Understanding Critical Public Health Issues in Sub-Saharan Africa through Decolonial Lenses

by

Mathew Nyashanu, Rosemary Chigevenga, and Mandu Stephen Ekpenyong

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Preface

Public health in Sub-Saharan Africa is shaped by a complex interaction of historical, political, economic, social, cultural and environmental forces. Although the region has experienced significant advances in disease prevention, healthcare delivery, research and population health, profound inequalities remain in access to healthcare, distribution of resources, health outcomes and participation in knowledge production. Understanding these inequalities requires more than examining contemporary epidemiological indicators or health-system performance. It requires critical engagement with the historical structures, knowledge hierarchies and power relationships through which public-health systems and priorities have developed.

Understanding Critical Public Health Issues in Sub-Saharan Africa through Decolonial Lenses emerges from the conviction that many contemporary public-health challenges cannot be adequately understood without examining their historical and structural foundations. Colonialism transformed economies, institutions, education, land ownership, social relations, healthcare systems and the production of knowledge. Its effects remain visible in contemporary inequalities and in the continued privileging of particular forms of knowledge within public health. This book therefore places decolonial thinking at the centre of an examination of critical public-health issues affecting Sub-Saharan Africa. Decolonisation is understood neither as a rejection of biomedical science nor as an uncritical celebration of Indigenous practices. Rather, it provides a framework for asking fundamental questions about knowledge and power: Who defines public-health priorities? Whose knowledge is considered legitimate? Who controls research

agendas and resources? Whose experiences inform policies and interventions? How can communities participate meaningfully in decisions affecting their health?

These questions are important because health inequalities rarely arise from a single determinant. They emerge through interconnected historical and contemporary processes involving poverty, gender, geography, disability, age, political economy, migration, education, culture and health-system capacity. The chapters therefore move beyond narrowly biomedical explanations to consider broader social, structural, cultural and historical determinants of health. A central argument throughout the book is that knowledge production is itself a public-health concern. African communities have generated sophisticated understandings of health, illness, healing, care and social responsibility. Nevertheless, colonial and subsequently dominant global knowledge systems have frequently positioned Western biomedical knowledge as universal while treating African Indigenous knowledge as peripheral. Such epistemic hierarchies influence service design, research funding, professional education and decisions about what constitutes legitimate evidence. A decolonial approach consequently requires greater epistemic plurality. This does not mean accepting practices without consideration of safety, effectiveness, ethics or human rights. Instead, it calls for respectful engagement among different systems of knowledge and for African communities, researchers, practitioners and institutions to exercise greater authority in defining health priorities and developing contextually appropriate solutions.

The book is organised into five thematic parts. **Part I, Foundations: Colonial Legacies, Knowledge and Health Inequalities**, establishes its historical and conceptual foundations. It examines how colonial governance, economic extraction, unequal development, healthcare

structures and the marginalisation of Indigenous knowledge continue to influence contemporary health inequalities. Importantly, colonialism is not presented as the sole explanation for every current challenge. Rather, the discussion considers the interaction between inherited structures and subsequent political, economic and policy decisions. **Part II, Health Systems, Community Care and Wellbeing**, examines mental health, palliative care, and maternal and child healthcare. These chapters demonstrate the importance of understanding health within cultural, social and community contexts. Mental health, for example, cannot be separated from family relationships, spirituality, social inequalities and culturally embedded understandings of distress and wellbeing. Palliative care similarly raises important questions concerning dignity, family, spirituality and culturally appropriate care, while maternal and child healthcare demonstrates how poverty, gender, geographical accessibility, trust and health-system structures influence service utilisation. **Part III, Sexual, Reproductive and Adolescent Health**, considers family planning, the sexual and reproductive health rights of people with learning disabilities, and substance and alcohol use among adolescents. The chapters foreground rights, agency and inclusion while drawing attention to populations whose experiences may be marginalised within mainstream research and healthcare. They demonstrate that effective interventions require engagement with social relationships, structural conditions, cultural expectations and community realities. **Part IV, HIV, Ageing and Health-System Resilience**, addresses HIV among older adults, barriers to HIV-service uptake among men, and the experiences of older adults living with HIV during COVID-19. These chapters highlight the importance of intersectionality, demonstrating how age, gender, poverty, stigma, geography and chronic illness interact to shape health experiences. COVID-19 further exposed longstanding inequalities and demonstrated the importance of resilient health systems capable of

