OFFICE OF THE PRESIDENT OF PARLIAMENT

SOAD LAW010

HEALTH, TRADITION AND MODERNITY

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Melvin Brown
President

Preamble

The purpose of this law, entitled “Health, Tradition and Modernity”, is to define the legal framework for the health policy of the State of the African Diaspora (SOAD). These provisions apply to the citizens of the State of the African Diaspora and those of countries benefiting from a health partnership with SOAD. Health is a fundamental issue everywhere, and very often a matter of life and death, but this is even truer for African communities on the continent and in the diaspora, as over the centuries they have experienced hardship, violence and crimes against humanity, which have left deep, painful and lasting scars on their flesh, minds and even genes.

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Before colonization, health care in Africa was based on traditional medicine and an ancestral relationship with nature, using medicinal plants. Holistic healing practices emphasize the balance between body, mind and environment. These traditions have been essential to the health and well-being of African populations for centuries, nurturing knowledge and practices that have stood the test of time.

One of the great African physicians of ancient times was Imhotep, the famous Egyptian scholar who lived in the third millennium BC. Physician, philosopher, architect and palace

administrator, he had a profound influence on ancient medicine. The Egyptians practiced surgery and had a rich pharmacopoeia. Their medicine was particularly renowned. In *The Odyssey*, Homer wrote: “In Egypt, men are more qualified in medicine than all other men”. The Greek historian Herodotus visited Egypt around 440 BC, and described the medical practices he observed with great precision and praise. The greatest Greek physicians, such as Herophilus, Erasistratus, Galen and Hippocrates, the so-called father of medicine, who gave his name to the Hippocratic oath, still in force around the world today, all trained in North Africa. In the Middle Ages, North Africa was still a hotbed of medicine, as shown by the example of Constantine of Africa, born in Carthage in 1020. He is the author of the *Liber Pantegni*, which links Arab and African medicine.

From the 16th century onwards, the arrival of Europeans in sub-Saharan Africa marked a turning point. Raids to obtain slaves caused considerable damage. Millions of people were injured or left for dead in the process. In addition, new diseases were introduced from Europe, such as smallpox, which wreaked havoc on the continent, in Togo and elsewhere. In the 19th century, new medicine was closely linked to colonial and racial anthropology. Bodies and skull shapes were examined (“craniology”), and attempts were made to define “indices of robustness” or particular characteristics according to different ethnic groups. Bambaras, for example, were supposed to be docile. While objectively auxiliaries to the occupying armies, doctors in Africa presented themselves as the “white saviors” who claimed to heal the indigenous populations, when in fact they came to recruit them for forced labor.

Patients were often used as guinea pigs, as in the case of Dr. Koch, the Nobel Prize-winning German specialist in tropical medicine, who was charged with “saving” the East African colonies in the Great Lakes region. He needed patients brought to him en masse, by force, and injected them with a drug, Atoxyl, containing arsenic. The results were disastrous: patients suffered even more, went blind or died. Therefore, the doctor increased the doses.

Against this backdrop, doctors took on a leading role in colonial administration. The case of colonel Jean-Joseph David is revealing. A physician for French colonial troops, in 1939 he was given responsibility for administering entire territories, notably in eastern Cameroon. He was known as the “Emperor of the East”. Eager to combat sleeping sickness, he used techniques that reinforced the epidemic. Although a decree stated that “work is free in Cameroon", he decided to introduce forced labor.

Colonial surgery often dispensed with anesthesia, as blacks were considered not to feel pain like whites. Even when colonial medicine cured patients, it almost always did so with scorn for traditional knowledge, considered primitive and backward. In some African countries, they were even forbidden and presented as acts of witchcraft by the colonial occupation authorities.

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In the diaspora, the health situation was not any better. Even before being deported to the colonies in America and the Indian Ocean, Africans found themselves “warehoused” and crammed into dungeons on the African coast, which were veritable sanitary hells. These were cramped, dark, insalubrious, terrifying spaces, filled with urine, faeces, vomit and menstrual fluids, favoring the spread of diseases such as tuberculosis, malaria and yellow fever. The situation was quite similar and mortifying in the bilges of the slave ships, during the middle

passage, where the mortality rate, due to mistreatment and subsequent illness, was generally between 10% and 15%.

