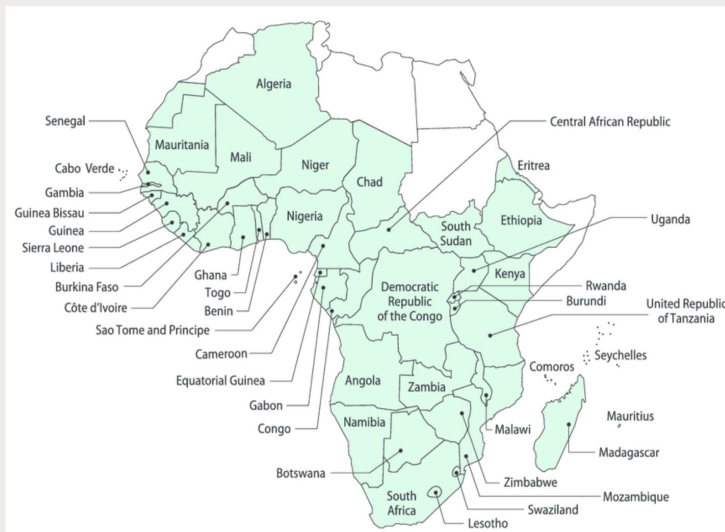
REGIONAL GUIDE
AFRO REGION

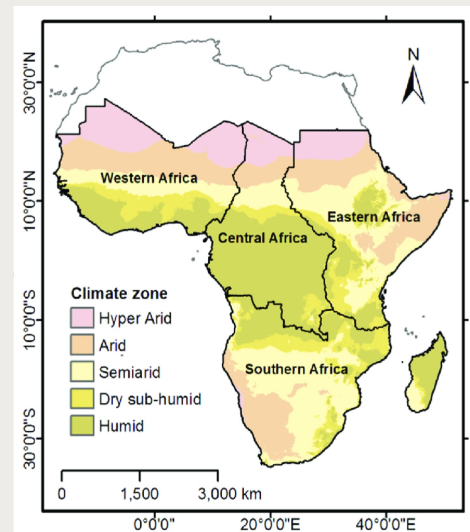
2025 AMWHO INTERNATIONAL CONFERENCE

Bridging Health and Healthcare Disparities between Low, Middle, and High-Income Countries to Achieve Universal Health Coverage

Introduction

The World Health Organization's AFRO region encompasses 47 countries across the African continent.[1] The AFRO region is typically divided into smaller sub-regions including West Africa, Central Africa, East Africa, and Southern Africa (see images below). Each subregion consists of a few countries, each with its own unique culture, language, and beliefs. Collectively, the region is home to an estimated 3,000 languages and several thousand ethnic groups.[2,3] Additionally, the dominant religions in the region are Christianity, Islam, and tribal religions.[4] AFRO's diversity extends beyond just cultural dimensions, the region also includes a wide range of geographic, economic, and natural resources from the Sahara desert in Sudan to the coasts of Capetown in South Africa. However, while this diversity is a hallmark of the region, these differences have also given way to a wide range of economic and healthcare disparities.





The AFRO region is depicted by all of the nations captured on the maps above.

The AFRO region's vast geographic distribution has made it rich in invaluable raw materials such as gold, oil, and arable land. However, this abundance rendered the AFRO region a target for exploitation by Western countries. Beginning in the 1880s, "The Scramble for Africa" resulted in the European colonization of nearly every country in the AFRO region with the only exceptions of Ethiopia and Liberia.[6] Western powers reaped the AFRO region of its natural resources, resulting in negative effects such as poverty, political instability, and economic ruin. While most AFRO nations have been liberated, the deep wounds of colonization have yet to heal as their economies and political landscapes are still recovering.

This legacy of colonialism still impacts the healthcare systems of countries in the AFRO region today, as many of them continuously struggle with the aftermath of the colonization.[7] Colonization prioritized monetary gain over the establishment of stable healthcare infrastructure, leaving behind frail healthcare systems that are ill-equipped to manage the medical needs of the region.[7] These weak health systems, coupled with unstable economies, have led to large healthcare inequities between low, middle, and high-income countries both within and outside of the region. [7] Today, these inequities are evident through multiple facets. Niger is a prime example of this, as it is a low-income country that continues to economically struggle stemming from a reliance on natural resources that were exploited during colonialism. This economic hardship has had a direct impact on the country's health system due to a lack of resources, as the World Health Organization has reported that Niger only has 0.25 healthcare workers per 1,000 people.[8] This falls short of the minimum of 4.45 healthcare workers per 1,000 people needed to sustain universal healthcare.[8] In contrast, high-income countries such as the Seychelles, which maintains a robust tourism-driven economy and was largely unaffected by colonization, have significantly better healthcare resources at 9.15 healthcare workers per 1,000 people.[9]