maintaining continuity of care while responding to public-health emergencies. **Part V, Synthesis and Future Directions**, brings together the central arguments and considers how decolonial principles can inform public-health policy, research, education, community engagement and health-system reform. Decolonisation must ultimately move beyond rhetoric towards observable institutional transformation, including changes in who controls resources, who participates in decision-making, who leads research, how knowledge is valued and whether global partnerships strengthen sustainable African capacity. Several principles therefore connect the chapters. The first is recognition of **structural inequality** and its historical foundations. The second is **epistemic justice**, requiring meaningful recognition of African scholarship, Indigenous knowledge and lived experience. The third is **community agency**, through which communities participate in defining priorities rather than simply receiving interventions. The fourth is **equity in global health partnerships**, characterised by reciprocity, transparency and shared leadership. Finally, the book emphasises movement from **decolonial critique towards practical transformation** capable of improving health systems and population health.

The book does not propose a single model for decolonising public health across Sub-Saharan Africa. The region encompasses diverse cultures, languages, economies, political systems and health structures. Approaches appropriate to one country or community cannot automatically be transferred elsewhere. Decolonial public health must therefore be contextually grounded, evidence-informed and developed collaboratively with the communities concerned. This volume is intended for students' academics, researchers, healthcare professionals, public-health practitioners and policymakers. It should also be relevant to those working in global health, health promotion, nursing and allied health professions, sociology, health policy and

international development. For students, it connects decolonial theory with contemporary public-health problems. For researchers, it raises questions about leadership, authorship, community participation and knowledge ownership. For practitioners and policymakers, it highlights the importance of culturally responsive, equitable and community-centred approaches. Ultimately, the purpose of this book is constructive. Decolonisation should not end with criticism of historical systems. Its greater contribution lies in supporting more equitable futures in which African communities exercise meaningful agency, African institutions contribute to and lead knowledge production, and Indigenous knowledge engages respectfully with scientific and biomedical approaches. We hope this book contributes to continuing conversations about a more equitable, culturally grounded and socially just public health. Decolonisation is approached not as a completed project, but as an ongoing process of critical reflection, dialogue, redistribution of power and institutional transformation. The challenge is not simply to reconsider what we know about health, but also who produces that knowledge, whose experiences are represented, how knowledge is applied and, ultimately, who benefits from it.

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We particularly acknowledge African communities and custodians of Indigenous knowledge whose understandings of health, illness, healing, family, community and wellbeing have endured despite long histories of marginalisation. Their knowledge, experiences and resilience provide an indispensable foundation for developing culturally meaningful, equitable and sustainable approaches to public health. We extend our sincere appreciation to our colleagues, collaborators and academic networks for their intellectual engagement, encouragement and constructive discussions throughout the development of this book. We are equally grateful to the contributors whose expertise has enabled this volume to address a diverse range of issues, including health inequalities, mental health, palliative care, maternal and child health, sexual and reproductive health, disability, adolescent health, HIV, ageing and pandemic preparedness.

We also acknowledge the students and colleagues with whom we have engaged through teaching, research, supervision, seminars and professional discussions. These interactions have continually encouraged us to question whose knowledge is represented within public-health education and research and to consider how African voices and perspectives can be more meaningfully incorporated into knowledge production. Our appreciation extends to the institutions and organisations that have supported our academic, research and professional activities. Their contribution has provided environments in which many of the ideas explored within this book have been developed and refined. We are grateful to the editorial and production team at **Ethics International Press** for the opportunity to bring this work to an international readership and for their support throughout the publication process. We also extend our appreciation to our families, friends and wider support networks for their patience, encouragement and understanding throughout the preparation of this volume. Above all, we acknowledge communities across Sub-Saharan Africa whose experiences, knowledge and aspirations give meaning to the continuing pursuit of health equity. We hope this book contributes to strengthening public-health approaches that respect their dignity, recognise their knowledge and place African voices, leadership and agency at the centre of decisions concerning health and wellbeing.

