Neocolonialism and Public Health in Africa

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Abstract

This paper illustrates the interconnectedness of neocolonialism and public health in Africa by highlighting the role of external influences on health systems, policy and outcomes across the continent. Africa's public health woes are not only the result of the usual suspects: domestic governance challenges or resource constraints; they are deeply shaped by both visible and invisible foreign interventions. Powerful international organizations, donor governments, and multinational pharmaceutical companies hold much power over health policies in Africa, many times in ways that do not serve the continent's needs for equitable and sustainable health care. This paper critically analyzes the influence of these external actors on public health priorities, funding mechanisms, and intervention approaches, often perpetuating dependency and exacerbating health inequities.

Keywords: Neocolonialism, Public Health, Foreign Interventions, Dependency Theory, Deneocoloniality

Introduction

Central to this analysis is an examination of the power dynamics foundational to global health governance, whereby neocolonial regimes and ideologies shape the distribution of resources and the ways in which certain health issues are foregrounded and others ignored. This paper assesses global health initiatives' role in influencing Africa's healthcare systems, disease prevention programs, and treatment accessibility among countries through empirical evidence and case studies. It also examines the agency and resistance of African states and communities in negotiating these power dynamics, and in asserting their own autonomy in public health decision-making. This paper aims to contribute to broader conversations linking health equity, social justice, and decolonial public health approaches in Africa through this investigation.

Nkrumah (1965) theorized neocolonialism as the economic, political and cultural domination of a former colony by external powers in the form of so-called aid, development, and technical assistance. Neocolonialism in public health is evident in expectations that foreign interests supersede local health needs; medical interventions designed externally that do not reflect the lived and contextual realities of the people affected; and economic and political coercion that perpetuates avoidable dependence without improving local capacity. This paper contends that a critical interrogation of these dynamics is crucial to understanding the extent to

which historical colonial legacies continue to shape contemporary global health governance and to entrench structural inequalities across Africa.

Importantly, understanding the interplay of neocolonialism and public health can reveal imbalances in global health relations where African voices and priorities are often subjugated (Prashad, 2008). In addition, it offers policymakers, researchers and public health stakeholders a guide to detect and tackle underlying factors contributing to neocolonialy-driven health inequities in Africa. Furthermore, it confronts dominant accounts that render the continent as eternally dependent on outsiders (Smilak and Putnam, 2022), and argues for an assertion of Africa's agency in generating and improving its own health interventions.

This paper calls for moving from a donor model in public health governance to a model emphasizing local agency, indigenous knowledge and African-led leadership. Such a transformation would empower African countries to negotiate with international actors from a position of strength to provide health initiatives that are culturally relevant, locally driven and sustainable in the long term (Alderwick, Hutchings, Briggs and Mays, 2021). In addition, greater awareness of neocolonial trends in the field of African public health can support the emergence of different approaches to health tailored to local contexts and needs, and the building of autonomous and resilient health systems—thus, deneocoloiality.

This paper is organized systematically. First, it provides a conceptual framework for understanding neocolonialism within African public health. Then it goes a bit deeper into the theoretical perspectives and methodological approaches used in this study. The paper also builds on some key case studies to highlight how neocolonial conditions have influenced health governance and policy implementation across Africa. The paper ends with a synopsis of key findings and recommendations for building a public health system in Africa that is more just and autonomous.

Conceptualization of Neocolonialism and African Public Health

Public health continues to be one of the most urgent global challenges facing humanity, along with climate change, energy security and food security. This is particularly true in Africa, where the health of the public is subject to both domestic policy decisions, as is the case internationally, and to the weighty legacy of neocolonial structures governing how health systems are arranged and guided. In African public health, the act of understanding neocolonialism nowadays helps us analyze not only the historical legacies of colonial rule but also the persisted influences of powerful foreign actors like international organizations, donor governments, and multinational corporations that provide oversight and governance of Africa's health policy and delivery systems. In this regard, neocolonialism acts as the underlying structure of power, a means by which great powers and their associated entities maintain hegemony over African nations, not necessarily through overtly coercive means, but through networks of economic, political and institutional relations that continue to perpetuate cycles of dependence rather than independence n the continent.