On the plantations and in the mines, the health situation of slaves was also very poor, due to exhaustion and mistreatment. On the plantations of Jamaica, the average life expectancy of slaves was six years. Doctors were called only as a last resort. In the 19th century, according to Samuel Cartwright, an American physician, slaves who tried to escape were in fact patients suffering from a mental illness: "drapetomania". As for those who did not work hard enough, according to him, they were suffering from "dysaethesia aethiopica", a "disease of the black race", producing "a great daze of the intellectual faculties" and a certain form of sickly laziness. In all cases, the whip was the appropriate remedy.

The punishments and tortures inflicted on slaves were not only excruciatingly painful, they also had a lasting effect on their physical health. Whippings, for example, could cause serious infections, especially when relatives were forbidden to treat the wounds. In some cases, the violence of the beating could simply dislocate the spinal column. In the French colonies, from Saint-Domingue to Reunion, the Black Code provided for the cutting off of ears in the event of escape, or the leg in the event of recidivism. Crippled slaves were therefore numerous. Less profitable, they could then be sold to doctors, for whom they could serve as guinea pigs or, later, as dissection cadavers. On the eve of the abolition of slavery in the United States, 10% of slaves were physically handicapped.

The mental health of slaves also needs to be mentioned. Deported, deprived of their loved ones, deprived of freedom for life and condemned to die in exile and captivity, slaves were exposed to depression by day, nightmares by night, all kinds of traumatic and post-traumatic disorders, and very often insanity. These disorders affected not only slaves, but also their descendants, sometimes several generations later, in the West Indies, and also in Africa, as demonstrated by Martinique psychiatrist Frantz Fanon, in *Peau noire, Masques blancs*. According to numerous studies, these major traumas have also been transmitted from generation to generation through epigenetic inheritance, and are therefore present even in DNA.

Women's health was particularly affected by the conditions associated with slavery. They were often raped by their masters, had to work practically until the last day of their pregnancy, and had to return to the fields sometimes as soon as the day after giving birth. As for gynecological treatment and neonatal care, it was more than rudimentary. Dr. James Marion Sims, widely regarded as the father of modern gynecology and inventor of the vaginal speculum, performed forced experiments on black women without anesthesia. One of these women underwent 30 forced operations without anesthesia. On April 17, 2018, the statue that paid tribute to this doctor in New York was finally removed by decision of the mayor, after the mobilization of black activists.

In Latin America, in Brazil, for example, epidemics ravaged slave populations, notably yellow fever in Rio de Janeiro in the 18th century, a city in which people of African descent lived crammed into unsanitary dwellings. The colonial authorities did little to combat these scourges, with most slaves dying with the general indifference of their rulers. In Argentina, these diseases were seen as an opportunity to “whiten the population”, as the political leaders wanted. In 1778, blacks made up almost half of Argentina's population. By the beginning of the 19th century, they had dwindled to a third; today, blacks in Argentina account for just 3% of the total population.

Faced with oblivion and neglect by colonial authorities, slaves demonstrated their resilience by developing forms of community care, often derived from their cultures of origin. Traditional healers, called “babalawos” in Brazil, or “babalao” in Cuba or Colombia, terms originating in the Yoruba tradition, or “ngangas” for healers originating in the Congo, played an important role in maintaining health within Afro-descendant communities, using medicinal plants and techniques inherited from Africa. These practices saved lives, even though they were often scorned and even repressed by colonial authorities.

In addition, slaves sometimes fled to isolated areas, such as quilombos in Brazil, or the palenques in Colombia and Central America, where they could escape exploitation and captivity. These communities, often located in hard-to-reach areas, were relatively self-sufficient and used traditional knowledge to protect their health, notably by growing medicinal plants and practicing healing rituals. In Jamaica's maroon communities, Queen Nanny is known and respected for her knowledge of medicinal plants.