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Dr Mandu Stephen Ekpenyong is a public health scholar, researcher and academic with interests in health inequalities, maternal health, health promotion, community health and the social determinants of health. Her work explores how social, cultural, economic and structural factors influence health experiences and outcomes within African communities, with particular attention to maternal health and the wellbeing of women and families. Dr Ekpenyong is committed to advancing public health knowledge that recognises African perspectives, Indigenous knowledge systems and community lived experiences. Her scholarly approach challenges the uncritical application of predominantly Western frameworks to African health contexts and promotes the inclusion of locally grounded knowledge in research, education and practice. Through teaching, research and

academic collaboration, she contributes to strengthening public health scholarship and developing culturally responsive approaches to maternal and community health, reducing health inequalities, improving access to appropriate services, and advancing equitable population health outcomes across Sub-Saharan Africa.

Organisation of the Book

The book is organised into five thematic parts. Part I establishes the historical and conceptual foundations for analysing colonial legacies, knowledge and health inequalities. Part II applies this framework to health systems, community care and wellbeing through mental health, palliative care, and maternal and child healthcare. Part III examines sexual, reproductive and adolescent health, with particular attention to reproductive agency, disability inclusion and adolescent substance and alcohol use. Part IV focuses on HIV, ageing and health-system resilience, bringing together questions of gender, long-term care and pandemic preparedness. Part V synthesises the book's arguments and develops a practical framework for decolonial public health action in Sub-Saharan Africa.

Part I:

Foundations: Colonial Legacies, Knowledge and Health Inequalities

Chapter 1
Colonial Legacies and Health Inequalities in Sub-Saharan Africa: The Case for Decolonising Health Systems

Abstract

This chapter critically examines how colonial legacies continue to shape contemporary health inequalities in Sub-Saharan Africa, arguing for the urgent need to decolonise health systems. It explores how colonial governance structures, extractive economic policies, and Eurocentric medical models disrupted indigenous health practices and entrenched unequal access to care. These historical dynamics persist in the form of under-resourced health infrastructures, donor dependency, and the marginalisation of local knowledge systems. The chapter highlights that dominant global health frameworks often prioritise Western biomedical approaches while overlooking the value of indigenous knowledge, community-based care, and culturally embedded healing practices. This imbalance not only limits the effectiveness of interventions but also perpetuates epistemic injustice. By critically analysing these dynamics, the chapter demonstrates how health inequalities are not merely technical issues but are deeply rooted in historical and structural power imbalances. It advocates for a decolonised approach to health systems that centres local agency, integrates indigenous knowledge, and promotes context-specific solutions. Such an approach requires rethinking policy frameworks, redistributing power in global health governance, and fostering equitable partnerships. Ultimately, the chapter positions

decolonisation as essential to achieving sustainable and just health outcomes in Sub-Saharan Africa.

Introduction and background

This chapter critically examines how colonial legacies continue to shape health inequalities in Sub-Saharan Africa, arguing that contemporary disparities cannot be fully understood without acknowledging their historical foundations. Colonial administrations in Sub-Saharan Africa established extractive economic systems, racially stratified social structures, and uneven health infrastructures designed primarily to serve colonial interests rather than local populations (Hope, (2025). These systems entrenched patterns of inequality that persist in post-independence health systems across the region, influencing access, quality, and the distribution of healthcare services.

Historical health inequalities in Sub-Saharan Africa refer to systematic differences in health outcomes and access to healthcare services among populations in the region. These disparities are shaped by socioeconomic, geographic, political, and environmental factors, including the legacies of colonialism, which facilitated the emergence of a two-tier system across various spheres of life over an extended period (Ameyaw & Panibratov, 2025). Sub-Saharan Africa continues to experience a myriad of disparities in health outcomes. The region bears a disproportionately high disease burden, including conditions such as HIV/AIDS, malaria, and tuberculosis. It is also characterised by high maternal and child mortality rates, recording some of the highest neonatal deaths globally, alongside limited access to skilled birth attendants (Bjornlund et al., 2020). Life expectancy gaps remain evident, with average life expectancy lower than global averages.