Neocolonialism is a wider concept and has been informed by Karl Marx's critique of capitalism as a stage of socioeconomic development. His seminal work, *Das Kapital* (1972), and *Preface to the Critique of Political Economy* (1977) articulate progressive insights into the exploitative nature of capitalist systems and also into how economic power is sustained. In the African context, Kwame Nkrumah (1965), in his book titled *Neocolonialism: The Last Stage of Imperialism* is credited for popularizing the term "neocolonialism." Following this, Nkrumah

explains that neocolonialism is a form of imperialist subjugation, whereby former colonized states are kept under the economic and political influence of foreign agents, not through active militaristic governance, but through treaties of economic dependency and a persistent governance structure that is akin to the one used by the former colonizers (Afisi, 2024). Other African intellectuals such as Ngũgĩ wa Thiong'o, Léopold Sédar Senghor, Sékou Touré, Julius Nyerere, and Obafemi Awolowo similarly critiqued imperialism, colonialism, and neocolonialism, and drew attention to how these forces continue to structure postcolonial African societies in myriad ways, including in public health. Noticeably in the African health systems, neocolonialism plays a significant role in exacerbating historical inequalities, consequently cementing the influence of foreign entities in the establishment and execution of health policies, thereby reducing the agency of African countries to tackle their own public health issues.

Obviously, health governance, foreign policy, and international aid come together in complex ways that determine the making and doing of health policies across Africa. Existing literature is demonstrating that the present state of international health governance (IHG) fails to meet the health needs of developing nations and even deepens health inequities that exist among developing nations (Dodgson, Lee and Drager, 2002). Meanwhile, the consequences of globalization on public health are also becoming more and more visible and, hence, the need to redesign health policies on a global scale is a necessity (McMichael and Beaglehole, 2000). Apparently, the process of globalization is a double-edged sword. On the one hand, globalization has enhanced the rapidly growing integration of different economic and social systems. On the other hand, the inadequacies in the current systems have led to an alternative framework of international health governance organizing health efforts globally, a concept known as "global health governance" (Dodgson, Lee and Drager, 2002).

Governance, as distinct from government, describes the structures, mechanisms and processes to coordinate collective action to pursue common goals (UNDP, 1997). In essence, the governance of health involves policy development, the mobilization and allocation of resources and the establishment of formal and informal mechanisms for decision-making and accountability (Dodgson, Lee and Drager, 2002). Governance can happen at many levels, including local, national, regional and global levels; however, with the mounting power of globalization the distinction between state and non-state actors in public health governance has become less clear-cut. Non-state actors, from civil society organizations to global advocacy networks, transnational corporations, consultancy firms, and international financial institutions, are increasingly powerful producers of health at the expense of national sovereignty and local priorities (Frenk and Moon, 2013).

This heterogeneity of power has given rise to growing suspicion around the effectiveness of African governments in self-governing their public health systems. Foreign entities dominate the setting of global health agendas established by governance structures that, although framed in terms of partnership, often serve as vehicles for neocolonial control (Dodgson, Lee and Drager, 2002). For instance, global health programs often have more to do with donor countries' interests than the actual health needs of Africans: the issue of poor people suffering from tropical diseases is a case in point. Such externally-driven health programs can be hapless, culturally insensitive, and poorly integrated in the sustainability of local health systems in the long run. This reliance on foreign aid exacerbates these challenges, with many African governments remaining dependent on external funding for essential health services, thereby limiting their ability to form and execute independent health policies (Smilak and Putnam, 2022).

Although foreign policy can boost the public health outcomes in some cases (Kickbusch, 2011), there is an increasing sense that an overreliance on foreign aid and donor-driven projects could reinforce unequal power relations. As Skinner rightly cautions, "giving too much help merely postpones the acquisition of effective behavior and makes it necessary always to have help" (1996, 63). In the African health sector, this view is especially pertinent, as ongoing donations from neocolonial states and global frameworks seem to strengthen structural dependencies instead of building sustainable resilience. Concerns about whether Africa will ever achieve health sovereignty abound, and many health policies and governance frameworks in the continent remain susceptible to external elements.

