Open Peer Review on Qeios

# [Commentary] Decolonisation of Health in Africa: Opinion Piece

Sanaa Said, Nateiya Yongolo, Sanjura Biswaro, Clive Kelly[1]

1 Newcastle University

Funding: An NIHR Grant was awarded to University of Glasgow and has supported some of the academic work described in this article. Additionally, Health Education England (NE) provided funding for some of the teaching referenced in the paper.

Potential competing interests: No potential competing interests to declare.

## Abstract

Access to healthcare is largely dependent on where you live and how much money you have. It is far from equally accessible to all. The National Health Service (NHS) was established in 1948 to improve access to reasonable standards of healthcare to all residents of the United Kingdom (UK) and to ensure that this was free at the point of delivery. The NHS has been described as ‘the envy of the world’ despite the well-documented challenges it faces. The NHS has driven quality and consistency of clinical care within the UK for decades, and along with universities and many other organisations, it has also fostered a reputation for excellent academic research and teaching. However, the long shadow of the UK’s colonial past on health care provision elsewhere is increasingly recognised. Far from producing and sharing its ‘commonwealth’ equally with people inhabiting the countries it colonised, the UK has been accused of exploiting them in a variety of ways. This opinion piece describes and discusses the past and present influence of the UK in African healthcare and offers some examples of practices that might facilitate improved clinical and academic outcomes for all marginalised people in the near future.

## Workforce

The NHS has traditionally relied on international medical graduates (IMGs) and overseas nurses, and this trend is accelerating. In 2019, 20% of registered General Practitioners (GPs) in England had qualified outside of the UK, with 80% of these coming from Africa and Asia [1]. Three years later, that percentage had doubled to over 40%[2], with Africa contributing the greatest number. This amounts to a reverse brain drain, with many African medics leaving their own countries after completing their medical training to support the ailing NHS, often replacing UK medical graduates who have elected to move overseas to work in Australia, New Zealand, Europe or North America. Concerns about exploitation and discrimination have also been voiced over the experiences of African nurses working in the UK [3]. This feels grossly unfair on the ordinary African whose access to health care in their own country remains diminished as a consequence of these trends.

## Politics

The situation was not helped by the UK's decision to reduce its support for developing countries in the wake of its own financial challenges following the Covid epidemic [4], and Africa bore the brunt of these cuts. However, Rishi Sunak, who was responsible for this decision as Chancellor, has now announced that he will host a UK / Africa investment summit conference in April 2024 as Prime Minister [5]. This may presage a return to previous levels of support for Africa. However, the present attitude of the UK Government towards immigrants and refugees has become increasingly aggressive and negative. Only those with qualifications deemed to be useful to the UK are welcomed. This selective approach applies especially to those with health care qualifications who are treated as 'persona grata', unlike many of their less favoured fellows. How can we begin to redress the global imbalance within healthcare access and delivery? Such a task needs to be undertaken with collaboration across many organisations. The British Medical Association (BMA) must reassess its policies and priorities from a decolonising perspective [6], whilst the British Broadcasting Company (BBC) needs to change its focus away from a UK-centric to a more global interest in healthcare [7]. A fundamental change in approach is required in the relationship between the Global North and Africa as the present mechanisms of support risk potentiating the tendency to maintain the present power base in 'coloniser countries' [8].