Weak health infrastructure, partly rooted in colonial systems of healthcare provision, has resulted in persistently low government expenditure on health and unequal access to services. Public health facilities are limited and often affected by shortages of medication, while well-equipped private hospitals remain accessible only to a small proportion of wealthy individuals. Rural populations are disproportionately disadvantaged compared to their urban counterparts. High levels of unemployment further constrain individuals' ability to afford both basic necessities and healthcare in Sub-Saharan Africa.

Income disparities across the region mean that poorer households experience worse health outcomes and reduced access to care. Access to education is similarly constrained by inadequate educational infrastructure, limiting opportunities for many individuals. Lower levels of education are associated with reduced health awareness and poorer health-seeking behaviour, a pattern evident across much of the population (Wamai & Shirley, 2022). Additionally, poor employment conditions limit access to health insurance and related benefits, further undermining health and wellbeing.

Since the end of colonial rule, many African countries have experienced political instability, conflict, and governance challenges, which have disrupted healthcare delivery across social groups. Inadequate water and sanitation systems inherited from colonial administrations have contributed to the persistence and resurgence of infectious diseases. Climate change has further exacerbated food insecurity, altered disease patterns, and increased health risks across the region.

Gender inequalities, rooted partly in colonial social structures that normalised discrimination, continue to shape access to healthcare. Patriarchal norms limit women's access to employment opportunities

and healthcare services. Women also face inadequate support in achieving positive maternal health outcomes due to weak health infrastructure and the marginalisation of women's issues. These challenges are compounded by gender-based violence, which negatively affects women's physical and mental health, contributes to family instability, and increases the prevalence of single-parent households.

Health system inefficiencies continue to hinder service delivery, including acute shortages of specialist health professionals and low doctor-to-patient ratios. These structural weaknesses have fostered reliance on external aid, which often influences the direction of health development and, in some cases, reintroduces colonial-style operational practices. Health inequalities in Sub-Saharan Africa are therefore multidimensional and deeply interconnected, driven by poverty, geography, gender disparities, and systemic weaknesses in healthcare systems. Addressing these challenges requires integrated policy approaches, sustained investment in healthcare infrastructure, and attention to broader social determinants of health, including the promotion of indigenous knowledge systems.

It is essential to analyse contemporary health inequalities in Sub-Saharan Africa through a critical, historically contextualised lens. Colonial systems shaped global economic, social, and political hierarchies that persist today. Unequal development between former colonies and colonisers has contributed to continued dependence on external aid, often accompanied by conditionalities (Addo et al., 2023). Such conditions can limit the integration of indigenous knowledge into healthcare systems across many Sub-Saharan African states.

During the colonial period, many Africans were forcibly relocated to areas known as Tribal Trust Lands (TTLs) (Yeboah, 2022). These were territories designated by colonial governments for African

populations, but they were neither owned nor freely controlled by those communities. Despite the implication of protection suggested by the term "trust," the land remained under colonial authority, which determined its use and governance. This system granted colonial administrations extensive powers to relocate indigenous populations, particularly in response to the discovery of valuable natural resources. These powers were later inherited by post-colonial governments and, in some cases, have been exercised in similar ways.

TTLs formed part of a broader system of racial land segregation. In colonies such as Zimbabwe, Zambia, Malawi, and Kenya, the most fertile and economically valuable land was allocated to European settlers, while African populations were confined to less productive areas (Austin, 2016). This deliberate arrangement supported settler agriculture and extractive industries while restricting African economic independence. In contemporary Sub-Saharan Africa, much of the fertile land formerly controlled by colonial settlers is now concentrated in the hands of a small elite, reflecting ongoing inequalities in the control of production and political power.

Administration within TTLs operated through indirect rule, whereby colonial authorities governed rural populations through local chiefs. While this system appeared to preserve traditional leadership structures, it often distorted them, as chiefs became accountable to colonial authorities rather than their communities. Similar patterns can be observed in some post-colonial contexts, where traditional leaders are used to reinforce political authority, sometimes contributing to the suppression of dissent.