Also, Frenk and Moon argue for a transition from "global health governance" (focused on international health cooperation) to "global governance for health" (a more inclusive and equitable approach to global health policymaking) (2013, 939). Indeed, despite the good arguments for state and non-state actors working together to mobilize resources and shape health interventions (Dodgson, Lee and Drager, 2002), the current architecture of global health governance is rife with neocolonialism. The institutions of international health governance, from funding mechanisms to policymaking frameworks, are frequently constructed to reflect neocolonial notions that prioritize the needs of wealthy states and multinational corporations over the interests of African populations.

Moreover, the question of neocolonialism in African public health governance is vast. Over-reliance on foreign aid and the associated continued influence of external expertise not only serves to undermine the development of local health institutions, but also stifles the ability of African nations to construct health policies that are context-specific. We must adopt a new approach that moves towards African ownership in health policy-making, self-sufficiency and decolonization of global health governance systems. African countries need more independence in their health policies and they should not in fact be determined by the public health solution that fits other interests except those of Africa. Through a critical lens interrogating the intersections of neocolonialism and public health, this paper shines a light on the structural inequalities ingrained within global health governance and promotes the case for more autonomous, equitable and sustainable health systems in the African continent.

Theoretical Framework and Research Methodology

Dependency Theory is an important frame for understanding the systemic underdevelopment and structural deprivation that characterize public health in Africa. The framework was first created to explain the economic disparities between industrialized and developing nations, while pointing out how global economic systems perpetuate this dependency, feeding wealthier nations while draining poorer ones of their resources. Dependency Theory, first developed by scholars such as Raúl Prebisch (1950) and subsequently supported by Andre Gunder Frank (1967) and Immanuel Wallerstein (1974), holds that developing countries (the peripheral states) are positioned in a subordinate role within the global economy, being forced to supply raw materials and low-value commodities in exchange for high-value manufactured goods, technology, and loans from wealthier, industrialized nations (the core states). Such economic features ripple beyond trade and finance, extending to structures of political, social and health-related systems, which together reproduce an ongoing cycle of dependency that stunts self-determined development (Dos Santos, 1970).

Also, Dependency Theory is an appropriate theoretical framework for understanding the

sociopolitical contextualization of African public health by investigating the ways in which historical models of economic and political subjugation continue to impact current health infrastructures. Colonial rule set in place an extractive economic and governance structure that influences the nature of governance and economic relations to this day, as the elites of the Global South remain dependent on external funding, medical technologies, pharmaceutical products and expertise to the Global North (Pfeiffer and Chapman, 2010). International financial institutions like the International Monetary Fund (IMF) and the World Bank have exacerbated this dependence through structural adjustment programs (SAPs) that, under the guise of promoting economic growth, have led to drastic reductions in public health funding, privatization of basic services, and heightened obstacles for underprivileged communities seeking healthcare (Kim, Millen, Irwin and Gershman, 2000). These policies show the relationship between dependency and health insecurity: African countries have little room to make up for inadequate health systems when wellbeing is subject to external terms.

In addition, Dependency Theory's strength lies in its ability to historicize and contextualize contemporary social and economic inequalities that impact health, especially global public health. While most micro-based economic models explain underdevelopment as a result of internal inefficiency, Dependency Theory places emphasis on the structural and systemic forces that keep asymmetrical relations between nations and classes. This eye has been central in explaining how global health governance structures such as the World Health Organization (WHO), the World Bank, and private philanthropic foundations seriously drive African health policies and how their agenda reflects priorities that may not always match the needs on the ground (Packard, 2016). It also underscores how multinational pharmaceutical companies capitalize on Africa's health challenges, marketing expensive patented medicines while restricting access to inexpensive generic substitutes, and perpetuating Africa's dependency on foreign health commodities (Biehl, 2013).

Moreover, this theory also tends to highlight the components of dependency perpetuated through foreign aid and donor-driven initiatives geared toward improving health systems. This is in the context of international health interventions in the African continent being largely externally-led in terms of design and implementation, thereby sidelining local actors and diminishing national policy space. Although these programs may treat acute health emergencies, they rarely estalish sustainable infrastructure or capacity, and countries are often left vulnerable as foreign assistance recedes. This tendency is reflected in vertical health programs focused on specific conditions like HIV/AIDS, malaria, and tuberculosis, which rely on external funding and risk detracting attention and resources from wider systemic health improvements like the strengthening of primary health care.

