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REGIONAL GUIDE

2024 AMWHO International Conference

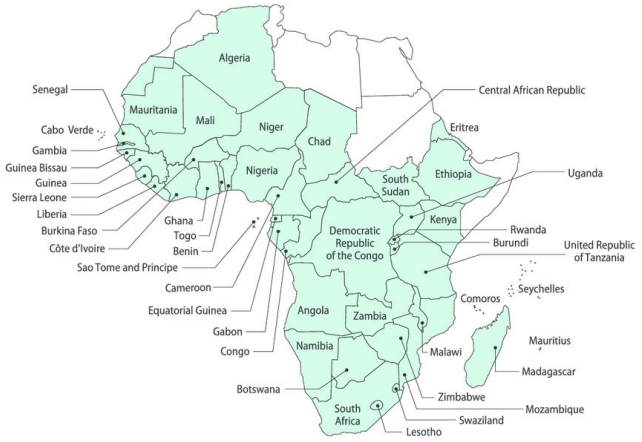
Rectifying Historical and Contemporary Prejudices and Oppressions Undermining Global Health

Introduction

The geography of the African region is an essential factor regarding the healthcare of many individuals. The WHO African Region is prone to natural disasters.[4] 622 natural disasters occurred in Africa from 2010 to 2020.[2] Rising temperatures due to climate change have also intensified famine in the drought-stricken Horn of Africa, Sahel, and Central Africa.[5] Health problems related to climate change include food and waterborne diseases, mental health and stress-related disorders, malnutrition, and chronic and non-communicable respiratory diseases.[2]

Interstate and intrastate wars have hindered economic development and political stability in Africa. 20% of the sub-Saharan population lives in countries at war within themselves.[5] Political tensions, protests, and rioting have led to a 6-year high of civil unrest.[6] Sub-Saharan Africa has also had more major armed conflicts in the past two decades than any other part of the world, leading to an adverse effect on health systems in the region.[6] Political instability has become endemic to sub-Saharan Africa, and this is negatively affecting economic and healthcare development.[5]

The root causes of conflict in Africa may have originated from colonization and differences based on ethnic and cultural diversity.[4] European colonizers drew boundaries between colonies regardless of existing cultural groups.[4] This artificial separation of ethnic groups in Africa destroyed culturally based governance institutions, imposed artificial zones of influence, and, in turn, led to an increase in conflict, ethnic cleansing, and the mass movement of refugees.[3]



The political state of Africa has adverse effects on healthcare. Political stability often disrupts healthcare services and infrastructure.[4] Conflict zones of war may also lack stabilized healthcare systems, which would lead to increased mortality rates.[4] Political instability in Africa can also lead to the deterioration of healthcare infrastructure as roads, electricity, or water supply may be compromised.[4] This may make it very difficult to transport medical supplies to those in need.[4]

The AMWHO Theme, "Rectifying Historical and Contemporary Prejudices and Oppressions Undermining Global Health," aims to unveil the significant healthcare disparities in this region today. The three subthemes, Racism in Healthcare, Gender, Sexual, and Queer Violence, and Effects of Colonialism and Imperialism on Global Health explored core public health issues such as the disparities in healthcare treatment found in South Africa and the implications of colonialism on the spread of infections. Through a greater understanding and knowledge of the healthcare disparities present in this region as a result of colonialism and political instability, global health issues can be better addressed.

Racism in Healthcare

Racism creates a barrier to achieving equitable healthcare as research has shown that it creates unequal processes of delivering, accessing, and receiving healthcare across many countries.[7] Within the African region, racism in healthcare is often linked to inequitable access to healthcare, lack of cultural competence from healthcare providers, and ethnic and tribal disparities.[7] Economic disparities, poverty, and lack of resources hinder individuals from accessing essential medical care.[7] Many healthcare providers also lack an understanding of the diversified African continent, which leads to communication barriers with patients from diverse backgrounds.[7] Experiences of racism are often correlated with a lack of trust and delay in seeking healthcare.[7]

Case Study #1: The Historical Black Experience of Healthcare in South Africa

The history of colonialism and apartheid in South Africa has shaped the healthcare system of South Africa and the challenges that Black South Africans face in the healthcare system.[8] Apartheid was the policy that governed the South African people before 1994 in which the white minority ruled over the non-white majority.[8] The legislation under this governing body included racial segregation which determined where Black people could live, operate businesses, go to school, or own land.[9] Many Black people (or Bantu as the government classified them in 1950) were displaced from their homes and businesses for white settlement.[8] The restrictions also determined the access (or lack thereof) to healthcare for South Africans based on race.[9] The consequences of these colonial and political systems still exist today and affect the healthcare system.[9] Although the economy of South Africa classifies it as a "middle-income country", its health outcomes are worse than many low-income countries.[9]