Following the abolition of slavery in the USA in 1865, Historically Black Colleges and Universities (HBCUs) played a crucial role in providing African Americans with access to education, particularly in the field of medicine. Created in a context of racial segregation, these institutions often housed medical schools to train black doctors. Meharry Medical College (founded in 1876) and Howard University College of Medicine (founded in 1868) are among the most famous. These schools have produced many black physicians who have left their mark on history. For example, Dr. Charles Drew, a Meharry graduate, is recognized for his pioneering research in blood banking. Dr. Virginia Alexander, a Howard University graduate, was one of the first black women to earn a medical degree and fought for African Americans’ access to quality medical care. These institutions contributed to the advancement of civil rights and the fight for health and justice.

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Since the 1960s, and in particular since the end of colonization, significant progress has been made with the introduction of public health policies, benefiting Africans on the continent and in the diaspora. In the Democratic Republic of Congo, life expectancy has increased by 20 years over the past 20 years, and now stands at 60.4 years for men and 64.4 years for women. South Africa is in the process of implementing universal health coverage ; in Morocco, 84% of the population has health coverage; in Rwanda, 80%. However, for the continent as a whole, the average coverage rate is 6%.

At the same time, the continent remains highly exposed to epidemics in general. Of the 40 million people who have died of AIDS over the past 40 years, half are in Africa, and particularly in southern Africa, which in 2005 was considered the AIDS and tuberculosis capital of the world. According to figures provided by the WHO in 2019, the main causes of death in Africa are neonatal conditions, followed by lower respiratory tract infections and diarrhoeal diseases (respectively 11.3%, 9.9% and 6.4% of all deaths). Children under five accounted for more than 1 in 3 deaths. However, the overall situation is improving: the crude death rate in Africa fell from around 1,317.3 deaths per 100,000 inhabitants in 2000 to 713.2 deaths per 100,000 inhabitants in 2019, a drop of 45.8%. In addition, 60-80% of Africans rely on traditional pharmacopoeia, which continues to exist alongside Western medicine.

In the diaspora, Afro-descendants remain more vulnerable than other citizens of the countries where they live to chronic diseases such as hypertension, diabetes and cardiovascular disease, often due to socio-economic factors such as limited access to healthy food, housing and

medical care. The situation is even more serious for migrants, who have less and less access to even basic healthcare, with the rise of the extreme right and xenophobia creating an environment that is hardly conducive to health care. In addition, racial stigmatization and prejudice against black populations contribute to a lack of trust in healthcare systems and less use of available services. In France, many healthcare providers continue to talk about the "Mediterranean syndrome", an urban legend claiming that patients from North Africa and sub-Saharan Africa exaggerate their symptoms and pain, leading to a deficit in care and a loss of opportunity for patients.

For example, in December 2017, Strasbourg resident Naomi Musenga called the emergency room because she felt she was going to die. But the operator replied that "everyone dies one day". The girl died five hours later. One wonders whether the operator would have reacted in the same way had the patient given a proper French name. The case made the headlines, and the operator was convicted two years later of non-assistance to a person in danger.

In the Diaspora, Afro-descendants make up a very large proportion of the healthcare teams: under-represented among doctors, they are very numerous among nurses, and over-represented among care assistants. In other words, in the healthcare sector, the further down the social ladder you go, the more blacks and Maghrebians you find. In the UK, for example, care for the elderly could not function without women of African origin. As for African doctors, they are both over-exploited (continuous on-call duty, disproportionate workloads) and underpaid, compared to their European colleagues.

Given this long and painful history, it is clear that the bill presented by the SOAD government must be part of a global vision of healthcare, taking into account the history and struggles of Africans on the continent and in the diaspora, with the aim of reparation, reconquest and renewal. It aims to build a healthcare system that is inclusive, supportive and respectful of cultural identities, in order to restore the dignity and well-being of African peoples and their descendants, wherever they may be.

In a global context marked by growing interdependence and increased population mobility, the State of the African Diaspora recognizes the importance of a coordinated and supportive approach to healthcare for its nationals, whether they reside on the African continent or in the various countries of the diaspora. In order to strengthen the integration of healthcare policies across the different communities on the continent and in the diaspora, it is imperative to create an innovative and inclusive legislative framework. This legislation aims to promote a global, preventive and accessible approach to healthcare, based on the results of scientific research and the principles of social justice and solidarity, coordinated with the countries of Africa and the Diaspora.