While Dependency Theory has its strengths, it has been criticized for being overly deterministic and for overlooking the agency of developing countries. Nonetheless, the criticisms of the theory suggest that external forces are stressed whereas the internal dynamics play a less significant role (Cardoso and Faletto, 1979). We argue instead that within the realm of public health, necolonial economic structures certainly limit African health systems but also that domestic policy choices, governance challenges and corruption also determine the prevailing health outcomes as pointed out by Acemoglu and Robinson (2012). Also, the view of countries as protagonists at either the "core" or "periphery" of global health overlooks the complexity in global health relationships that exist within the regional context, for example, overlooking variations within African countries and the role of middle-income countries in global health governance (Ruckert and Labonté, 2014).

Nevertheless, the theory lacks the ability to account for successful cases of economic and health development in certain previously dependent countries. Emerging countries like Malaysia, Thailand, and South Korea were at some point seen to exist outside a global order, contributing toward a worse structural peripheralism, but they managed to reach a higher level of both economic and health system development by using globalization in their favor (Wade, 1990). This implies that even though external dependence is a major hindrance, it is not an unpassable one, and policy making and investing in home grown health structure can help nations to get out of consolidation traps.

We believe that despite its shortcomings, Dependency Theory maintains significant relevance when applied to understanding the neocolonial networks that affect African public health. The theory sheds light on the modes of power structure through which global health governance maintains inequality and dependency by examining the impact of international organizations, donor states and multinational corporations on health policy within African states.

Next, this study employs a mixed-method approach: i.e., case studies and empirical reviews to explore the impact of neocolonialism on public health in Africa. The methodology involves selecting case studies from diverse African countries, including Nigeria, Kenya, and South Africa, to provide detailed insights into how international organizations, donor countries, and pharmaceutical companies influence health policies and outcomes. The empirical reviews analyze existing literature, statistical data, and reports from credible sources such as the World Health Organization (WHO) and the International Monetary Fund (IMF). Using case studies allows for an in-depth examination of specific instances where neocolonial influences have shaped health policies and systems, providing contextual richness and detailed narratives that highlight the complex dynamics at play. Empirical reviews complement this by offering a broader overview of trends and patterns across multiple contexts, thereby allowing for the generalizability of findings and the identification of common themes and divergences. According to Creswell and Plano Clark (2017), this combination of qualitative and quantitative data strengthens a study's validity and reliability, providing a comprehensive understanding of the subject matter.

Nonetheless, one of the main limitations of the case study approach is its potential lack of generalizability. While case studies provide deep insights into particular contexts, they may not fully represent the diversity of experiences across all African countries. This limitation can be mitigated by selecting a diverse range of case studies, but it remains a concern in terms of the broader applicability of the findings. Additionally, the reliance on available empirical data can introduce biases or gaps in reporting, as the data may reflect the perspectives of those who produced it. The interpretation of qualitative data in case studies can also be influenced by a researcher's perspectives, potentially leading to subjective conclusions (Yin, 2018).

In applying the adopted mixed-method approach to the study of neocolonialism and public health, the methodology provides a robust framework for investigating how external influences shape health systems in Africa. For instance, we use case studies to examine how SAPs have impacted public health in specific countries like Nigeria and Kenya, while empirical reviews provide a comparative analysis of health outcomes across multiple African nations (see, for example, Borghi et al., 2013).

Case Studies of Neocolonialism in African Public Health

There is a visible neocolonial dynamic at play in African public health — characterized by an

overreliance on foreign funding, foreign-organizations and proponents of major, donor-driven initiatives to tackle pressing health challenges—but which often compromise national autonomy over healthcare governance. This section analyzes the impact of foreign interference on health policies, disease priorities and dependencies, using some relevant African countries as case studies. Noticeably, international partnerships have played a role in controlling disease and developing healthcare; however, these partnerships reaffirm structural inequalities and can hinder local agency and sustainable strengthening of health systems.