Due to racial segregation and most land allocated to white people, Black families were forced into slums in urban areas that were typically overcrowded which led to unsanitary conditions.[9] These conditions greatly increased the prevalence of communicable diseases (sometimes called poverty-related diseases) like tuberculosis, malaria, and syphilis in the Black communities.[9,10]

In addition, infant mortality was high for the Black population at 20% versus 2% for the white population.[11] Even in the modern day, post-apartheid society in South Africa, the prevalence of diseases and negative health outcomes are much greater in the Black population than in the white population.[11] For example the prevalence of HIV in South Africa is highest in the Black population at 20.54% compared to 0.37% for the white population.[12] Infant mortality for the Black population is a 47 per 1,000 while the white infant mortality rate is at 11 per 1,000.[13]

Health disparities also exist in access to healthcare. During apartheid, when private insurance (also called medical schemes) was established, it was only allowed for white people until the late 1970s.[14] These restrictions still have lasting effects on the Black population today.[15] Only 10% of Black South Africans have medical schemes compared to the 73% of white South Africans that have medical schemes.[16]

In addition, the patient-to-healthcare provider ratio for the segregated hospitals was a large contributor to the disparities seen in healthcare access.[9] During apartheid, the medical field was segregated. Black doctors could only go to a few black medical schools.[9,17] In the 1930s, there were only ten black doctors in all of South Africa.[17] Black students under the apartheid government were extremely disadvantaged in the classroom as well as economically which led to very low graduation rates.[17] This leads to an extremely inequitable patient-to-doctor ratio. There was one doctor to 308 white people ratio and one doctor for up to 30,000 Black people ratio.[15]

All these factors contribute to the inequalities and disparities that the Black population in South Africa faces today. Solutions to these health concerns include addressing and implementing solutions with the unique historical context in mind. Instead of placing accountability on the individual as a product of their past, we should be focused on the systems that have created these inequalities and how they can be reshaped to benefit the populations that they have consistently failed.

Case Study # 2: Ethical Concerns of Medical Voluntourism in Relation to the White Savior Industrial Complex

Medical volunteerism, or medical voluntourism, involves students or practitioners from wealthy countries undertaking generally short-term overseas work.[18] This practice usually takes place in the healthcare settings of "poor" countries.[18] "Voluntourist" organizations often assist universities with planning international clinical placements for students, doctors, and health professionals.[18] While these organizations claim that these clinical placements aid the development of the communities, less attention has been given to the experiences and views of those in host communities.[18] Medical volunteerism began in the 1960s when healthcare professionals were sent to "third world" countries to apply Western medicine in areas that lacked "qualified" healthcare staff.[18] Many believed volunteerism was a noble or well-intentioned effort to assist sick "poor" people.[18] Clinical volunteer locations are often popular tourist locations or former colonies.[18] Some of these countries are South Africa, Ghana, and Tanzania. For example, in Tanzania, medical volunteers were used in order to aid the staff's struggle to meet the overwhelming needs of patients and inadequate resources.[19] But in turn, inadequately skilled volunteers were placed in the hands of patients.[19]

There are several known justifications for volunteerism. Some include social responsibility, the "other rhetoric", and colonist ideologies.[18] Many practitioners participate in international volunteerism to fulfill a sense of "social responsibility".[18] By doing so, they believe they are assisting communities in developing countries and, in turn, reducing global health inequities.[18] Next, for centuries, images and anecdotes have been narrating the continent of Africa as incapable of escaping poverty and disease.[18] In turn, potential volunteers view their patients in placement areas as "unlucky" and in need of outside intervention in order to "save" them.[18] Lastly, volunteers (regardless of their experience level) had assumed expertise just by being white.[18] Volunteers often also conceptualized themselves as affiliated with real medicine, even though they had not received their medical degrees.[19]

Furthermore, even though the volunteers often had low medical training, their poor quality work was often justified "as good enough." By doing so, these volunteers were applying clinical knowledge in a real-world setting that would never be permitted elsewhere.[20] These justifications enforce the "White Savior Industrial Complex.[18] This is when white people adopt the role of a "savior."[18] In the case of volunteerism, these volunteers arrive in Africa to "save" African communities without considering how they are aiding the harm of these communities.[18] Although medical volunteerism was created to benefit African communities, they often do more harm than good.[18] Volunteers often perform procedures that would be "illegal" in their home countries due to their inexperience.[18] Healthcare given by a first-year medical student is deemed adequate for many African patients, even though this would be unacceptable in many other countries.[20]