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Health, Tradition and Modernity Bill

Title 1: Definitions and Principles

Article 1: Definitions

For the purposes of this Act, the following terms are defined as follows:

1. Health: Health is not merely the absence of disease or infirmity; it is more generally the complete state of physical, mental, spiritual and social well-being of an individual or a population.

2. **Health infrastructure**: All facilities, equipment and human resources dedicated to health care.

3. **Traditional medicine: All knowledge and practices relating to health, based on cultural and ancestral traditions**.

4. **Telemedicine**: The practice of medicine at a distance, using information and communication technologies to provide healthcare services.

5. **Medicines** : Substances or preparations used to treat, prevent or cure diseases and disorders.

6. **Disability**: Any physical, sensory, mental or cognitive impairment that limits a person's activities.

7. **Spiritual wellbeing**: Education, practices and activities that nurture a sense of purpose, connection, and inner peace.

Article 2 : Principles

The health policy of the State of the African Diaspora is based on the following principles:

1. **Universality**: All citizens of the State of the African Diaspora are entitled to quality healthcare, without discrimination of any kind, discrimination being understood here in the sense defined in the February 2024 law on citizens' rights.

2. **Equity**: The State guarantees an equitable distribution of healthcare resources between different communities, including the most vulnerable populations.

3. **Accessibility**: All citizens must have easy access to healthcare services.

4. **Prevention**: Health promotion and disease prevention must be national priorities.

5. **Respect for cultures**: Health practices must respect the cultural values and traditions of Pan-African communities, but practitioners must ensure that they incorporate all relevant health innovations in the interests of the populations concerned.

6. **Respect for rights**: respect for human rights must be preserved. Treatments may not be administered without the informed consent of patients, except in strict cases to be defined by regulations subsequently promulgated by the executive.

Title 2 : Cooperation and Infrastructures

Article 3 : Health and International Cooperation

The State of the African Diaspora will set up health infrastructures in Africa and in the diaspora, in cooperation with the relevant authorities. The financial, scientific and technical terms of this cooperation will be defined by both parties on a case-by-case basis, articulating the standards of the host country and the standards of the State of the African Diaspora. This sectoral cooperation may be set up by the Ministry of Health, the Ministry of Traditional Medicine and/or the Ministry of International Cooperation, under the authority of the Prime Minister.

Article 4 : Accessibility of infrastructures

Health infrastructures must be as accessible as possible to all citizens, particularly the elderly, pregnant women, children, people with disabilities and people living in rural areas. Healthcare facilities must be adapted to the specific needs of different populations, which will be defined in conjunction with the relevant local authorities.

Title 3 : Education and Research

Article 5 : Training for healthcare professionals

The State is committed to developing a solid health education system, training competent and qualified health professionals, with particular emphasis on skills in preventive medicine and community care. This health education system will be set up within the framework of the State's medical complexes, which will include diploma courses (medical faculties, pharmacy faculties, dental faculties, nursing schools, etc.), placed under the joint authority of the Ministry of Health or the Ministry of Traditional Medicine on the one hand, and the Ministry of Education on the other.

Article 6 : Health research

The State will support scientific health research, in particular studies into diseases prevalent in Africa and the African Diaspora, as well as research into traditional medicine and new medical technologies.This research will be developed in particular within the framework of the medical complexes and the higher education faculties they will house. It will adhere fully to the ethical principles applicable to medical research involving human beings, as defined in the World Medical Association's Declaration of Helsinki.

Title 4 : Traditional Medicine

Article 7 : Integration of traditional medicine

Traditional medicine is recognized as an integral part of the health system of the State of the African Diaspora. The State will encourage traditional health practices, while ensuring their regulation in order to guarantee their reliability, safety and efficacy, as well as their dissemination and promotion.