## Changing Clinical Priorities and Practice

A recent British Medical Journal (BMJ) editorial encouraged us all to be "brave, hopeful and essential" in decolonising health [9] and we would like to share our experiences in that endeavour. Over the last 5 years we have worked together in Tanzania to design, develop and deliver clinical services for patients with non-communicable disease (NCD). We agree that "efforts must begin with medical education and training" [10], as the Tanzanian medical curriculum previously focussed largely on infectious disease. As NCDs now account for nearly half of all deaths [11] and much morbidity across East Africa, we facilitated a program combining medical education, clinical research and service development replicated across several sites. African and European hospitals and universities have worked in tandem to exchange knowledge within an equitable partnership to provide and sustain evidence-based clinical practices. The rapid changes in the patterns of disease in Africa have implications for the training and responsibilities of all health care workers across the continent. There is a huge need to develop and staff screening programs for the detection and treatment of hypertension and diabetes which requires investment in teaching and training in these areas. Likewise, there is increasing recognition of the importance of auto-immune disorders [12] and musculoskeletal disease [13][14] across all age groups [15] in East Africa, although the present provision of rheumatological services remains woefully behind that available for the rest of the continent [16]. Evidence exists that an increasing burden of systemic complications of these chronic disorders is recognised [17], and that mental health issues are becoming a bigger issue among younger Africans[18]. Together these carry a growing clinical, economic and societal burden for East Africa [19].

Much rhetoric has been expressed over the principles of decolonising medicine, but less has been written about the practical aspects of how to achieve this at a clinical level. Following the recognition that there is a gross lack of darker skin tones among clinical learning resources [20], we have developed medical educational videos of African doctors examining Africans with Swahili commentary, along with a photo library to show disorders present in patients with dark skin. These will soon be freely accessible by all African clinicians. The Tanzanian medical curriculum has been expanded to incorporate the increasing burden of NCDs for all staff and consolidated in a series of open access powerpoint presentations. Clinical services have been established with ongoing input from self-funding UK clinicians during sabbaticals and study leave, who continue to facilitate online seminars, case discussions and advice via regular virtual meetings and WhatsApp consultations. It is essential that these initiatives are not just directed towards doctors but extend to all health care workers who play a huge part in providing clinical care, especially in the community.

## Academic Challenges

The situation in academic medicine has also placed Africans at a distinct disadvantage for decades. Not only does it take non-native English speakers longer to read and write scientific papers [21], but preprints from the African continent are over 50% less likely to be published as full peer-reviewed papers [22]. This is consistent with reduced resources and editorial bias. One African author had a paper rejected from a prominent journal when he gave an African address, but the same paper was accepted with minimal corrections when it was submitted from the UK [7]. Whilst academic output was never our priority, we have published eight articles which document our collaboration spanning several clinical domains. With the equality, diversity, inclusivity and justice (EDIJ) agenda visibly linked to decolonisation, it is worth noting that 60% of our authors are African, while 57% are female. Furthermore, the majority of first authors are African and last authors female. Publishing such work in African journals needs to be more actively encouraged by increasing their value and visibility. As stated in the BMJ podcast series, Journal editors have a huge influence in this area. Developing a 'global health' BMJ and Lancet is an acknowledgement “that you give equal weight to the quality of life and to the rights of all populations” [7], but all true ''partnerships must be built on humility, a willingness to learn, and a shift of power to individuals and institutions'' in the global south [9], and this philosophy should extend to academic as well as to clinical arenas.

Too many publications using data from Africa are published in western journals by western researchers without inclusion of those who collected the data or to whom the data relates. In addition to placing Africans at an academic disadvantage, this approach reduces the likelihood of a change in approach as a result of the study as those most affected are less likely to receive appropriate feedback. A recent paper on the microbiome of hunter-gatherers in Tanzania excluded those who collected the data and offered no feedback to the tribe who had agreed to produce the samples in exchange for scientific advice [23]. However, equitable access to grant funding and authorship for Africans is entirely feasible and should be the rule rather than the exception. A cross-sectional multi-centre study is underway to investigate sickle cell disease mutational burden across Uganda and Tanzania, with ethically matched controls in the USA and UK, and has the potential to unlock gene therapy for this devastating condition [24]. It is self-evident, in an academic environment where success is judged on the quality and quantity of published papers in tandem with grant funding achieved, that African researchers should have equitable access to grant funding and should be encouraged to seek greater representation on the editorial boards of influential journals. Indeed, not only editorial support but positive discrimination should be considered [9][25].