Life in TTLs was characterised by structural constraints. Overcrowding and poor-quality land limited agricultural productivity, while restrictions on land ownership forced many Africans into wage labour in colonial industries such as mining and

commercial agriculture. TTLs thus functioned as labour reservoirs, supplying cheap labour to the colonial economy. This dynamic has persisted in various forms in post-colonial states, where inequalities in access to resources and opportunities remain entrenched (Langan, 2018). In some cases, colonial-era legislation has been retained or adapted to suppress opposition and maintain political control in postcolonial Sub-Saharan Africa

The long-term consequences of TTLs have been profound, contributing to persistent rural poverty, disrupted land-use systems, and enduring inequalities across Sub-Saharan Africa. In countries such as Zimbabwe, contemporary land disputes can be traced to the legacy of colonial land policies. Colonial legacies therefore remain central to issues of land distribution and conflict across Sub-Saharan Africa and directly impacting on food production and associated health outcomes.

Many political, legal, and administrative systems in Sub-Saharan Africa are inherited from colonial rule (Yuni, 2017). Examining these systems helps to identify institutional strengths and weaknesses, as well as patterns of political instability and corruption that continue to affect healthcare delivery and broader societal outcomes. Colonialism also reshaped identities, languages, and cultures, producing hybrid identities and cultural transformations that influence contemporary society. Indigenous knowledge systems, such as Ubuntu, offer valuable perspectives for reimagining healthcare systems in the region.

Colonial education systems prioritised European languages such as English and French, often excluding indigenous populations who lacked access to formal education (Dascombe, 2019). This linguistic shift contributed to the marginalisation of local languages and created

barriers to understanding health information. These challenges persist in many post-colonial contexts.

Engaging with colonial legacies fosters critical reflection on power, history, and interdisciplinary perspectives, including history, politics, economics, and sociology. Such analysis enables a more nuanced understanding of contemporary health inequalities and strengthens academic argumentation by linking past structures to present realities.

Colonial economies in Sub-Saharan Africa were primarily extractive and externally oriented, with minimal investment in domestic development, including housing and healthcare systems (Azevedo, 2017). Healthcare provision during this period largely served colonial populations and remained inaccessible to indigenous communities (Adetiba & Msindo, 2022). In the post-colonial era, many countries have continued to rely on the export of raw materials, a model inherited from colonial economic structures. This has constrained industrialisation and limited the financial capacity to develop resilient healthcare systems. Consequently, health systems across Sub-Saharan Africa continue to face significant challenges related to underfunding and structural weakness.

A decolonial reading of these inequalities requires more than identifying colonialism as a historical event. It requires attention to the institutional pathways through which colonial priorities became embedded in post-independence systems. Colonial administrations shaped where hospitals were built, which populations were trained as health professionals, which diseases attracted surveillance and investment, and which forms of knowledge were recognised as legitimate. These decisions created forms of path dependence: once infrastructure, professional hierarchies, administrative routines, and financing arrangements had been established, newly independent

states inherited systems that were costly and politically difficult to redesign. Consequently, contemporary inequalities should not be interpreted simply as evidence of post-independence policy failure. They also reflect historically produced constraints within which governments have attempted to expand access, respond to population growth, and address changing disease burdens (Azevedo, 2017; Møller & Roberts, 2017).

This historical framing is important because it avoids two analytical extremes. The first is historical determinism, which assumes that colonialism explains every contemporary health-system weakness and thereby underestimates the role of post-independence governance, policy choices, conflict, corruption, and domestic inequalities. The second is historical amnesia, which evaluates present systems as though countries began independence with equal institutional, economic, and human-resource foundations. A more useful position recognises interaction between inherited structures and subsequent political choices. Colonial legacies created unequal starting points and institutional incentives, while postcolonial governments, international institutions, private actors, and local communities have subsequently reproduced, modified, or resisted those structures. Decolonising health systems therefore involves both historical accountability and contemporary institutional reform.