Article 8: Training and Certification of Traditional Medicine Practitioners

Training and certification programs will be set up for practitioners of traditional medicine who will have to work within the framework of the infrastructures created by the State of the African Diaspora, in order to ensure the quality of the care provided while respecting health safety standards.These programs will be set up in conjunction with national and regional associations approved by the State of the African Diaspora in general, and by the Ministry in charge of Traditional Medicine in particular.

Title 5 : Telemedicine

Article 9 : Development of telemedicine

The State encourages the use of telemedicine to make healthcare accessible at a distance, particularly for rural communities and for specialized consultations.The medical complexes and diagnostic cubes set up by the State will be organized in such a way as to encourage connections between hospital doctors in urban areas and populations in rural areas.

Article 10 : Regulation of telemedicine

The State of the African Diaspora will discuss with the partner country a framework agreement for telemedicine booths and medical complexes. Regulations will be drawn up at a later date to guarantee the confidentiality and security of patient data, the accessibility of technologies, the quality of services and protection against abuse.

Title 6 : Medicines

Article 11: Access to medicines

The State will ensure that essential medicines are accessible to all citizens, at affordable prices, and that they meet international quality and safety standards. A medicines agency will be created, with normative and regulatory powers.

Article 12 : Drug manufacturing and distribution

Policies will be put in place to encourage the local production of medicines and guarantee their equitable distribution throughout Africa and the African Diaspora. Particular attention will be paid to combating counterfeit medicines, which are a scourge on the continent, jeopardizing health security while financing international criminal networks.

Title 7 : Health System

Article 13 : Organization of the healthcare system

The purpose of the health system of the State of the African Diaspora shall be to provide assistance to the citizens of the State, particularly in the infrastructures under its jurisdiction. It will be organized in coordination with that of the countries where these infrastructures are set up. The ultimate aim will be to achieve universal coverage for the citizens of the State of the African Diaspora. It will be digitized, and associated with the other services made available to the State's citizens.

Article 14 : Financing the healthcare system

The financing of the healthcare system will be based on a mixed model, combining public resources, citizens' contributions, private investments and international partnerships.

Title 8 : Information and Public Health

Article 15 : Health awareness and education

The State will implement awareness-raising campaigns on public health issues, in particular on the prevention of infectious and chronic diseases, hygiene and health-promoting behaviors, not forgetting mental health and suicide prevention, in consideration to social determinants.

Article 16 : Collection and dissemination of health information

The State will encourage the collection, analysis and dissemination of public health care data in order to improve health policies and ensure a rapid response to health crises, while guaranteeing the confidentiality of the data collected.

Title 9 : Health and Disability

Article 17 : Access to healthcare for people with disabilities

The State will guarantee access to healthcare for people with disabilities, providing health services adapted to their specific needs, particularly in terms of rehabilitation and specialized care.

Article 18 : Inclusion of people with disabilities in health policies

Health policies must be inclusive and take into account the needs of people with disabilities at all levels of the health system, including infrastructure, care and information.

Title 10 : Health and nutrition

Article 19 : Promoting sports activities, and healthy and balanced nutrition

The State will take the necessary measures to promote sport activities, in conjunction with the Ministry of Sports, as well as a healthy, balanced and nutritious diet in conjunction with the

Ministry of Agriculture. Food policies and partnerships with approved companies will be put in place to combat malnutrition and diseases linked to poor nutrition.

Article 20 : Food quality control

Strict standards will be established to guarantee the food safety and quality of food products available on the market, in accordance with the regulations set out in the State of the African Diaspora Law on Agriculture (Law of March 1, 2024). A food quality agency will be created, with regulatory and normative powers.

Title 11: Spiritual Wellbeing

Article 21 : Workshops and Seminars

The State of the African Diaspora through its university (USOAD) and its partners shall provide events on personal development centered around well-defined topics, such as stress management, overcoming traumas, emotional resilience and indigenous healing, etc.

Article 22 : Wellness Centers/Wellness Retreats

Within the Smart Cities and SOAD partnerships, there shall be designated facilities focused on promoting overall health and well-being through a variety of locations providing holistic services and treatments and shall cater to improve physical, mental, and spiritual wellbeing.

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