The difficulties caused for academics during the recent covid pandemic were felt more keenly in Africa than in the Global North [26]. Community involvement, an essential element of clinical research, was particularly affected in Africa, where survival in the absence of protective equipment or vaccination was the priority [27]. This led to an inevitable dependency on remote access which was often impractical in the absence of reliable internet access [28] or appropriate electronic devices [29]. Colonialism still influences the structure and function of health care systems in East Africa, long after other legacies have left [30]. Covid-19 was only the latest in a series of African epidemics, following hot on the heels of the Ebola crisis, which was related to chronic underfunding of the health care system as a result of funds being previously prioritised for profitable mining operations [31]. This hints at the heart of the issue. European guidelines for maternity and ante-natal services recommend access to hospital support services for all [32], whereas global guidelines in Africa accept a much more basic level of care with the attendant difficulties in transportation to Hospital if complications arise [33]. As Yanful et al state ‘Highlighting such double standards may push health systems to change course, develop innovative solutions to facilitate access to comprehensive services before labour begins, and help achieve more equitable and effective systems’ [30].

## Future Priorities

A change in the balance of power is required with the evolution of an ‘equal access to healthcare for all’ philosophy[34]. The Global North must learn to work in partnership with Africans on their terms and in their own environment [35]. Clear outcome measures must be discussed and agreed, with an expectation of mutual knowledge exchange [35]. Practical, affordable, and culturally acceptable change must be considered in the context of a sound evidence-base, with lessons learned shared with the population from whence the data was derived [36]. Indeed, given that patient and public involvement (PPI) has become engrained into the philosophy adopted by clinical researchers in the Global North, why should Africans accept anything less? At a teaching level too, a change in approach is overdue. Perhaps the curriculum should include a reflection on the nature of colonialism and its effects on present day societal structures and related healthcare priorities? Such an approach could encourage creative thinking and constructive change, facilitating greater independence and ultimately redressing the inequities that have evolved [37].

Although this paper focusses chiefly on decolonisation and its specific application to healthcare and medicine, it would seem incomplete to conclude without reference to the EDIJ agenda on a broader basis for other disadvantaged groups. There is ample evidence that disability can be associated with reduced representation in academic circles [38], and that diversity may therefore be under-represented among academics as a result [39]. Given that a significant number of PhD candidates identify as neurodivergent, there may be a reduced probability of progression for autistic people, and those with ADHD, to fixed-term tenure in academy [40]. Furthermore, it appears that early-career researchers with disability can struggle to get their work published for a variety of reasons [41], despite often possessing specific qualities that can facilitate successful research [42]. There is a parallel to be drawn with the challenges faced by many people of colour in this regard. It seems self-evident that the motto ‘nothing about us without us’ [43] should be applied equally to all minority groups, and that academic proposals should invite, involve, and include those on whom the research focusses and without whom there would be no story to tell. However, it is well-documented that this is not always the case. As recently as 2021, the proposed Spectrum-10K study came under heavy criticism for not including sufficient input from the autistic community within its construct, leading to a 2-year voluntary pause for detailed consultation [44].

We have published seven papers in the field of neurodivergence over the last few years, acknowledging that people with these conditions often present with a variety of physical symptoms to our medical clinics. We recognised that we could only undertake this work with appropriate input and involvement from this patient group. We invited a range of neurodivergent patients and academics to discuss the rationale for investigating the reasons for such symptoms and recruited interested individuals to help design and complete a series of studies. Overall, the authors of our papers feature 70% females and 50% neurodivergent people. Such an approach is essential if work is to be relevant and credible, and this approach facilitates a wider distribution of relevant information among those to whom the study recommendations apply. Such an approach is commended wherever possible for all people-based research as required by patient public involvement (PPI) [45]. Recent practical resources facilitating widespread adoption of these principles are now published [46].