Relevant Public Health System Initiatives and Elements of Neocolonialism in Some Countries

We divide the discussion in this subsection into tertiary sections. This is done to facilitate cohesion and ease of understanding for the reader.

Kenya and Dual Impacts of International Health Partnerships

Located in East Africa, Kenya has greatly benefitted from international donor interventions in its healthcare system, in large part because of funding received from global health financing institutions like the Global Fund and Gavi, the Vaccine Alliance. These organizations have been pivotal in the fight against serious threats to public health such as HIV/AIDS, tuberculosis and vaccine-preventable diseases. The Global Fund is one of Kenya's major funding partners in the fight against HIV/AIDS and tuberculosis, providing over $407 million in the 2024-2026 funding cycle for treatment and prevention (Global Fund, 2024). Likewise, Gavi has given more than Sh120 million to Kenya's immunization programs, improving childhood vaccination rates and decreasing the prevalence communicable diseases. These programs have shown improvements in health indicators, with declining mortality rates and better prevention strategies.

Despite these advantages, however, Kenya's health system remains largely dependent on foreign aid, raising questions about its long-term sustainability. Over half of the $1 billion invested in HIV/AIDS programs in Kenya in 2018 was supported by donors, which is worrying given the potential lack of sustainability of these programs if donor funding decreases (Brookings, 2021). A significant aspect of neocolonialism in Kenya is the over-reliance on external funding that hampers the country's ability to build health systems and policies that are suited to its citizen's needs. This means that donors are effectively setting the national agenda, and the health system becomes biased to respond to donor interests, leaving whole areas neglected; certain diseases are prioritized while wider system-level reforms are limited or absent.

A second challenge is the fragility of Kenya's health financing model. As Kenya's economy continues to grow, the country is expected to move from low- to middle-income status, which will render it ineligible for some types of aid. This transition will demand that the government direct more domestic resources to healthcare, but limited budgets currently make this challenging. For example, Kenya continues to be far from allocating a minimum of 15% of its annual budgets to the health sector as articulated in the Abuja Declaration (World Health Organization [WHO], 2011). The challenge for Kenya is balancing its short-term donor-funding solution to ameliorating evident health emergencies, with the need for a more lasting health system emerging from increased domestic investment and financial reform.

To address this challenge, Kenya needs to adopt an "and not or" approach by continuing engagement with key donors such as Gavi and the Global Fund while at the same time

strengthening its domestic health financing mechanisms. This would entail raising government health spending, looking into alternative financing mechanisms like public-private partnerships, and improving domestic resource mobilization for health. Moreover, the strengthening of local healthcare infrastructure and workforce capacity will be crucial for longer-term resilience to health crises without over-dependence on external aid (Barasa, Mbau and Gilson, 2018).

South Africa: A Health system Stressed by Inequality and Foreign Intervention

South Africa's health care system is a hetero system that fuses the public and private sectors, but it is still highly fragmented by socioeconomic and racial divisions. The country has a double burden of disease, with high prevalence of HIV/AIDS and tuberculosis and new epidemics of non-communicable disease, including diabetes and hypertension. International health partnerships, most importantly the United States' President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund, have been key to South Africa's HIV/AIDS response by providing billions of dollars to treatment and prevention programs. These initiatives have indeed broadened access to life-saving medications; however, they have also exacerbated the country's dependence on foreign sources of funding, thereby raising questions about long-term sustainability.

South Africa received the largest amount of funding from the United States Agency for International Development (USAID) under the PEPFAR. It received $462 million just to support AIDS/HIV programs in 2023. South Africa, with roughly eight million people infected with the virus, and 150,000 new infections every year, still relies on external financial support to control the epidemic.

Indeed, the Donald Trump Administration (2017–2021) proposed steep cuts to PEPFAR and other global health initiatives. In 2017, the administration tried to slash $800 million from worldwide HIV/AIDS programs, which drew widespread criticism among health experts and advocacy organizations. These budget proposals did not eliminate PEPFAR funding outright, but they did affect how much money was available for PEPFAR funding, with a greater emphasis on a focus of financial sustainability and self-reliance in countries receiving PEPFAR funding, including South Africa. While this change led to a shift in funding priorities instead of actual funding cuts, it nevertheless sent a message that policymakers are trending toward diminishing reliance on support from the United States over the long run.