In Tanzania, the consequences of medical voluntourism are often drastic. Despite the medical volunteers being instructed to "observe only," volunteers often dismissed trained Tanzania health professionals to practice independently.[18] These volunteers were also inexperienced and needed more technical knowledge and training.[19] Additionally, these volunteers in Tanzania undervalued local staff knowledge and experience and needed more cultural awareness.[19] Medical volunteers were also not only inexperienced but also caused severe harm to their patients.[19] Concerning the "White Savior Industrial Complex," these volunteers often believed that "doing something" is better than "doing nothing".[18] Volunteers were also extremely dishonest about their qualifications and endangered the lives of patients, often resulting in patient death.[18]

Another example of the drastic impacts of unqualified individuals providing healthcare was in 2010 with a lady named Renee Bach.[21] From 2010 to 2015, although she had no medical training, she decided to move to Uganda to develop a medical center for impoverished children.[21] She was severely underqualified and had no right to give healthcare to those patients. Consequently, 20% of the 129 children she took under her care in 2011 died.[21] A third of them passed away in the first 48 hours. In 2012, the death rate among these in-patient cases was 18%.[21]

Medical volunteerism is most meaningful when it is carried out with a long-term vision.[18] This is only possible if volunteers view their host communities as a short-term vacation. In order to effectively provide proper healthcare for the communities they serve, these volunteers must fight against the language barrier, critically examine the communities they aim to serve and evaluate the services they are qualified to administer.[18] In countries such as Tanzania and South Africa, improving access to basic healthcare for disadvantaged groups cannot be solved through foreign volunteer attention solely.[22]

Gender, Sexual, and Queer Violence

Gender, sexual and queer violence are all high challenges faced by gender and sexual minorities in the AFRO region.[23] Violence against these communities is a public health problem that plays a large role in the morbidity and mortality of these communities and greatly affects many components of their health.[23-25] In many parts of Eastern and Southern Africa, being a sexual or gender minority is a risk factor for experiencing violence.[23] In many of these countries, the judicial system is typically not used to address gender sexual and queer violence, for example in 31 countries, same-sex acts are criminalized.[26] Studies have shown that countries in Africa have an extremely high prevalence of emotional, sexual, and physical gender-based violence (GBV) against women.[25] These are driven by factors such as poverty, shame, harmful cultural practices that empower men, normalization of violence, and weak judicial systems that fail to take action to address the needs of GBV survivors.[25]

Case Study #1: Gender-Based Violence Against Women and Girls in South Sudan

South Sudan has dealt with decades of conflict that have perpetuated intense gender-based violence (GBV) against women and girls.[27] GBV is one of the greatest challenges that women and children face in South Sudan.[27] This has come in the forms of domestic violence, abduction, sexual assault, rape, and forced marriages, to name a few.[27] Events like the attacks, raids, and wars, such as the third civil war of 2016, make women and girls especially vulnerable and subject to different forms of GBV. Although this has been internationally recognized as a widespread problem for the women and girls of South Sudan, the incidences of GBV against women have not decreased.[27] In fact, it is common for abusers to avoid accountability, and women that end up in refugees lack the legal assistance to address the violence they have endured and hold their abusers accountable.[27]

UNICEF estimates that around 65% of women and girls in South Sudan have faced sexual or physical violence and 51% have faced intimate partner violence.[28] Sexual violence during raids and attacks from non-partners has affected around 33% of women and girls, and the majority of the GBV that occurs towards women and girls in South Sudan is faced by girls under 18 years of age.[28] Rapes during attacks and raids are seen as a military tactic used by armed groups. They are typically not condemned or prevented by government agencies. [29]

In addition, forced child marriages are widely enforced and practiced, especially during conflict.[30] Statistics show that 52% of girls in South Sudan are married before the age of 18 and 1 in 3 girls are pregnant before the age of 15.[30] This is due to economic challenges, social norms, and cultural practices.[30] During conflict, the economy of the country is extremely unstable and it is common for families to marry off their very young daughters to collect a dowry.[30] Additionally, low levels of education and the risk that come from child marriages have fueled early forced marriages of the girls of South Sudan.[30] There are many deep-rooted cultural and social norms in the history of South Sudan that relate to gender and have created the space for the norm of early and forced child marriages.[30] Child marriages also encourage early childbirth which comes with risks and complications that could have lifelong, irreversible consequences.[30]

The environment of the nation has created a space where GBV can thrive. GBV against women is extremely accepted and normalized.[27] In addition, the justice system is ill-equipped to handle cases of GBV, and many of the people responsible are not held accountable. The system is typically disinterested and ineffective at assisting survivors in obtaining legal counsel on their cases and bringing justice to their abusers.[27] This leads to numbers being underreported and fear of speaking out.[27]