The ultimate aim of decolonisation must be to provide parity across every domain to all people independent of who they are and where they live. Whilst gross inequality remains evident even within the UK, we must not let this distract us from trying to level the playing field elsewhere, especially as the global north was responsible for marking out the pitch as well as inventing the rules. As a bard once famously wrote "All the world's a stage and all the men and women merely players" [47]. Given the UK's recent political and financial disinvestment in Africa, we have a lot of ground to make up. We like to think that the development of equitable partnerships facilitates sustainable independence and that those willing to invest their time and experience in catalysing this process will be galvanised by the prospect of shared success.

## Acknowledgements

We would like to acknowledge the essential parts played by the University of Glasgow, Kilimanjaro Clinical Research Unit, Newcastle University, Northumbria Hospitals, Kilimanjaro Christian Medical Centre, Health Education England (NE) and Mnazi Mmoja Hospital on Zanzibar, in addition to the contributions made by many individuals both from these Institutions and independently. Without their support, none of this could have happened

## Other References

- Hedt-Gauthier BL, Jeufack HM, Neufeld NH, et al. Stuck in the middle: a systematic review of authorship in collaborative health research in Africa, 2014–2016. BMJ Glob Health. 2019; 4e001853

## References

1. ^*International migration and the healthcare workforce - Office for National Statistics (ons.gov.uk)*
2. ^*bma-gptc-factsheet_img-should know.pdf*
3. ^*Likupe G. Experiences of African nurses in the UK National Health Service: a literature review. J Clin Nurs. 2006 Oct;15(10):1213-20. doi: 10.1111/j.1365-2702.2006.01380.x. PMID: 16968425.*
4. ^*Cameron-Chileshe J. Overseas aid cuts make Britain an outlier among G7. Financial Times. July 15th 2021. Overseas aid cuts make UK an outlier among G7 (ft.com)*
5. ^*UK-Africa Investment Summit announced for April 2024 - The Africa Report.com*
6. ^*Akinnawonu L. Student activism drives decolonisation in medicine. BMJ 2023; 383 doi: https://doi.org/10.1136/bmj.p2337 (Published 16 October 2023)*
7. a, b, c *Looi M-K. What should decolonisation of medical institutions look like? BMJ 2023; 383 doi: https://doi.org/10.1136/bmj.p2257 (Published 16 October 2023)*
8. ^*Rasheed M. The case for a Global South centred model in global health. BMJ 2023; 383 doi: https://doi.org/10.1136/bmj.p2256 (Published 16 October 2023)*
9. a, b, c *Abbasi K. Decolonising medicine and health: brave, hopeful, and essential. BMJ 2023; 383 doi: https://doi.org/10.1136/bmj.p2414 (Published 19 October 2023)*
10. ^*Naidu T. Coloniality lives on through medical education. BMJ 2023; 383 doi: https://doi.org/10.1136/bmj.p2294 (Published 16 October 2023)*
11. ^*Kraef C, Juma PA, Mucumbitsi J, et al. Fighting non-communicable diseases in East Africa: assessing progress and identifying the next steps. BMJ Global Health 2020;5:e003325.*
12. ^*Krauth S, Yongolo N, Biswaro S, Kelly C, Walker R, Siebert S, et al. Prevalence and associated factors of musculoskeletal joint disease in the community setting in Hai district, northern Tanzania, Rheumatology, Volume 61, Issue Supplement_1, May 2022, keac133.104, https://doi.org/10.1093/rheumatology/keac133.104*
13. ^*Kuo C, Black L, Barber S and Kelly CA. Arthritis in East Africa. African Journal Rheumatol 28 Feb 2023 Vol. 11;1 (2023), pages 3 – 9.*
14. ^*Yongolo N, Krauth S, Biswaro S, Moshi B, Mwanswila M, Hemed A, et al. A retrospective survey of arthritis among inpatients at a consultant hospital in Northern Tanzania from 2017 to 2019, Rheumatology, Volume 61, Issue*