Therefore, civil unrest over United States funding policies has kept public health experts worried. A 2023 report warned of a "bloodbath" in the global HIV/AIDS response after United States contributions were reduced (Cohen, 2023), reinforcing the continued risks of financial fragility in donor-dependent health systems. And challenges remain: the United States is the single largest donor to South Africa's HIV response, but the fluctuation of funding levels continues to put the sustainability of life-saving treatment and prevention programs at risk. Meanwhile, in 2025, the total cut of USAID to South Africa was announced by Trump, and experts analyzed such action as a punishment for South African backing of Palestine, and for being against Israel over the ongoing war in Gaza.

Additionally, South Africa's National Health Insurance (NHI) scheme is a vital step toward universal health coverage. As part of a broader approach to address health inequities in the country, the NHI integrates all healthcare financing and access into a single system that covers every citizen, with the specific goal of ensuring that marginalized populations have equitable access to care. The deployment of the NHI comes despite longstanding structural and

financial constraints on the public health sector, which remains both overburdened and underfunded. The public system is overstretched in a country where a rich private healthcare sector exists alongside and reinforces inequalities, disproportionately impacting historically marginalized communities, especially Black South Africans.

The shadows of colonialism and apartheid remain a force in South Africa's inequities in healthcare. Some researchers contend that South Africa's healthcare crisis cannot be understood solely in terms of widespread deficiencies in healthcare policies; that in fact, its roots lie in historical injustices that have led to deeply embedded structural inequalities (Villiers, 2021). The Coronavirus Disease (COVID)-2019 pandemic has compounded these challenges by drawing resources away from healthcare utilization toward response activities, which has impacted these essential health services.

Neocolonial dominance of healthcare in South Africa is also exemplified by the pharmaceutical industry that decides which drugs are accessible and at what price. Although South Africa has made progress in scaling up access to antiretroviral therapy, multinational pharmaceutical companies still call the shots when it comes to what can be charged for a product, often restricting the capacity of the country to produce generic medicines at affordable prices. Marking a well-deserved scholarly note, the pervasive delays experienced by poorer nations in the procurement of COVID-2019 vaccines became so prominent throughout the pandemic because they were fueled by intellectual property restraints and deplorable vaccine nationalism exhibited by richer nations. The situation exposed the longstanding inequities that infect global health governance.

The journey toward a more equitable and sustainable healthcare system for South Africa will not be a simple feat to achieve; it will be a multifaceted and multipronged plan. It would include tackling social determinants of health, strengthening public health care systems, and decreasing the country´s dependence on foreign aid. Further large scale investment and expansion of domestic pharmaceutical manufacturing, as well as the pursuit of more just and equitable global trade policies in the purchase of these medicines, will be other important strands of activity in reducing such external dependency. By reinforcing regional health cooperation bodies within Africa, like the African Medicines Agency (AMA), it can provide an avenue for greater independence not only in healthcare governance but also in the production of medicines and pharmaceuticals. Doing these things may also terminate or reduce some ridicule and financial trauma countries like South Africa may be facing right now due to the recent termination USAID to South Africa.

The Dynamics of Neocolonial Influence on African Public Health: SomeRelevant Cases

As we did in the preceding subsection, we also segment the analysis here into tertiary sections for the same reason.

Conditionality of Aid: IMF and World Bank

Both the IMF and the World Bank have been instrumental in the design of African health systems through financial assistance programs that frequently carry strict economic conditions. Although these institutions play a pivotal role in funding, especially in the wake of crises like the COVID-2019 pandemic, their policies often represent neocolonial power dynamics through

prioritizing economic liberalization and austerity measures over substantial investments into public health (World Economic Forum, 2023). The example of the IMF's austerity measures introduced throughout Africa in the 1980s and 1990s shows how this can be damaging. The accompanying programs required drastic cuts in public spending, including on health services, freezes on workforce recruitment, and the privatization of essential services (ActionAid, 2023). In Zambia, SAPs resulted in mass retrenchments among healthcare workers, devastating health service delivery (ActionAid, 2023). And in Nigeria, SAP-related cuts weakened public health infrastructure, diminishing the country's ability to respond to health emergencies (IMF, 2023). IMF-imposed policies have also led to the underfunding of health care in both Kenya and Ghana, exacerbating inequalities in access to vital services (ActionAid, 2023).