Studies have shown that poverty, gender inequality, patriarchal systems, and lack of knowledge are drivers of GBV.[27] In South Sudan, all of these aspects come into play, especially in times of conflict. The social norms of society are also contributors to GBV.[27] For example in South Sudan, if a young girl is raped, the male could simply pay a bride price and marry her, and it is no longer counted as rape. Or if a married woman is raped, it is considered adultery and the man pays a fine to the husband of the woman. In most situations, the patriarchal structures that exist in the communities exclude the women and girls who were harmed.[27] There is also a power dynamic that exists that causes women to fear reporting and speaking out due to shame, lack of support, and potential additional violence that they might face.[27] For the betterment and safety of women and girls in South Sudan, there needs to be a stronger humanitarian focus on protecting women and girls against GBV in times of crisis and conflict, alongside a strengthening of women's rights in the legal system.

Case Study #2 - The Negative Impacts of the Same-Sex Marriage Prohibition Act in Nigeria on the LGBTQ+ community

In 2014, Nigeria's former president, Goodluck Johnathan, signed the Same-Sex Marriage Bill (SSMPA) into law.[31] This law criminalizes same-sex relationships and those who advocate for LGBTQ+ rights.[31] Anyone who enters a same-sex marriage or relationship in Nigeria is jailed for 14 years.[32] This law also punishes anyone who participates in or supports gay clubs, societies, and organizations with ten years of prison.[31]

The SSMPA has led to an increase in extortion and violence against LGBTQ+ people and has also created restrictions on organizations providing essential services to the LGBTQ+ community.[32] Many members of the LGBTQ+ community can no longer live openly in Nigeria out of fear of losing their family's trust, their livelihood, and even their lives.[32]
This law has allowed members of the public to engage in homophobic violence without fear of legal consequences.[32] When officials and law enforcement officials condone or commit violence, this creates a climate of fear that fuels human rights violations.[32]

There was not only an increase in violence against members who identify as part of the LGBTQ+ community, but also an increase in physical violence, aggression, and harassment of human rights defenders working on sexual minority cases.[31] For example, in 2014, a group of 50 individuals armed with weapons dragged 50 people from their homes and beat 14 men they suspected of being gay.[32] This discrimination against the LGBTQ+ community in Nigeria not only threatens their life but also restricts their access to healthcare services, such as HIV treatment.[31]

After the SSMPA was passed, police officers and members of the public were allowed to legitimize abuse against the LGBTQ+ community.[32] These violent acts include extortion, mob violence, torture in detention, and physical and sexual violence.[32] Because of this law, members of the LGBTQ+ community cannot live in peace in Nigeria and are often subject to violent attacks as there has been an increase in crimes committed against them.[32] For example, in 2023, Nigerian police arrested 76 people for organizing a gay wedding.[32]

Acts of public violence have been a common occurrence since the law was passed. Various areas in Nigerian cities witnessed an upsurge in violence directed against LGBTQ+ people.[32] This included mob attacks, with police often joining in the attack. These mob attacks did not take place before SSMPA.[32] Not only is there an increase in crime, but the police are often the leading members enforcing violent acts.[31] Many police officers in Nigeria use the SSMPA as a way of condoning arbitrary arrests and extortion.[31] After police members arrest individuals they suspect identify as LGBTQ+ members, they often force bribes of 25,000 Naira ($32-64 USD) as a way of making money off those they arrest.[32] The police often use humiliation tactics during arrests, such as forcing LGBTQ+ individuals to undress during their visit to the police station.[32]

LGBTQ+ victims of crimes also often do not file or report complaints with the police out of fear that they would be treated as criminals under the SSMPA.[32] Fear of being outed is another reason many individuals cannot report the crimes committed against them.[31]

The SSMPA not only endangers the public safety of LGBTQ+ individuals, but it also creates a barrier between HIV prevention and treatment for gay men in Nigeria.[31] Discrimination based on sexual orientation and gender identity, combined with high levels of physical, psychological, and sexual violence against gay men, impedes sustainable national responses to HIV.[32] The climate of fear created in Nigeria prevents gay men from seeking HIV treatment.[31] After the law was passed, many individuals could not go to the hospitals for STIs (sexually transmitted infections) or HIV because doctors would often directly ask how they got infected.[32]

A study was conducted to investigate the effects of SSMPA and HIV prevention.[33] The study found that avoidance of healthcare and loss of follow-up appointments in members of the LGBTQ+ community became more evident after the SSMPA was passed.[33] Out of the 161 (89%) of 181 HIV Infected MSM (Men who have sex with men), those who had disclosed their sexual behavior with a healthcare provider were less likely to disclose any information after SSMPA was passed.[33] His study also found that the SSMPA negatively impacts STI and HIV treatment and lowers global goals of HIV eradication in Nigeria.[33]