*Supplement_1, May 2022, P208 keac133.207, https://doi.org/10.1093/rheumatology/keac133.207*

15. ^*Walsh R, Mwingwa A, Yongolo N, Biswaro S, Mwanswila M, Kelly C et al. (2022) The spectrum and burden of in-patient paediatric musculoskeletal diseases in Northern Tanzania, Paediatrics and International Child Health, DOI: 10.1080/20469047.2022.2062561*
16. ^*Mody G, Tikly M, Hajjaj-Hassouni N. Global excellence in rheumatology: Africa. Front. Med., 28 April 2023 Rheumatology 10 - 2023 https://doi.org/10.3389/fmed.2023.1201020*
17. ^*Said S, Omar N, Juma F, and Kelly CA. Clinical, serological and radiological findings in patients with rheumatoid arthritis from Zanzibar comparing those with and without interstitial lung disease: 'Trends in Immunotherapy' October 2023*
18. ^*Elinisa M, Lugata S, Doshi B, Kelly CA, Ngocho JS. Journal of Mental Health. Symptoms and predictors of depression among university students in the Kilimanjaro region of Tanzania: a cross-sectional study. J Mental Health 2020 https://www.tandfonline.com/eprint/J42TTPRHBG6FJ4KEIG8K/full?target=10.1080/09638237.2020.1793129*
19. ^*Mmbaga, B. T. et al. (2023) Musculoskeletal (MSK) disorders with arthritis screening in Tanzania: new insights into the growing clinical, economic and societal burden of non-communicable disease. Tanzania Public Health Bulletin, 10(1), pp. 8-14.*
20. ^*Abduelmula A, Akuffo-Addo E, Joseph M. The progression of skin color diversity and representation in dermatology textbooks. J Cutan Med Surg 2022; 26:523-5.*
21. ^*Amano T, Ramírez-Castañeda V, Berdejo-Espinola V, Borokini I, Chowdhury S, Golivets M, et al. (2023) The manifold costs of being a non-native English speaker in science. PLoS Biol 21(7): e3002184. https://doi.org/10.1371/journal.pbio.3002184*
22. ^*Eckmann P, Bandrowski A (2023) A tool for preprint to publication detection shows global inequities in scientific publication. PLoS ONE 18(3): e0281659. https://doi.org/10.1371/journal.pone.0281659*
23. ^*Carter M, Olm M, Merrill B, Jha A, Sonnenburg E, Sonnenburg J. Ultra-deep sequencing of Hadza hunter-gatherers recovers vanishing gut microbes. Cell. 2023 VOLUME 186, ISSUE 14, P3111-3124.E13, JULY 06, 2023 https://doi.org/10.1016/j.cell.2023.05.046*
24. ^*Igbineweka N, Okoli S, Sohal M et al. Understanding genome-wide mutational burden in patients with sickle cell disease: experience in the United Kingdom.*
25. ^*Clark J, Hurley R, Ladher N, Jarvies D. What next for decolonising health and medicine? BMJ2023;383:p2302. doi:10.1136/bmj.p2302 pmid:37844958*
26. ^*Rose ES, Rabin TL, Samaan J, et al. COVID-19 pandemic impact on academic global health programs: results of a large International survey. Ann Glob Health 2022;88:84. doi:10.5334/aogh.3843Google Scholar*
27. ^*Nembaware V, Munung NS, Matimba A, et al. Patient-centric research in the time of COVID-19: conducting ethical COVID-19 research in Africa. BMJ Glob Health 2020;5:e003035. doi:10.1136/bmjgh-2020-003035Google Scholar*
28. ^*Tremblay S, Castiglione S, Audet L-A, et al. Conducting qualitative research to respond to COVID-19 challenges: reflections for the present and beyond. International Journal of Qualitative Methods 2021;20. doi:10.1177/16094069211009679Google Scholar*
29. ^*Makri A. Bridging the digital divide in health care. The Lancet Digital Health 2019;1:e204–5. doi:10.1016/S2589-*