IMF and World Bank policies are often lauded for stimulating economic growth but ignore sustainable health system development in Africa. World Bank loans often come with conditions linked to neoliberal economic reforms that disproportionately affect vulnerable groups, such as privatizing healthcare services. This focus on economic efficiency has sometimes overshadowed the necessity for strong public health infrastructure, and many countries in Africa find themselves unprepared for health crises (World Bank, 2023).

Notable Neocolonial Effects on Public Health: A Case of Three African States and a Synthesis of Past Experiences and Future Expectations on Decolonizing Health Systems in Africa

The introduction of SAPs in Nigeria in the 1980s and 1990s meant cuts to health systems at the community level that led to a serious decay of health infrastructure; as well as the availability of well-trained health workers (IMF, 2023). International aid has contributed significantly to tackling HIV/AIDS and malaria, alongside neglecting areas of national health priorities and leaving others such as maternal and child health underfunded in Nigeria.

Therefore, as a case in point, neocolonial relationships in Nigerian, like other African, health systems are reflected in the financial policies of international financial institutions, donor-led health priorities, and pharmaceutical industry capture. External forces shape the national health agenda, but not necessarily in ways that encourage self-sufficiency. In a bid to reduce such forces and decolonizing health care, local resistance and health system autonomy are needed in Nigeria and other African countries. They should adopt decolonial health strategies that prioritize local autonomy, indigenous knowledge, and sustainable health financing. This is a massive opportunity; the world has just seen that locally-driven health reforms like those in Rwanda and Ethiopia can deliver huge gains in health outcomes. Across the African continent, some governments and communities have employed a range of strategies to mitigate the detrimental impact of neocolonial forces on their health systems. They typically focus on asserting control of the policy landscape, diversifying funding streams, and nurturing local innovations. One well-documented example is Rwanda's healthcare reform following the 1994 genocide, which prioritized self-reliance over foreign aid community-based health insurance. The Mutuelles de Santé program improved healthcare access and reduced the frugality of foreign funding (Binagwaho et al, 2014).

Other African countries have adjusted their policies to local requirements with fewer foreign influences. In Ethiopia, the Health Extension Program (HEP) sends trained health extension workers (HEWs) to offer critical services in the rural parts of the country. Albeit implemented with the assistance of international donors, the design of the program encourages local ownership, resulting in an increase in maternal and child healthcare (Admassie et al., 2016).

Likewise, Tanzania's CHF, which initially relied on donations, has shifted toward government financing to guarantee sustainability and the government directing its funding toward national-health-political priorities (Borghi et al., 2013). The Ugandan government's rejection of IMF recommendations for eliminating spending on public health services epitomizes the role of local agency in resisting external economic pressures and the ability to maintain and even expand rural healthcare services such as the village health teams.

We also believe that grassroots movements can shape public health policy. These movements are the ones that mobilize communities, push for policy reforms, and hold governments accountable. One of the most powerful was South Africa's Treatment Action Campaign (TAC) which battled the government for universal access to antiretroviral therapy and against restrictive policies from multinational pharmaceutical companies (Heywood, 2009). In a similar vein, improvements in sanitation and healthcare in informal settlements in Kenya through the Slum Dwellers Movement (*Muungano wa Wanavijiji*) have involved collaboration between the local authorities and donors, which has resulted in much better health outcomes in the communities. For example, in the remote regions of Uganda, Village Health Teams (VHTs) made up of volunteer community members have expanded healthcare access to the local population, showcasing the power of grassroots health initiatives. These struggles highlight the power of collective efforts on minimizing neocolonial dependence and advancing autonomous and economically egalitarian health initiatives.