The impacts of colonialism also extend beyond the fragile healthcare system it left behind and are visible in the prevalence of infectious diseases in the AFRO region.[10] The prioritization of profitable industries and disruption of local healthcare systems have led to many Africans lacking the necessary resources to combat infectious diseases and public health crises effectively.[10] As a result, the AFRO region carries a disproportionate burden of infectious disease with 56% of all cases of HIV attributed to eight lower-income countries in Southern and Eastern Africa.[10] These poor conditions have left many AFRO nation's regions reliant on foreign aid, leaving Non-Governmental Organizations to address overwhelming public health issues. Organizations such as the World Health Organization, UNICEF, and The Global Fund to Fight AIDS, are advocating to achieve universal healthcare coverage in the AFRO region to combat public health issues.[10] However, many challenges such as political instability, insufficient infrastructure, and ongoing economic reliance on foreign aid remain as the path toward universal healthcare coverage requires the bridging of disparities across low, middle, and high-income countries.[11,12,13]

Subtheme 4: Prioritization of Mental Health

Poor overall healthcare infrastructure has led to a large lack of medical resources within the AFRO region, distinctly within mental health support. The infrastructure gap includes insufficient healthcare facilities, a shortage of trained medical professionals, and limited access to medical supplies, all of which contribute to the suppression of mental health care. This deficiency in healthcare can be felt throughout the region but is most prominent in low-income countries in which mental health crises are aggravated further by additional regional issues such as poor economic status and war.[14] In 2022, the AFRO region was home to six of the ten countries with the highest annual suicide rates in the world.[14] Lesotho, a lower-middle income country, had the highest suicide rate of 87.5 deaths per 100,000 people compared to the global average of 9 deaths per 100,000 people.[15]

Additionally, the AFRO region has the highest male suicide rate of all WHO regions at 18 deaths per 100,000 people[8]. This mental health crisis can be traced to the healthcare issues faced by the region beyond just mental disease. Those diagnosed with chronic long-term illnesses such as HIV/AIDs experience a variety of mental health issues due to difficulty adjusting to their illness and a lack of both medical and mental support. A catalyst of this issue is the extreme lack of mental health professionals in the AFRO region with only 1.4 mental health professionals per 100,000 people compared to the global average of 9 workers per 100,000 people.[15] Unfortunately, the few psychiatric resources that are available are inaccessible to most citizens of the AFRO region due to geographic isolation and poverty, leaving millions without necessary care.

CASE STUDY 1: PROVIDING SUSTAINABLE MENTAL AND NEUROLOGICAL HEALTHCARE IN KENYA

Kenya, located in eastern Africa, is classified as a lower-middle-income country in which mental health issues are the second leading factor of death within the population.[10] There is a severe deficiency of mental health resources as only 88 psychiatrists are available to the population of 58 million people.[16] Of Kenya's 47 counties, only 16 of them have at least a single psychiatrist practicing in the public sector.[16] However, a majority of the counties with psychiatrists are urban and exclude rural populations which suffer the most from mental health issues. Stigma and lack of awareness regarding mental health issues also exponentiate this issue as physicians are not properly trained to recognize and treat mental health disorders due to a weak medical education system. A study conducted within several healthcare facilities found that 42% of all patients displayed signs of mild to severe depression, however only 4.1% of those patients were diagnosed or referred to a psychiatrist.[17]

The stigma surrounding mental health issues also remains a significant barrier to accessing mental healthcare in Kenya. All sectors, from legislative to medical, consider mental health as a neglectable cause.[17] A majority of government funding and public health initiatives within the country are directed towards health crises that are considered most urgent/fatal such as malaria, HIV/AIDS, and malnutrition.[17] This leaves mental health resources underfunded and largely ignored. A similar hostility towards mental health is also displayed within the medical field of the country as psychiatric personnel were regularly reported as describing patients as "mental cases" in a stigmatizing and condescending manner.[17]

Recognizing the critical need to address Kenya's lack of mental health resources, the country has initiated efforts to improve access to mental health resources and quality. New medical practices allow mental health resources to be coupled as supporting treatments for diseases that are recognized as conventional medical issues such as HIV/AIDS and malaria. This could provide an opportunity for increased funding and mental health support throughout the country. This increase in governmental support for mental health issues could also initiate the training of more healthcare workers within the public sector. These steps would foster a more inclusive and effective mental healthcare landscape in Kenya.