*7500(19)30111-6Google Scholar*

30. [a], [b]*Yanful B, Kumar M, Elorrio E, Atim C, Roder-DeWan S. Decolonisation and quality of care. BMJ 2023; 380 doi: https://doi.org/10.1136/bmj-2022-071585 (Published 13 March 2023),*
31. ^*Frankfurter R, Kardas-Nelson M, Benton A, et al. Indirect rule redux: the political economy of diamond mining and its relation to the Ebola outbreak in Kono District, Sierra Leone. Rev Afr Polit Econ2019; 45:522-40. doi:10.1080/03056244.2018.1547188 pmid:31772418CrossRefPubMedGoogle Scholar*
32. ^*European Foundation for Care of Newborn Infants. European standards of care for newborn health: birth and transfer. 2018. https://newborn-health-standards.org/wp-content/uploads/2022/08/2022_09_01_TEG_Birth_Transfer_all.pdf*
33. ^*World Health Organization, UN Population Fund, Mailman School of Public Health Averting Maternal Health and Disability, Unicef. Monitoring emergency obstetric care: a handbook. 2009. https://apps.who.int/iris/handle/10665/44121*
34. ^*Basu L, Pronovost P, Molello NE, Syed SB, Wu AW. The role of South-North partnerships in promoting shared learning and knowledge transfer. Global Health2017;13:64. doi:10.1186/s12992-017-0289-6 pmid:28830489CrossRefPubMedGoogle Scholar*
35. [a], [b]*Victora CG and Moreira CB. North–south relations in scientific publications: editorial racism? Rev Saude Publica. 2006; 40 (in Portuguese): 36-42*
36. ^*Bhakuni H, Abimbola S. Epistemic injustice in academic global health. Lancet Global Health: August 09, 2021 DOI: https://doi.org/10.1016/S2214-109X (21)00301-6*
37. ^*Skopec M, Issa H, Reed J, Harris M The role of geographic bias in knowledge diffusion: a systematic review and narrative synthesis. Res Integr Peer Rev. 2020; 5: 2*
38. ^*Lewis, N.A. What universities say versus do about diversity, equity and inclusion. Nat Hum Behav 6, 610 (2022). https://doi.org/10.1038/s41562-022-01339-1*
39. ^*von Below R, Spaeth E and Horlin C. (2021) Autism in Higher Education: dissonance between educators' perceived knowledge and reported teaching behaviour, International Journal of Inclusive Education, DOI: 10.1080/13603116.2021.1988159*
40. ^*Stark, E.A. Empowering autistic academics. Nat Hum Behav 6, 1184 (2022). https://doi.org/10.1038/s41562-022-01446-z*
41. ^*Milton, D. E. (2012). On the ontological status of autism: The 'double empathy problem'. Disability & Society, 27(6), 883-887.*
42. ^*Fletcher-Watson, S., Adams, J., Brook, K., et al. (2019). Making the future together: Shaping autism research through meaningful participation. Autism, 23(4), 943-953.*
43. ^*Charlton JI. Nothing about us without us. In. Nothing About Us Without Us: University of California Press; 1998.*
44. ^*Sanderson K. High-profile autism genetics project paused amid backlash. Nature 598, 17-18 (2021) doi: https://doi.org/10.1038/d41586-021-02602-7*
45. ^*Jackson, T., Pinnock, H., Liew, S.M. et al. Patient and public involvement in research: from tokenistic box ticking to valued team members. BMC Med 18, 79 (2020). https://doi.org/10.1186/s12916-020-01544-7*
46. ^*Arumugam A, Phillips L, Moore A et al. Patient and public involvement in research: a review of practical resources for*

*young investigators. BMC Rheumatol 7,2 (2023) https://doi.org/10.1186/s41927-023-00327-w*

47. ^*Shakespeare W. 'As you like it' 1623: Act 2, scene 7.*