Conclusions and Recommendations

This paper has explained the extent to which neocolonial practices infiltrate and impact public health systems in Africa. For the SAPs, the consequences of the IMF are on the observed changes in Africa's healthcare that were not only of quantity, since SAPs have been directed toward the privatization and conversion of the public social services including the health public system to accommodate the free-market system, not to attain quality. This implies that healthcare services are more expensive, characterized by low accessibility and affordability; causing more vulnerable populations to have a much poorer access to this social health. Aid conditionality, although successful in combating diseases such as HIV/AIDS funded by programs such as PEPFAR, it does not tend to align with local public health priorities and leads to misallocation of healthcare spending. Prohibitive drug prices and patentees in the hands of pharmaceutical companies limit access to life-saving medications, resulting in health disparities.

The results in the preceding sections highlight the need for a reassessment of global health policies. Public health practice in Africa post-COVID-2019 must be equitable, sustainable and be done within the bounds of local sovereignty. Deneocolonial approaches prioritizing local autonomy and indigenous knowledge must lead to improved health outcomes, as exemplified by Rwanda's community-based health insurance scheme and Ethiopia's HEP. To strengthen resilient and self-sufficient health systems, building international solidarity is needed through mutual capacity building and partnerships based on respect.

It is vital that the global health governance system is reformed to give African countries a fairer representation and decision-making power. Shifting from disease-based interventions to systematic health systems strengthening will ensure that services are sustainable and equitable over the long run. Adopting these principles would be one way to offer African countries health sovereignty and ultimately, better health for all.

The recommendations that follow are made possible by the findings of this study in order

to denounce neocolonial influences on public health systems in Africa and work towards equitable and sustainable health outcomes. First, there must be a re-evaluation of international health policies to ensure the promotion of health equity and respect for local sovereignty. It is more important that policies be contextually relevant and country-driven as opposed to one-size-fits-all solutions. International organizations such as the IMF and World Bank need to take a broader, context-sensitive approach that places building local health systems at the forefront (ActionAid, 2023; World Bank, 2023).

Second, African countries need to build strong and resilient health systems that can weather external shocks and decrease reliance on international aid. Any investment must prioritize infrastructure, healthcare workforce training, and the delivery of essential services, both in cities and rural areas (Admassie et al., 2016).

Third, public health policies and practices should evoke decolonial strategies. These approaches must prioritize local autonomy, additional use of traditional knowledge, and local involvement in health decision-making. African countries should be motivated to establish and adopt health policies that acknowledge their cultural, social and economic backgrounds (Farmer et al., 2013).

Fourth, partnership with the international community should be based on the principles of mutual upholding of dignity, equality and solidarity. That is a question to which donor countries and international organizations should pay attention: How do we make capacity-building initiatives, at the local health systems strengthening initiatives that empower local health systems without putting dependencies? Another concept, south-south cooperation, through which developing countries exchange their best practices and support one another, should be promoted to reach sustainable development (World Health Organization, 2020).

Fifth, there should be balances put in place through international trade agreements and pharmaceutical companies whereby drugs are accessible and affordable by all. Policies should balance the need for intellectual property rights with the public health needs of low-income countries; Approaches such as compulsory licensing and pooled procurement are identified as ways to reduce the price of drugs and thus improve access (World Economic Forum, 2023).

Sixth, Africa needs a greater seat at the table on world health (IMF, 2023) The governance structures of organizations such as the IMF and World Bank must be reformed to ensure that African nations have an equal say in how their countries will claim their sovereign spaces, but also be practical with equality and representation.

Seventh, health measures must adopt a broader perspective on health than the narrow definition of specific diseases. So, programs should deliver services for infectious diseases, non-communicable diseases, maternal and child health and mental health in an integrated manner to provide holistic care and improve overall health outcomes (PEPFAR, 2023; Mayosi and Benatar, 2014).

Eighth and finally, sustainable financing mechanisms for health that are not reliant on external funding should be established. Governments need to look for other innovative sources of financing, such as public-private partnerships, health insurance schemes, and stronger domestic resource mobilization for long-term sustainability of health programs (Barasa et al., 2017). If these recommendations are implemented, they would prevent neocolonial actors and practices from undermining health systems in Africa, and this would enable African countries to ensure equity, sustainability and sovereignty in their health systems, thereby promoting denecoloniality.

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