Addressing and reducing gender, sexual, and queer violence against the LGBTQ+ community can be facilitated in many different aspects. Advocacy against the SSMPA would aid in decriminalizing the violent behavior that is currently being committed against the LGBTQ+ community. Secondly, training law enforcement in sensitivity treatment would help ensure fair and unbiased treatment of LGBTQ+ individuals.[32]

Next, providing adequate legal aid and support for LGBTQ+ individuals by ensuring victims of violence can file criminal complaints against their attackers will help these individuals have their voices and stories heard.[33] Lastly, providing inclusive healthcare services through non-discriminatory services and an increase in mental health services will help ensure that LGBTQ+ individuals have access to HIV services, care, and treatment.[31]

Effects of Colonialism and Imperialism on Global Health

At the end of the nineteenth century, most of the African continent was conquered by 6 European countries: Britain, Spain, France, Germany, Belgium, and Portugal.[34] Many of these countries sought to “civilize”, “develop”, and create and influence social structures across the continent.[34] The European countries were also interested in improving the overall health of these countries, however, they wildly underestimated the state of the health conditions across the colonies and were ineffective in improving health.[34] In fact, disease and malnutrition worsened during colonial years due to the disruption and chaos of conquest, the extraction of resources, and the increased need for labor to contribute to the European agenda.[34] Without the complete eradication of colonialism and imperialism, there is no end to the health challenges that these newly independent countries face.

Case Study #1: An Overview of the Negative Implications of Colonialism on Infectious Disease and Healthcare Systems in Africa

From the late nineteenth to the early twentieth century, many European countries rushed to acquire and establish colonies in Africa.[35] Trade routes developed through colonization led to the spread of new pathogens and, in turn, devastated indigenous populations.[36] Through colonizing African countries, the European contribution to global pathogen exposure created a "global homogenization of disease".[36] No border was left uncrossed in the spread of infectious diseases.[36]

Many colonial powers promoted medical advancements only when diseases affected their people.[37] The colonists only medically aided locals when it was in the colonies' best interests.[37] The main goal of colonization was to secure unfair trade advantages, but there were other motives, such as religious conversion and racial discrimination.[38] However, the main obstacle of these goals was malaria, as this disease limited military control and threatened all colonization activities.[38] As a result, malaria became a critical threat to colonial ambitions and a significant priority for study and resolution.[38] The colonists' medical research did not focus on medical issues that impacted several African countries, such as sanitary sewerage or water filtration.[38] Instead, their research was focused on bacteriology and parasitology, as this research would have increased their immune responses to several infectious diseases.[38] The pattern of malaria we see today was produced by colonialism, and the study of malaria was not intended to help Indigenous people defeat the disease.[38] Instead, the academic study of malaria was intended to protect colonial interests as this would help sustain the spread of the disease, providing more ways for Europeans to colonize more effectively.[38]

Inadequate responses to infectious diseases were also evident in the European's response to the sleeping sickness disease.[38] This was the first reported major epidemic in East Africa.[39] Sleeping sickness disease is transmitted by Tsetse flies and is fatal to humans unless treated.[40] This disease affected territories surrounding Lake Victoria, including Congo, Uganda, Sudan, and Tanzania.[38] When this epidemic broke out in European colonies, many colonial powers responded quickly for humanitarian and racist reasons.[39] Through coercive tactics, the colonists forced large numbers of people to leave their villages to stop the spread of disease. Through drug treatment and violent removal, the spread of the epidemic slowed.[40]

European colonization of several African countries also initiated the implementation of new forms of healthcare services. However, European medical services in Africa were very ineffective and provided inadequate care to African colonial patients.[41] Because medical services and resources were often only used to meet the needs of Europeans, colonial healthcare never adequately addressed the many needs of the African countries.[39]

After the end of colonization, many African countries attempted to continue using the healthcare systems their colonizers provided.[36] However, these often consisted of inadequate structures based on Western medical models.[36] Small rural clinics and state health systems were often underfunded, understaffed, and, thus, less effective.[36] Post-colonialism, medical consent was rarely sought, leading to mistrust, misunderstanding, and resistance from many African patients.[38] Colonialism in Africa has led to many challenges in achieving equitable healthcare for many. Some solutions to increasing the health of many African patients post-colonialism include restructuring healthcare systems by incorporating traditional healing practices, prioritizing preventive healthcare measures, and investing in upgraded healthcare infrastructure.[36]

Case Study #2- The effects of German and British Colonialism on malnutrition and healthcare in Tanzania

