shaped by the patriarchal system in Uganda, which typically privileges men and enforces rigid gender roles and expectations. These norms sustain a hierarchy of power and privilege that typically advantages masculine over feminine traits, perpetuating systemic inequalities that undermine the rights and opportunities of women and girls.[3] In this context, decisions about safe sex predominantly fall to men, depriving young women of agency and autonomy, but also impeding their ability to effectively negotiate preventive measures. This barrier undermines their capacity to engage in proactive health behaviours, exacerbating their exposure to HIV transmission.[4] For example, the cultural norms that sanction unequal power dynamics in relationships, unjustly acknowledge male sexual freedom over female autonomy, restrict women's mobility, and reinforce female submission to their partners' sexual needs exacerbate this vulnerability.[4] However, women's ability to negotiate the conditions and timing of sex, such as refusing sex and asking for condom use with their partners, is key to preventing several reproductive health outcomes.[5]

Although women's autonomy in decision making has gained much attention as a means of enhancing their lives and that of their families, the link between limited decision-making autonomy and high rates of HIV infection among young women remains understudied and demands immediate attention. This relationship poses a serious threat to women's health and wellbeing. By empowering young women's voices and fostering autonomy, we can create a safer environment that reduces their exposure to HIV. This movement will yield added benefits as we strive to achieve Sustainable Development Goals 5 (ie, to achieve gender equality and empower all women and girls) and 11 (ie, making cities and human settlements inclusive, safe, resilient, and sustainable). Therefore, implementing interventions that empower young women in the sexual sphere as well as other dimensions of their lives will provide them with the necessary autonomy to make informed choices. Often, these young women have the capability to make informed decisions, but societal barriers such as limited social space and capacity to express their viewpoints hinder their ability to enforce decisions concerning their sexual lives. Policy makers, researchers, and health-care providers must prioritise this issue in their efforts to combat the HIV epidemic in Uganda.

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1 UNAIDS. UNAIDS Global AIDS Update 2023. 2023. https://www.unaids.org/sites/default/files/media_asset/2023-unaids-global-aids-update_en.pdf (accessed April 30, 2024).
2 Uganda population-based HIV impact assessment: UPHIA 2020–2021. https://phia.icap.columbia.edu/wp-content/uploads/2022/08/UPHIA-Summary-Sheet-2020.pdf (accessed May 9, 2024).
3 Heise L, Greene ME, Opper N, et al. Gender inequality and restrictive gender norms: framing the challenges to health. *Lancet* 2019; **393:** 2440–54.
4 Ahinkorah BO, Ameyaw EK, Seidu A-A. Socio-economic and demographic predictors of unmet need for contraception among young women in sub-Saharan Africa: evidence from cross-sectional surveys. *Reprod Health* 2020; **17:** 163.
5 Seidu A-A, Aboagye RG, Okyere J, et al. Women's autonomy in household decision-making and safer sex negotiation in sub-Saharan Africa: an analysis of data from 27 demographic and health surveys. *SSM Popul Health* 2021; **14:** 100773.

Lancet Commissions must challenge colonial knowledge hegemony

A recent Correspondence highlighted the well known fact that the *O'Neill*–Lancet *Commission on Racism, Structural Discrimination, and Global Health* was launched in Mexico without including any of the Commissioners based there or elsewhere in Latin America.[1] However, the authors conflate such an omission with the potential to perpetuate power imbalances in global health and propose a symbolic (tokenising) reparation as an inclusive approach. If colonising enterprises were designed to engage (subjugate) us all, the decolonising project should concern (empower) us all. Decolonising implies an ongoing process of liberation from the hegemony of Eurocentric knowledge systems.[2]

We find *Lancet* Commissions to overwhelmingly uphold European and North American colonial powers and epistemologies in knowledge production and decision making (eg, the O'Neill Institute is based in Washington, DC, USA and *The Lancet* in London, UK). Since colonisation assumes the superiority of colonial centres (ie, inequity), a truly decolonising endeavour must challenge institutional hierarchies and monopolies of knowledge, and actively work towards decentring colonialist nations.

Is it possible to find opportunities for decolonisation in the O'Neill or any other *Lancet* Commission? A good place to begin *The Lancet*'s journey towards decolonisation is to question the very need for such Commissions, followed by making them transparent about how Commissioners are designated, who funds them, how they self-evaluate, and whether non-*Lancet* affiliated individuals and organisations (ie, the colonised) can evaluate them. We call for more creativity (against hegemony), destandardisation (sensitivity to difference), and solidarity (deprioritisation of those who have power over others) to tackle structural racism in global health initiatives.

