspire; and participation of the group in spaces such as international conferences and multilateral meetings to shift from insight to action.

BOX 5. Implementing decolonial feminist pathways towards our desired futures.

Rooted in sexism, racism, classism, ageism, ableism, and more, colonial notions of capacity and value remain in play today. Identifying decolonial feminist pathways towards our desired futures necessitates confronting and dismantling those assumptions to strengthen collective and continued action. To do so will require multi-generational cooperation. Our final conversation starter drew on her experiences and expertise as a youth activist to share the importance of co-creating pathways to our futures with today's youth, who will ultimately inherit the futures we shape in the present.

Overall, the group expressed a strong desire to develop a collective plan of action moving forward; first steps towards this were taken at the meeting itself, with experts identifying potential opportunities for collaboration. Individuals also shared their plans to integrate either or both a futures approach and a decolonial feminist lens into their own work.

Finally, the meeting ended with a sense of urgency to do something, and soon, as the horrors documented in the collapse scenario are already a reality for many. In the immediate future, the team at UNU-IIGH will continue working with our experts to expand the group and develop actionable and impactful next steps. Decolonial feminist values must and will be centred as we work towards our desired futures, as they compel us to design current actions and future plans that best serve the whole of society rather than a fragment of it and, in doing so, ensure that no one is left behind as we embark on a collective journey towards our futures.

ABOUT UNU-IIGH

UNU International Institute for Global Health (UNU-IIGH), Kuala Lumpur, Malaysia is the designated UN think tank on global health, serving as a policy translation hub for UN member states, agencies and programmes. It was established by a statute adopted by the Council of the United Nations University in December 2005.

The Institute generates policy-relevant analysis by applying a gender lens to inform the development, implementation and evaluation of health programmes. UNU-IIGH also supports capacity development of local decision-makers and stakeholders to engage effectively with global health challenges within the 2030 Agenda for Sustainable Development.

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