CASE STUDY 2: SHORTAGE OF PSYCHIATRISTS

An increasing scarcity of mental healthcare professionals in Zimbabwe has been devastating for the youth population of the country. Currently, only one child psychologist is working in the country, only serving the private sector This single psychologist must accommodate the mental health needs of over 7 million children in the country.[19] Zimbabwe is not only suffering from a shortage of mental healthcare workers in the field but also a shortage of medical students interested in pursuing psychiatry. This lack of interest in the mental health field has led to a critical gap in the country's ability to provide mental health support for its citizens.

Zimbabwe is home to around 7.7 million children. Around 14.7% of children between the ages of 5-14 work for a living and another 16% work while balancing school.[20] The majority of these children work in the agricultural sector. A recent study from 2022 has shown that out of 634 young people ages 13-24 in Zimbabwe, 37.4% of them tested positive for common mental health disorders, more than twice the global rate of 15% for this age group.[21,22] While mental health issues run rampant throughout the country, the lack of providers available to help these children in addition to the poor quality of life in the country is creating a mental health crisis epidemic.

Additionally, the country only has one medical school at The University of Zimbabwe. Only two students from the university pursue a master's in Psychology because the field is not considered lucrative. This mindset also applies to the field of psychiatry, resulting in very few medical students specializing in psychiatry regardless of the huge demand for child psychiatrists in the country. Students do not consider this field to be lucrative because of the stigma surrounding mental health.[23] In a society that views only surgeons, physicians, and other forms of medicine as real, it will be hard for students to pursue a field that has such a taboo association with mental health and get their families to accept them.[23] This is simply not a risk that some are willing to take. [23]

The few who do want to fully pursue psychiatry try to lean away from pursuing it within the nation. They know that sometimes institutionalization or incarceration may follow them if they choose to pursue psychiatry within Zimbabwe. They would much rather trade for a better life on another day. This causes the brain drain: the best and brightest of the nation leave the territory because they believe their talents will be better used there.

Zimbabwe's lack of mental healthcare resources, especially for children, can be attributed to the country's rigorous process for medical professionals who would like to join the field. The high demands of those who would like to pursue psychiatry, including a two-semester internship in addition to their master's program and a year-long additional internship, often lead to burnout and disinterest amongst potential psychiatrists.[23] As Zimbabwe looks to strengthen its mental health resources, restructuring the educational system for psychiatry may provide opportunities for a larger interest in the field. Programs and reforms of the educational system could result in a larger workforce within mental health practices, and a more sustainable psychiatric landscape for the country, contributing to more equitable and available mental health support to those who need it.

Subtheme 2: Disparities in Access to Quality Healthcare

Access to quality healthcare is a paramount issue within the AFRO region. Governmental corruption and instability have led to a lack of healthcare infrastructure, with a majority of healthcare being insufficient quality throughout the region. The few healthcare resources that may be considered adequate are usually inaccessible and unaffordable to the majority of lower and middle-class communities in these countries. This poor condition of healthcare is evident as observed in the high infant and maternal mortality rates of the region as well as the high rates of infectious diseases such as HIV/AIDs.[25] These disparities are not only based on socioeconomic class but ethnic identity as well. Many Indigenous and ethnic minorities in the AFRO region have far more limited access to healthcare than their privileged counterparts due to historic systematic discrimination and oppression. Consequently, a wide range of disparities in access to quality healthcare exist throughout the region, both between countries and the different demographics within them.

CASE STUDY 1: SOUTH AFRICA'S SOCIAL INNOVATION IN HEALTH LANDSCAPE

South Africa is a diverse country with a rich history and culture. The country was colonized in the 19th century and had a system of apartheid throughout the 1900s, which eventually collapsed in the 1990s.[25] Despite the collapse of the apartheid system, racial and economic barriers to healthcare still exist.[25] A significant and growing gap in accessibility to healthcare remains between the inherently privileged white class and the indigenous Black population.