Tanzania was conquered by Germany in the 1880s. The Germans ruled the colony for 30 years.[42] Majority of the German rule consisted of extracting goods, food, and cheap labor from the Tanzanian people, which left very few resources for the native people to survive on.[43] They also introduced a system of taxation and forced labor.[42] The economic system that colonial rule depended on was agricultural pursuits for export that would bring in a flow of cash.[44] The goods would come from one of two sources: African farmers or European plantation owners.[44] When using European plantation owners, the colonial government established policies that would ensure the plantation owners had a large enough labor force to tend to their plantations.[44]

Due to this system instituted by colonial rule, domestic food production was largely ignored which created an increase in malnutrition and health issues, especially for women and children.[44] Many men were forced to migrate to other areas and look for work in order to pay taxes that were imposed by them by colonial rule.[44] This resulted in the neglect of local farms and land causing extreme malnutrition and poor health, particularly in rural areas.[44] Women were only allowed small gardens to plant cropped, which they overcrowded due to lack of space which subsequently caused a failed cropping season.[44] Women were hesitant to move for fear of losing ownership to their land.[44] Groundnuts and other plants that were potential good sources of protein were exported and there was very little dietary diversity, leaving most people to survive off primarily cassava for years.[44] All these factors played into the intensity of malnutrition the Tanzanian people had to face.

In addition to the cash crop system, World War I and II left devastating effects on health in Tanzania.[44] The majority of the East African campaign of World War I was fought in Tanzania which not only destroyed infrastructure and land, but also caused great famine.[44] Cattle were used to feed German and British troops which caused a major decline in food available for natives.[45] It also caused extreme population decreases. After World War I, the League of Nations (now known as the United Nations) gave Tanzania to Britain in 1920.[44]

Very little data was collected and preserved on population and health statistics prior to British rule. This transition left Britain to deal with a broken health system and a huge problem of malnutrition. [44] These issues were the result of colonial neglect from German rule.[45] The burden of infection that the population as a whole suffered was extensive.[45] The British medical department found that people suffered from various diseases like malaria, dysentery, tropical fever, anthrax, sleeping sickness, smallpox, tuberculosis, bubonic plague, and many many more.[45] Apart from smallpox, many of these diseases still run rampant in Tanzania today. Many of these infections are either caused by or exacerbated by a lack of adequate nutrition. This is the effect of a failed healthcare system instituted by colonial rule.[44]

The healthcare system built by the British colonial rule was extremely ineffective in treating and addressing the health issues of Tanzania- an extremely poor country at the time.[44] Preventive health was largely ignored and many campaigns were reactions to major health crises.[44] For example, vaccine campaigns were only done during an epidemic.[44]

In addition, the majority of the health budget was used in the urban areas and rural areas were typically underfunded and neglected.[44] This not only limited the access to healthcare in rural areas, but also the number of Tanzanian doctors that existed during colonial rule.[44] When Tanzania gained their independence in 1961, there were only 17 Tanzanian medical doctors.[44] There was also a widespread colonial restriction on traditional medicine and cultural practices that Tanzanians used to improve health outcomes.[44]

German and British colonial rule of Tanzania extremely disadvantaged the health and healthcare system of the country. The combination of the exploitation of resources, cash crop system, forced labor, taxation, and later on, failed healthcare system and medical neglect directly caused the intense burden of malnutrition and disease that ravaged through Tanzania and still impacts the country today.[44] In order to overcome this, past colonial powers need to recognize and address their part in the existence of these disparities.

Conclusion

Africa has had to overcome a multitude of challenges and injustices over the years. From the Trans-Atlantic Slave trade to neo-colonialism, many entities have attempted to marginalize African countries and exploit them. The results of these activities have greatly affected health and healthcare across the African continent. There must be local, national, and international approaches in improving the health outcomes of Africans and the overall healthcare systems that have been undermined and neglected for centuries. With the right collaboration, cultural humility, and respect, the goals of improving health and safety for all across the continent can be achieved.