Historical foundations of colonial health systems

When Sub-Saharan Africa was colonised by Western powers, indigenous societies had already developed well-established institutional frameworks, including sophisticated health systems (Sakue-Collins, 2026). These systems persisted alongside colonial medical structures, albeit under significant epistemological and political constraints. Such tensions arose from the incompatibility between indigenous knowledge systems and the biomedical

paradigms underpinning colonial medicine. Healthcare in pre-colonial contexts was delivered primarily by herbalists, spiritual healers, and traditional birth attendants, who collectively functioned as custodians of indigenous medical knowledge and maternal health systems. Illness was conceptualised holistically, encompassing physical, spiritual, and social dimensions (Ahlberg, 2017). These practices were community-based, culturally embedded, and often accompanied by rituals that reinforced collective interpretations of health and wellbeing.

In contrast, colonial health systems were introduced primarily to advance economic, political, and administrative control. Western medicine was institutionalised largely to protect colonial officials from tropical diseases and to sustain the productivity of African labour forces within extractive and plantation economies. Health interventions were therefore strategically aligned with the preservation of colonial economic interests rather than the wellbeing of indigenous populations (Berman & Lonsdale, 1980). This resulted in a highly stratified system characterised by racial and spatial inequalities. A dual structure emerged, whereby well-resourced facilities served European settlers, while services designated for African populations remained underfunded and poorly equipped. Urban centres and mining regions received disproportionate investment due to their economic significance, while rural areas were largely neglected, entrenching a long-term urban bias in healthcare provision.

Missionary organisations played a significant complementary role in the delivery of healthcare, particularly among rural populations overlooked by colonial administrations (Azevedo, 2017). By establishing clinics and hospitals in remote areas, missionaries provided basic medical services and education, often intertwined

with religious conversion efforts. In many rural contexts, these institutions represented the only accessible form of formal healthcare. However, the broader colonial health agenda prioritised disease control rather than the development of comprehensive and equitable health systems. Public health interventions frequently adopted coercive approaches, including forced treatment and quarantines, which were often implemented within racially discriminatory frameworks.

Colonial authorities maintained centralised control over healthcare governance and financing, systematically excluding indigenous populations from decision-making processes. At the same time, indigenous knowledge systems were delegitimised and dismissed as primitive or unscientific. This epistemic marginalisation was reinforced by both colonial medical practitioners and missionary discourse, which often framed traditional practices as incompatible with modernity or even as spiritually illegitimate. As a result, indigenous health systems were not only constrained institutionally but also undermined culturally.

Patterns of investment during the colonial period further exacerbated inequalities. Health infrastructure development was concentrated in urban administrative centres and economically productive regions, while rural communities remained under-resourced. These disparities were compounded by broader colonial policies, including forced displacement from fertile land, which disrupted traditional livelihoods and social structures. Consequently, colonialism produced enduring spatial and socio-economic inequalities that continue to shape health outcomes across Sub-Saharan Africa.

The colonial legacy also significantly influenced the structure of the health workforce. Indigenous Africans were primarily trained for subordinate roles, such as nurses, auxiliaries, and assistants, under the

supervision of European professionals. Opportunities for advanced medical training were extremely limited, resulting in a shortage of locally trained doctors and specialists. This structural imbalance fostered long-term dependence on foreign medical expertise, a pattern that persists in many African health systems today.

Furthermore, the marginalisation of indigenous medicine led to the emergence of a dual healthcare system comprising formal (Western) and informal (traditional) sectors. While colonial authorities privileged Western medicine, access to these services was often limited for indigenous populations due to cost, distance, and systemic discrimination. Consequently, many individuals continued to rely on traditional medicine, which remained more accessible, affordable, and culturally aligned with local beliefs. Despite its marginalisation, indigenous healthcare persisted as a critical component of community health.

The legacy of colonial health systems continues to exert a profound influence on contemporary healthcare structures in Sub-Saharan Africa. Persistent urban bias, underinvestment in public health infrastructure, and systemic inequalities remain defining features of many national health systems. Additionally, the historical reliance on external actors has contributed to ongoing dependence on foreign aid, which is often accompanied by political and economic conditionalities. In some cases, this dependency has discouraged sustained domestic investment in healthcare, with governments anticipating that non-governmental organisations and international agencies will fill critical service gaps.