The issue of accessibility to quality healthcare in South Africa can be simplified into three critical categories: physical accessibility, affordability, and acceptability. Starting with physical accessibility, many citizens of South Africa cannot seek treatment for their conditions due to limited resources in their geographic location. More than 500,000 South Africans living in rural areas only have access to 5 hospitals which have heavily limited resources.[25] Furthermore, the few hospitals that are accessible are often not affordable for the indigenous, Black communities that live in these rural areas. These costs also extend beyond just the hospital bill, as South Africans must consider the opportunity cost of seeking medical help, including things such as transportation and time, due to their economic disadvantages.[25] Additionally, South Africa is a country with 11 nationally recognized languages. Among those, English is considered the country's official language. This, however, is a barrier to healthcare for those who live in lower-income Indigenous and rural communities, where English is not widely spoken.[25] This results in a healthcare system that is intimidating and hard to accept, posing the issue of the acceptability of healthcare for those communities.

These issues regarding the quality of healthcare for lower and middle-income communities in South Africa are a juxtaposition to the experience of the white upper class of South Africa. Quality healthcare is easily geographically, financially, and linguistically accessible for the upper class with hospitals being centered in urban areas and being English-focused.[25]

Although South Africa faces multifaceted issues within its healthcare system, there are plausible ways to combat this. For example, the implementation of cost-efficient healthcare resources for all citizens would pave the way for more equitable and accessible healthcare. In South Africa, The Ministry of Health has been working on providing quality, accessible healthcare to all South Africans through the National Health Insurance Fund. This program provides low and middle-income South Africans with quality healthcare based on their medical needs and regardless of socioeconomic status.[25] Solutions and programs like these could serve as the foundation for further progress regarding accessibility to quality healthcare in South Africa.

CASE STUDY 2: PERCEPTIONS OF HEALTH, HEALTH CARE, AND COMMUNITY-ORIENTED HEALTH INTERVENTIONS IN POOR URBAN COMMUNITIES OF KINSHASA, DEMOCRATIC REPUBLIC OF CONGO

The Democratic Republic of the Congo is another nation that struggles with health disparities.[26] 1 of every six people living in poverty in Sub-Saharan Africa live specifically within the Democratic Republic of Congo.[26] These elevated poverty levels have a major impact on the country's healthcare system, limiting its ability to provide quality infrastructure, access, and medical equipment to patients. This systemic poverty has not only hindered physical resources but also contributed to deep mistrust within the healthcare system.

According to "Perceptions of Health, Health Care and Community-Oriented Health Interventions in Poor Urban Communities of Kinshasa, Democratic Republic of Congo", there is quite a bit of mistrust within the healthcare system as much of the general public within the country believes that the DRC health centers are very profit driven. While these centers may be of great access to the people of the DRC, the patients have not felt safe within these profit-driven environments. On top of being profit-driven, much of the public seems to hold the belief that DRC healthcare systems do not communicate well about healthcare issues and how to resolve them.[26] When asked what side effects a certain drug would present, people report how they were not given a clear response. This type of communication resulted in more mistrust of doctors within the community, ensuring that people who have healthcare issues or conditions do not seek out hospitals as a source of healthcare. Most of the population seems to believe that doctors and other providers behave this way because they do not believe patients can pay for their treatments.[26] While patients may be willing to set money aside the lack of concern for theirs and their loved ones' conditions leads to a lack of willingness to invest in the healthcare system they are provided.

Potential approaches to making quality healthcare more accessible include exploring and implementing models of universal healthcare, in which all citizens are provided some standard of healthcare that is government-funded or extremely low cost. This, however, would require much government funding, involvement, and investment. However, although the implementation of universal health coverage would be a high commitment, it would also be fruitful for the lower-income communities that could benefit from it. However, to ensure such a system takes place, the country must show a commitment to the issue through unwavering support in terms of finances, governance, and policy.

Subtheme 3: Sustainable Community-Based Initiatives

Throughout the AFRO region, a lack of public and private healthcare resources has caused a gap in necessary medical care for many people. Although, in many regions, this gap is filled by community-based healthcare initiatives. Community-based healthcare initiatives differ from typical public/private healthcare in a few fundamental ways. While medical care often focuses on specific health services, community-based care entails a broader view of healthcare beyond physical issues such as healthcare education. Additionally, community-based care is rooted in the cooperation of a group of individuals working together to solve healthcare issues rather than, for example, one-on-one interactions between patients and doctors. A few examples of these community-based healthcare initiatives include family planning resources, vaccination clinics, and healthcare education programs. Although these initiatives are impactful, the sustainability of their operations is still a critical point of concern. Community-based care must be a long-term process with consistent results to positively impact the healthcare outcomes of a population.