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1 Bernal-Serrano D, Campos PA, Velasco-Vasquez R. Missing voices from Latin America in the O'Neill–*Lancet* Commission. *Lancet* 2024; **403**: 436.
2 Büyüm AM, Kenney C, Koris A, Mkumba L, Raveendran Y. Decolonising global health: if not now, when? *BMJ Glob Healt* 2020; **5**: e003394.

Learn from Japan's rehabilitation professionals

Richard Horton commented on how Japan's health has been protected and advanced through the efforts of public health nurses, and highlighted the importance of learning from their experiences.[1] In addition to public health nurses, rehabilitation professionals have also made substantial contributions to community health in Japan, where the ageing rate is the highest worldwide.

In Japan, the first training school for rehabilitation professionals was established in 1963, followed by the introduction of national examinations for physical therapists and occupational therapists in 1966, and speech–language–hearing therapists in 1999.[2] Currently, the number of qualified therapists exceeds 350 000 (calculated using data from the Ministry of Health, Labour and Welfare; Japanese Physical Therapy Association; Japanese Association of Occupational Therapists; and Japanese Association of Speech–Language–Hearing Therapists).

In the Great East Japan Earthquake in 2011, disaster-related deaths—caused by changes in the environment or deterioration of health after the earthquake—became a major problem. In particular, the health of older adults (aged ≥65 years) who were forced to live in unfamiliar environments was easily compromised.[3] To address this issue, visiting rehabilitation stations were established by rehabilitation professional associations in disaster-stricken areas as an exception to the law, and continue to provide services.[2] Even during the COVID-19 pandemic, rehabilitation professionals silently fought to protect patients from the threat of disuse syndrome caused by restrictions on going out.[4]

However, similar to public health nurses, there are many challenges for rehabilitation professionals, such as the lack of an educational system for interdisciplinary collaboration, the unfair evaluation of preventive activities whose results are invisible, and low social recognition. To strengthen the resilience of community health to disasters, infectious diseases, and ageing-related problems, it is important to learn from the experiences of Japan's rehabilitation professionals.

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1 Horton R. Offline: Japan's hidden secret. *Lancet* 2024; **403:** 2578.
2 Japan Physical Therapy Association. 50 years of history: Japan Physical Therapy Association 50th anniversary site. http://50th.japanpt.or.jp/history/ (accessed June 20, 2024).
3 Tsunoo S, Sugawara Y, Tsuji I. Association between social isolation and the risk of incident functional disability in elderly survivors after the Great East Japan Earthquake. *Tohoku J Exp Med* 2023; **261:** 325–33.
4 The Japanese Association of Rehabilitation Medicine. Statement by the president on COVID-19. https://www.jarm.or.jp/topics/topics/9667.html (accessed June 20, 2024).

Public health nurses in Japan

We thank Richard Horton for recognising the contributions of Japan's public health nurses in his recent Offline.[1] These nurses represent the front line of our health system, are equipped and empowered to know their communities, understand health dynamics and health outcomes, act with compassion, and are informed by evidence. Public health nurses have had a crucial role in Japan's health achievements through their community health-care services,[2] combining health promotion and prevention (including health screening), home visits, and identification and strategising around community health needs through local data collection, analysis, and evaluation in partnership with the community.

Core to their approach is establishing trust.[3] For example, public health nurses use culturally competent approaches to inform their disaster response action to support community and health system resilience, including identifying locally appropriate transportation and evacuation routes, leveraging local social networks to share information about missing relatives, and observing social cues to adapt service delivery.[4] Public health nurses have become the backbone for community-based care, and rehabilitation of and support for older adults is crucial for an ageing population.[5] As the health system has evolved, the role of these nurses has adapted and expanded over time, increasing their contribution and impact but also leading to challenges such as resource constraints and high workloads, the replacement of hands-on community care with administrative tasks—which nurses find less rewarding—and the ambiguity of public health nurses' role within the health system hierarchy.[2]

Public health nurses have similarly crucial roles in other countries' health systems, where front-line, community-based health workers bridge the gap between communities and health-care facilities. The role of community-based health workers is one of the potential areas of focus at the Universal Health Coverage Knowledge Hub, which Japan is establishing in close collaboration with WHO and the World Bank. Health policy and systems research can have an important role in capturing the achievements of public health nurses in Japan and analysing the contributions of nursing and other health and care professions to Japan's national health goals. Japan is honoured to welcome the world to Nagasaki this year for