In summary, colonialism fundamentally reshaped health systems in Sub-Saharan Africa by introducing racially stratified, economically driven, and spatially uneven structures that marginalised indigenous knowledge systems. These historical processes have produced

enduring inequalities and institutional weaknesses that continue to challenge efforts toward equitable and sustainable healthcare development in the region.

The distinction between biomedical knowledge itself and the political organisation of biomedical authority is also crucial. Decolonisation does not require rejecting biomedical science or romanticising all indigenous practices. Rather, it asks who has authority to define health problems, whose evidence counts, who controls resources, and whether interventions are responsive to local histories and lived realities. Indigenous knowledge systems can offer important understandings of social relationships, spirituality, caregiving, prevention, and community responsibility, while biomedical approaches provide powerful diagnostic and therapeutic technologies. The challenge is to create ethically governed forms of knowledge pluralism in which different systems can be evaluated for safety, effectiveness, cultural acceptability, and relevance without automatically positioning Western knowledge as universal and African knowledge as secondary (Ahlberg, 2017; Mehjabeen et al., 2025).

Structural legacies of colonialism in health systems of Sub-Saharan Africa

The contemporary health systems of Sub-Saharan Africa are deeply rooted in colonial-era structures, which were primarily designed to safeguard the health of European settlers, colonial administrators, and the indigenous labour force essential for extractive economies (Møller & Roberts, 2017). During the colonial period, health infrastructure was not developed as a universal public good but rather as a strategic tool to sustain economic productivity and maintain political control. Medical services were therefore geographically concentrated around

mining enclaves, plantation zones, and major transport and trade routes. These spatial patterns of investment reflected the economic priorities of colonial administrations rather than the epidemiological or social needs of the wider population. As a result, indigenous communities—despite constituting the majority and forming the backbone of the labour force—were systematically excluded from equitable access to healthcare services.

This exclusion was institutionalised through a racially stratified, two-tier health system that privileged Europeans and, to a lesser extent, Asians and mixed-race populations, while marginalising indigenous Africans. The structure of healthcare provision mirrored broader colonial social hierarchies, reinforcing inequality through policy and practice. Well-funded hospitals, equipped with modern facilities and staffed by trained professionals, were reserved for Europeans, whereas Africans were relegated to poorly resourced clinics or mission-based facilities. In many cases, healthcare provision for indigenous populations relied on minimally trained personnel operating under severe financial and logistical constraints. This system can be characterised as an apartheid-like model of healthcare delivery, where access, quality, and outcomes were determined by race. These inequalities extended beyond the health sector, intersecting with disparities in education, housing, and employment opportunities, thereby entrenching long-term structural disadvantage.

The centralised and authoritarian nature of colonial governance further reinforced these inequities. Decision-making processes were highly top-down, with little or no involvement of indigenous populations in the design or implementation of health policies. Health systems were administered through rigid bureaucratic structures that prioritised control and efficiency over responsiveness to local needs.

Importantly, many post-independence governments inherited and retained these administrative systems, often due to limited institutional capacity or political incentives to maintain centralised control. Consequently, health systems in many Sub-Saharan African countries have struggled to adapt to diverse local contexts, limiting their effectiveness in addressing community-specific health challenges.

Colonial health interventions were also characterised by a narrow, disease-specific focus. Efforts were primarily directed at controlling diseases such as malaria, sleeping sickness, and yellow fever conditions that posed direct threats to colonial economic interests and the health of European populations. This led to the establishment of vertical health programmes, which targeted specific diseases in isolation rather than promoting integrated and comprehensive healthcare systems. While these programmes achieved some success in disease control, they often diverted resources away from broader system development, including primary healthcare infrastructure and preventive services. The legacy of this approach is still evident today, as many health systems continue to rely on externally funded, disease-specific initiatives that may not align with national health priorities.

In addition to shaping institutional structures, colonial rule significantly undermined indigenous medical knowledge systems. Traditional healing practices, which had long been central to community health and wellbeing, were frequently dismissed, delegitimised, or even criminalised by colonial authorities. This facilitated the dominance of Eurocentric biomedical models, which were often imposed without regard for cultural context or local health beliefs. The marginalisation of traditional medicine has had lasting implications, contributing to ongoing tensions between formal healthcare systems and community-based practices. In many settings,