CASE STUDY 1: ACCEPTABILITY BY COMMUNITY HEALTH WORKERS IN SENEGAL OF COMBINING COMMUNITY CASE MANAGEMENT OF MALARIA AND SEASONAL MALARIA CHEMOPREVENTION

Senegal, located on the western coast of Africa, has experienced frequent malaria epidemics.[27] The country's warm climate and distinct rainy season make it a breeding ground for malaria-carrying mosquitoes.[27] While hospitals and physicians have made efforts to medicate those with malaria in efforts to slow its infection rates through medication and vaccination, the country's lack of infrastructure makes it difficult for these tactics to be effective on a large scale due to a lack of accessibility to these resources. Citizens of lower socioeconomic status or who live in rural areas are the most vulnerable to malaria due to both poor living conditions and a lack of medical resources.[27] In recent years, however, there has been a rise in community health care workers (CHWs) throughout Senegal.[27] These are individuals who are trained in health care and education specific to their community and environment. In Senegal, these workers take on the task of educating the community members about preventative measures regarding malaria infection and how to treat malaria once contracted. [27]

Community healthcare workers in Senegal consist of both healthcare professionals as well as community members who have been trained in healthcare education. For example, this includes religious and community leaders as well as village chiefs. These CHWs provide medical advice and education about malaria to citizens at established health huts, which are locations throughout rural and urban areas distributing healthcare information and treatments, to community members in day-to-day life. After accessing these community health care workers and health huts, 92% of participants in this study showed a correct association between mosquito bites and malaria infection. Additionally, 52% of those who were aware of the services provided by the health huts would seek treatment there within 24 hours of their infection.[28] The health huts and CHWs also distribute mosquito nets to citizens, increasing bet net ownership to 99.1% which is a primary and effective preventative measure against malaria infection.[28]

While CHWs have improved the overall healthcare landscape in Senegal, the stability of these programs is still a concern.[29] Community-based care can easily be jeopardized by unforeseen obstacles such as the COVID-19 pandemic, natural disasters, and limited resources. Regardless, the strong foundations and simple design of community-based care such as health huts in Senegal is impactful and well-functioning, showing hope for the future of community-based care in the AFRO region.

CASE STUDY 2: ETHIOPIA'S COMMITMENT TOWARDS ACHIEVING SUSTAINABLE DEVELOPMENT GOAL ON REDUCTION OF MATERNAL MORTALITY

Ethiopia is a country located in the northeastern part of the AFRO region. One of the major issues the country faces is the maternal mortality rate. In 2015, the United Nations set sustainable development goals to reduce global mortality rates to 70 per 100,000 live births by 2030.[29] However, Ethiopia is reported to have a death rate of 401 deaths per every 100,000 births. [29] While the maternal mortality rate has declined since the turn of the century, the maternal mortality rate still remains high. There are numerous reasons for the high maternal mortality rate (MMR) in Ethiopia such as a woman's proximity to a healthcare service, age, complications from birth, and delays in seeking care.[30] Rural populations are severely disadvantaged as they are found far from hospital sites. Younger, less educated women do not have full awareness of pregnancy risks and often die. Many women experience complications during home births, and fail to seek medical help promptly, or are unaware of complications, resulting in death.[30]

With hopes to increase healthcare access within the rural Ethiopian communities, government officials launched the CBHI program in 2010. CBHI is community-based healthcare insurance and this seeks to enhance healthcare financing to improve access to primary care.[31] Particularly, the government was hoping to address the issue of maternal mortality through more access to prenatal and preventative care for women. Another study examined utilizing a coordinated set of interventions such as decentralizing obstetric care, training non-professionals how to perform C-sections, improving midwifery, and enhancing referrals within the system world. This study proved that the MMR improved by 60% in the study group within a four-year period.[32]

While both of these community-based initiatives are useful, maternal mortality rates in Africa are still well above the recommended guideline set by the UN. Some advised solutions to the issue are universal coverage of interventions, especially emergency care, to reduce maternal mortality even more.[33] While having preventative care and prenatal care covered financially will be useful to those before their pregnancy, women still run the major risk of complications postpartum. To address these there must be financing available to these women to stress the importance of going to the doctor after birth if something goes awry. [34]

Conclusion

The social determinants of health play a crucial role in the healthcare landscape of the AFRO region. Many people face economic factors, social disparities, and historical adversities that have inadequately prepared the region to handle healthcare issues. While it seems that a lot of progress has been made in terms of community-based initiatives and health policy, challenges like socioeconomic barriers, lack of resources for mental health, and limited access to professional healthcare remain a huge issue. If the region continues to invest in policy changes, infrastructure, education, and policy changes, it could pave the way to achieve more sustainable outcomes over time.

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