Review of: "Decolonisation of Health in East Africa: Opinion Piece"

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Potential competing interests: No potential competing interests to declare.

In general, I had some difficulty in reading and understanding this paper, and in following its line of argument and conclusions. I am still puzzled by a mixture of topics (NHS braindrain, use of research data without solid representation from African countries, unequal access to funding and publishing research data, and problems faced by neurodivergent and other disabled people) – and I am afraid that I got lost between these four. If these four are all examples of the same principle, that will have to be argued more clearly; and I would also like to see more concrete recommendations (the current set is rather general and vague)

Specific comments:

In 2019, 20% of registered General Practitioners (GPs) in England had qualified outside of the UK, with 80% of these coming from Africa and Asia [1]. Three years later, that percentage had doubled to over 40%[2], with Africa contributing the greatest number.

I am puzzled by the exact figures of 20%, 40% and 80% - they seem more like estimates to me. If there are exact figures underlying these percentages, please provide them

However, Rishi Sunak, who was responsible for this decision as Chancellor, has now announced that he will host a UK / Africa investment summit conference in April 2024 as Prime Minister [5]. This may presage a return to previous levels of support for Africa.

I do not think at all this will lead to a return to levels of support – to me this smells like more investing commercially (not a good thing for equitable medical care in general), or encouraging UK support only where it leads to economic return.

Colonialism still influences the structure and function of health care systems in East Africa, long after other legacies have left [31].

I do not really see the link of this sentence with the one before or the one after. It is not that I disagree, but I seem to miss the arguments behind the statement.

I like the pictures, but would suggest some description to go with them, preferably explaining the specific contribution the picture can make to the argument.

The second picture: what does it show? Twenty white Europeans drinking coffee in de tropics. Not a single Tanzanian in

sight! No discussion, no contact, no equality between partners. This does not at all look like dekolonizing global health to me, more like medical tourism.

which was related to chronic underfunding of the health care system as a result of funds being previously prioritised for profitable mining operations [32].

I do not understand the argument – who took the health defunding decision? I suppose the national government. Is this related to dekolonizing global health ? – if so, please explain

European guidelines for maternity and ante-natal services recommend access to hospital support services for all [33], whereas global guidelines in Africa accept a much more basic level of care with the attendant difficulties in transportation to Hospital if complications arise [34].

Yes, I think Europe can now afford to promote hospital-based deliveries; but that does not apply to most African countries. In that sense there is no “global standard”. Most African countries cannot afford this and it may be too early to expect or even promote that (which would disfavour rural areas). Instead, WHO has helped to define quality obstretric care, including essential referrals, based on the concept of basic obstetric care and basic emergency obstetric care, as a “best buy” within the given circumstances. Do not forget that most African countries, including Tanzania, can only spend about US$100-200 per person per year on health, while the UK has something like US$ 4-5000 per person per year. A global and common health care standard is an illusion. Same for essential medicines; in the UK medicine expenditure will be around US$500-700 pp/y; in LIC and MIC it is usually less than US13pp/y (LIC) and less than US$ 50pp/y (MIC). But even within these amounts, a reasonable package of 200 essential medicines is possible for US$ 13-25 pp/year (see Lancet Commission on Essential Medicine Policies, 2017).

At the root, the huge differences in income and GDP are linked to kolonization; a clever package of “essential health care” is not – that is just good thinking and efficient use of limited resources.

Such an approach is commended wherever possible for all people-based research as required by PPI[42].

Please write PPI in full here (you only do so later)

Perhaps the curriculum should include a reflection on the nature of colonialism and its effects on present day societal structures and related healthcare priorities?

You seem to suggest that the selection of health care priorities in African countries is a colonial issue. Is that so? Can you give some good examples, please? If you refer to lack of pharmaceutical R&D and investment in neglected diseases (eg Ebola vaccin) because of lack of economic potential – please explain whether that is a colonial issue or just an illustration of the fact that important public health investments cannot be left to the free market alone. So a commercial issue, rather than a colonial one. If you refer to frequent and very practical health systems advice given by WHO to national governments, you will have go prove that this advice is in itself colonial-driven rather than just solid evidence-based advice by the global community.