References

1. Health and well-being for all in the WHO African Region: a summary. Published 2023. Accessed December 22, 2023. https://files.aho.afro.who.int/afahobckpcontainer/production/files/Health-for-all_Regional_Factsheet.pdf
2. African Trails. Africa Culture and History. African Tours with African Trails. https://www.africantrails.co.uk/tour-info/africa-culture-and-history/
3. The role of cultural diversity in conflict resolution in Africa – Ideas for Peace. Accessed November 11, 2023. https://ideasforpeace.org/content/the-role-of-cultural-diversity-in-conflict-resolution-in-africa/
4. Mbaku JM. Political Instability and Economic Development in Sub-Saharan Africa: Some Recent Evidence. The Review of Black Political Economy. 1988;17(1):89-111. doi:https://doi.org/10.1007/bf02900956
5. Kedem S. Civil unrest in Africa soars to six-year high. African Business. Published May 25, 2023. https://african.business/2023/05/politics/civil-unrest-in-africa-soars-to-six-year-high
6. Chol C, Negin J, Garcia-Basteiro A, et al. Health system reforms in five sub-Saharan African countries that experienced major armed conflicts (wars) during 1990–2015: a literature review. Global Health Action. 2018;11(1):1517931. doi:https://doi.org/10.1080/16549716.2018.1517931
7. Hamed S, Bradby H, Ahlberg BM, Thapar-Björkert S. Racism in healthcare: a scoping review. BMC Public Health. 2022;22(1). doi:https://doi.org/10.1186/s12889-022-13122-y
8. Apartheid | South Africa, Definition, Facts, Beginning, & End | Britannica. Britannica. Published November 5, 2023. Accessed November 8, 2023. https://www.britannica.com/topic/apartheid
9. Coovadia H, Jewkes R, Barron P, Sanders D, McIntyre D. The health and health system of South Africa: historical roots of current public health challenges. *Lancet Lond Engl*. 2009;374(9692):817-834. doi:10.1016/S0140-6736(09)60951-X
10. Alexander L. Health Disparities During Apartheid in South Africa. The Borgen Project. Published April 7, 2020. Accessed November 8, 2023. https://borgenproject.org/health-disparities-during-apartheid/
11. Kon ZR, Lackan N. Ethnic Disparities in Access to Care in Post-Apartheid South Africa. *Am J Public Health*. 2008;98(12):2272-2277. doi:10.2105/AJPH.2007.127829
12. Bell GJ, Ncayiyana J, Sholomon A, Goel V, Zuma K, Emch M. Race, Place, and HIV: The Legacies of Apartheid and Racist Policy in South Africa. *Soc Sci Med 1982*. 2022;296:114755. doi:10.1016/j.socscimed.2022.114755
13. Anderson NB, Bulatao RA, Cohen B, National Research Council (US) Panel on Race E. An Exploratory Investigation into Racial Disparities in the Health of Older South Africans. In: *Critical Perspectives on Racial and Ethnic Differences in Health in Late Life*. National Academies Press (US); 2004. Accessed November 8, 2023. https://www.ncbi.nlm.nih.gov/books/NBK25536/
14. McIntyre DE, Dorrington RE. Trends in the distribution of South African health care expenditure. *South Afr Med J Suid-Afr Tydskr Vir Geneeskd*. 1990;78(3):125-129.
15. SOUTH AFRICA | Summary. Columbia University Mailman School of Public Health. Published January 16, 2021. Accessed November 8, 2023. https://www.publichealth.columbia.edu/research/others/comparative-health-policy-library/south-africa-summary
16. Health | South African Government. Accessed November 8, 2023. https://www.gov.za/about-sa/health
17. Digby A. Black Doctors and Discrimination under South Africa's Apartheid Regime. *Med Hist*. 2013;57(2):269-290. doi:10.1017/mdh.2012.106
18. https://tdtmvjournal.biomedcentral.com/articles/10.1186/s40794-017-0048-y

