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Decolonizing Medical Training for Development Impact in West Africa

The first medical school in West Africa was established when a college branch of the University of London was set up in 1948 in Ibadan to train doctors along the traditions of UK Universities. These first set of ten doctors in Nigeria jointly trained by the University of Ibadan and the University of London graduated in 1951. However, the official opening of the University of Ibadan to function as an independent and self-serving University did not happen until 1957, while the first set of indigenously trained doctors of the University graduated in 1960.

Following this development, it was not surprising that when the first University that offered medicine as a course began to operate independently in West Africa, it adopted the curricula and methods of training in medicine from the UK. As the pioneer teachers in Ibadan later led the establishment of Universities across Nigeria, it was natural that they extended the UK curriculum to all succeeding Universities.

Additionally, when postgraduate training began with the West African postgraduate Medical College and the Nigerian postgraduate Medical College in the 1980s, most of the trainers and the curricula were drawn from curricula and experiences in the UK training programmes, with limited efforts made to adapt them to local realities. In consequence, nearly all academic training institutions and universities offering medicine and related health sciences professional education at both the undergraduate and postgraduate levels in Nigeria and other West African countries derived their impetus from the UK model of medical education.

The relevant question therefore is: "to what extent has the UK method of teaching and training in medicine helped the process of development in Nigeria and other West African countries"? This question is relevant given the relentless health challenges faced in the region, and the limited ability of health paradigms and policymaking to address those challenges. Specifically, I hypothesize that a training curriculum based on colonial and post-colonial experiences has limited capacity to address the indigenous deter-minants of health, and will do little to galvanize local methods, stakeholders, and experiences to promote health, or to establish links with local historical and modernizing methods for animating various health parameters. It stifles innovations that identify local approaches for promoting health and helps to accentuate a dependency culture on foreign methods for promoting healthcare.

Jim Campbell[1] defines a colonized curriculum as "a curriculum in a conquered territory so as to control and administer it according to purposes established by the colonizing authority". The history of the establishment of orthodox health care in Nigeria is replete with narratives that suggest that orthodox health care was established by colonizers to care for the medical conditions that affected the European colonizing elites,[2–4] while existing indigenous methods of care were not taken into account. Unfortunately, this pattern continued throughout the colonial period and was inexorably adopted as the health care philosophies of many African countries even after the colonizers left the scene. As a result of indoctrinated colonial and post-colonial stranglehold, it has been difficult from that time till now for any real change to occur in terms of decolonizing the curriculum for the benefit of the development of the health infrastructures and doctrines of the indigenous African population.

There can be no doubt that colonized medical curricula have helped the develop-ment of health in Africa in many ways. It has helped to introduce the global practice of health as a universal and evidence-informed discipline and has also linked African medical scientists to global discourses and practices in health care. However, as Mutegi posits,[5] the concept of "science for all" is inadequate to address the inequalities and inequities that exist in health care access and provision among different populations around the world. He argued eloquently that due to the dis-advantages and disparities that Africans have suffered in the application of science (in this care medical sciences), that African training institutions will benefit from a transformative approach to curricula development that enables them to meet their unique socio-historical needs.

Based on this analysis, it is critical and relevant that we point out several areas that colonized medical curricula have failed to address or have complicated health care delivery in Africa, and to identify areas for immediate remediating actions.

I will mention a few to illustrate the case being made in this article. The first is the lack of recognition, the denigration, and the downgrading of traditional medical practice. While it is true that science relies on the best available evidence to chose a method of medical treatment, it is also true that the limited attention given to traditional medical practice by colonizers is the reason for the limited research and recognition given to traditional medical practice to this day. Yet, it is widely recognized that where a disease is most prevalent is also the most likely source for the identification of its therapeutic remedies. It is therefore not surprising that a disease such as malaria has found its most efficacious treatments in roots and medicinal plants that exist in indigenous populations. However, despite the tacit approval given to research and development of traditional medical care by the World Health Organisation,[6] and by Nigeria's Federal Ministry of Health,[7] there has been a lack of curricula design to integrate traditional medicine into under-graduate and post-graduate training in Nigeria and other African countries.

A second area is what is now outlandishly called "neglected tropical diseases". These are a diverse group of 20 conditions that are largely found in tropical African countries, for which effective treatment and eradication have been elusive. These include diseases caused by bacterial and viruses such as Buruli ulcer, Chagas disease, guinea worm, dengue fever, echino-coccosis, foodborne nematode infections, trypanosomiasis, yellow fever, and leishmaniasis that have been identified by the World Health Organisation (WHO).[8] To this, we would add Ebola fever and Lassa fever, which are a growing list of severe viral diseases limited to the African region. While these diseases are now largely non-existent in other parts of the world, they remain prevalent in Africa largely because of the continued use of colonial training curricula that did not feature relevant approaches for tackling such diseases. These diseases did not exist in the colonizing countries and therefore, colonizers did not see the need to include them in the curricula handed over to colonized countries. It is for this reason that these diseases remain "neglected" in terms of research, innovations, and service delivery in many African countries to this day. Indeed, it is doubtful whether the elements relating to the knowledge and training about these diseases feature in many medical training curricula to this day.