19. BUJPH. Discussions in Global Health Volunteering: Imperialism, Incompetence, and Indifference. Brown Undergraduate Journal of Public Health. Published December 12, 2021. Accessed January 22, 2024. https://sites.brown.edu/publichealthjournal/2021/12/12/global/
20. Müller A, Daskilewicz K, Kabwe ML, et al. Experience of and factors associated with violence against sexual and gender minorities in nine African countries: a cross-sectional study. *BMC Public Health*. 2021;21(1):357. doi:10.1186/s12889-021-10314-w
21. Aizenman N, Gharib M. NPR Choice page. Npr.org. Published 2019. https://www.npr.org/sections/goatsandsoda/2019/08/09/749005287/american-with-no-medical-training-ran-center-for-malnourished-ugandan-kids-105-d
22. Sullivan N. International clinical volunteering in Tanzania: A postcolonial analysis of a Global Health business. Global Public Health. 2017;13(3):310-324. doi:https://doi.org/10.1080/17441692.2017.1346695
23. Müller A, Daskilewicz K, Kabwe ML, et al. Experience of and factors associated with violence against sexual and gender minorities in nine African countries: a cross-sectional study. *BMC Public Health*. 2021;21(1):357. doi:10.1186/s12889-021-10314-w
24. Nuwabaine L, Kawuki J, Amwiine E, et al. Sexual violence and associated factors among women of reproductive age in Rwanda: a 2020 nationwide cross-sectional survey. *Arch Public Health*. 2023;81(1):112. doi:10.1186/s13690-023-01109-z
25. Muluneh MD, Stulz V, Francis L, Agho K. Gender Based Violence against Women in Sub-Saharan Africa: A Systematic Review and Meta-Analysis of Cross-Sectional Studies. *Int J Environ Res Public Health*. 2020;17(3):903. doi:10.3390/ijerph17030903
26. Lay KPS Timothy. Political Violence Targeting LGBT+ Communities in Africa. ACLED. Published December 14, 2021. Accessed November 29, 2023.
27. *Initial Assessment and Mapping: Reducing Inequality and Gender-Based Violence in South Sudan*. South Sudan Women Empowerment Network; 2021. https://www.eeas.europa.eu/sites/default/files/south_sudan_womens_empowerment_network_6.12.2021_1_002.pdf
28. *Briefing Note Gender Based Violence*. UNICEF; 2019. https://www.unicef.org/southsudan/media/2071/file/UNICEF-South-Sudan-GBV-Briefing-Note-Aug-2019.pdf?mc_cid=df23736a5b&mc_eid=edad8600b3
29. South Sudan: UN report highlights widespread sexual violence against women and girls in conflict, fueled by systemic impunity. OHCHR. Accessed November 29, 2023. https://www.ohchr.org/en/press-releases/2022/03/south-sudan-un-report-highlights-widespread-sexual-violence-against-women
30. Some things are not fit for children – marriage is one of them. Accessed November 28, 2023.https://www.unicef.org/southsudan/press-releases/some-things-are-not-fit-for-children
31. Nigeria: Harsh Law's Severe Impact on LGBT Community. Human Rights Watch. Published October 20, 2016.
32. Human Rights Watch. "Tell Me Where I Can Be Safe" | The Impact of Nigeria's Same Sex Marriage (Prohibition) Act. Human Rights Watch. Published June 6, 2017. https://www.hrw.org/report/2016/10/20/tell-me-where-i-can-be-safe/impact-nigerias-same-sex-marriage-prohibition-act
33. Schwartz SR, Nowak RG, Orazulike I, et al. The immediate effect of the Same-Sex Marriage Prohibition Act on stigma, discrimination, and engagement on HIV prevention and treatment services in men who have sex with men in Nigeria: analysis of prospective data from the TRUST cohort. The Lancet HIV. 2015;2(7):e299-e306. doi:https://doi.org/10.1016/s2352-3018(15)00078-8

34. Tilley H. Medicine, Empires, and Ethics in Colonial Africa. *AMA J Ethics*. 2016;18(7):743-753. doi:10.1001/journalofethics.2016.18.7.mhst1-1607
35. Eds. Kilbourne EDAWGS. *Human Ecology and Public Health*. Macmillan,; 1969.
36. Stilson B. A Failure to Care: Colonial Power and Healthcare in Africa, 1850-1939. The Undergraduate Historical Journal at UC Merced. 2019;6(1). doi:https://doi.org/10.5070/h361046187
37. Bump JB, Aniebo I. Colonialism, malaria, and the decolonization of global health. Demetriades AK, ed. PLOS Global Public Health. 2022;2(9):e0000936. doi:https://doi.org/10.1371/journal.pgph.0000936
38. Tilley H. Medicine, Empires, and Ethics in Colonial Africa. AMA Journal of Ethics. 2013;18(7):743-753. doi:https://doi.org/10.1001/journalofethics.2016.18.7.mhst1-1607.
39. Hussain M, Sadigh M, Sadigh M, Rastegar A, Sewankambo N. Colonization and decolonization of global health: which way forward? Global Health Action. 2023;16(1):2186575. doi:https://doi.org/10.1080/16549716.2023.2186575
40. Headrick DR. Sleeping Sickness Epidemics and Colonial Responses in East and Central Africa, 1900–1940.
41. Büscher P, ed. PLoS Neglected Tropical Diseases. 2014;8(4):e2772. doi:https://doi.org/10.1371/journal.pntd.0002772
42. 19.5A: Colonialism and the Spread of Diseases. Social Sci LibreTexts. Published August 28, 2018. https://socialsci.libretexts.org/Bookshelves/Sociology/Introduction_to_Sociology/Sociology_(Boundless)/19%3A_Health_and_Illness/19.05%3A_Modern_Issues_in_Health_Care/19.5A%3A_Colonialism_and_the_Spread_of_Diseases
43. Turshen M. The Impact of Colonialism on Health and Health Services in Tanzania. *Int J Health Serv*. 1977;7(1):7-35. doi:10.2190/L9G4-KJVK-AW7A-Q9JD
44. *Maji Maji Research Project, 1968: Collected Papers*. University College; 1968.
45. Tanzania (Zanzibar), 1913-1947. British Online Archives. Accessed January 12, 2024. https://microform.digital/boa/collections/39/volumes/239/tanzania-zanzibar-1913-1947
46. Maclean G. Medical Administration in the Tropics. *Br Med J*. 1950;1(4656):756-761. doi:10.1136/bmj.1.4656.756