A third category of unresolved effects of a colonized curriculum is the failure to address the social, economic, cultural, and religious determinants of health, while focusing on treatment and prevention methods that are based on medical interventions. It is well known that inexplicable socio-economic and cultural factors are associated with the high burden of disease in many African countries. Not conversant with these factors, the colonizers failed to recognize them in their design of medical training curricula, and focused largely on disease outcomes rather than the social context that potentiate the origin of diseases. Thus, existing medical training curricula while accounting for these determinants of health separated it into a training concept called "community health" or "public health", which they offer in enfeeblement and disparaging ways that do not permit the proper integration of its tenets into real-time practices in medicine. By contrast, it is conceivable that every medical discipline in medicine has its background social and economic deter-minants. It is therefore important that the proper approaches for recognizing and managing them are integrated into every medical training discipline and curricula so that all health care practitioners adopt comprehensive community consultative approaches in their delivery of health services.

A fourth area where colonization has not helped the process of health and social development in Africa relates to the application of the rights and social justice approach to the implementation of health care. An example is the rights ascribed to women at the International Conference on Population and Development (ICPD)[9,10] which took place in Cairo, Egypt in 1994 to be able to make independent decisions on when they would have sex, with whom, and without cohesion. At that conference, countries also agreed that women have the liberty to decide whether or not to be pregnant and to have access to safe abortion care should they decide not to continue with an unwanted pregnancy.

Before this conference, the British colonial government had passed a law in 1861 in its colonial territories[11] that prohibited abortion as necessary only when it is required to save the life of a woman. It was of interest that the UK and other Western countries led the promulgation of a new paradigm shift that placed the onus of decision making on induced abortion on women. Thus, while abortion remains legal to this day in the UK, it has remained illegal in Nigeria and many of its previously colonized countries with many women dying from complications of botched abortion in those countries each year.

Finally, it can be argued that the current high rate of migration of doctors and medical personnel from Nigeria and other African countries to UK is attributable to the colonized method of training they received. The reason for this is because many have been trained to UK standards and will be able to practice in the UK with little additional training. It is now standard practice for universities training medical doctors and health professionals to seek accreditation with UK universities and health practices boards, and many have improved their training curriculum to focus on UK training standards. By contrast, very limited attempts have been made to potentiate local indigenous training standards, which in my view accounts for the high rate of migration of local health practitioners to western countries, with incentives provided by better salaries and improved living conditions in those countries. But this method of migration is a huge gain for western countries that receive high quality graduates that have been trained at the expense of tax-payers in poor Africa countries, while the African countries continue to suffer the misfortune of shortages of health personnel. In my view, this is a form of neo-colonialism that benefits western countries at the expense of African countries.

Clearly, there is a need for undergraduate and post-graduate medical training programs in West Africa that focus on decolonizing training curricula for greater development impact in the region. Decolonization is defined in this context as identifying, challenging and rectifying the ways in which colonial and post-colonial experiences have impacted on medical practices and the experiences with health care delivery in colonialized countries. These include the review of medical training curricula to build greater content for local disease patterns, provide greater integrated understanding of the socio-economic and cultural determinants of health, and that foster better integration and partnerships with indigenous populations. Interestingly, it was within this context that the National Universities Commission (NUC) of Nigeria recently

sought to review the health sciences curricula used by Nigerian Universities to highlight local content and local realities. This approach co-named the Core Curriculum and Minimum Academic Standards (CCMAS)[12] for 17 programmes covering various first-degree courses was launched by the Vice-President of Nigeria in 2022. It has been intended to replace the Benchmark Minimum Academic Standards (BMAS) which have been in use in the Nigerian University System (NUS) for decades.

If well implemented for the medical sciences curricula, CCMAS promises to help to scale up the decolonization of the medical training curricula in Nigeria in a sustainable manner. Such an approach should be used to decolonize the current postgraduate training curricula offered by the medical postgraduate training programmes in West Africa. In this regard, a toolbox was recently developed[13] which interested institutions would find useful for the purpose.

In conclusion, while acknowledging the role that colonization has played in the development of training curricula and healthcare systems in Nigeria and other West African countries, it is trite to identify specific areas were colonization have not helped health processes in the region. We strongly recommend a decolonization process that holds on to the best aspects of colonial methods and curricula of medical education, while reforming those that limit the indigenization of medical training for the long-term impact on development and social reform in Africa.

Conflict of Interest

None.

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