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References


Parkinson’s disease in Africa

In sub-Saharan Africa, in common with many developing countries, there is a perpetual shortage of health workers and resources. Social and economic effects and long-term conflict coupled with a high incidence of diseases such as HIV/AIDS and malaria stretch health systems to the limit and this is compounded by the loss of trained staff to more developed parts of the world [1].

The paper by Dotchin et al. [2] reminds us that Africa remains a dark continent in terms of our knowledge of neurological diseases and Parkinson’s disease in particular. Even in Europe, diagnosis of a disease with no biological markers, no specific imaging abnormalities and a variable presentation can be difficult, and given the compounding factors of vascular [3] and infectious disease any epidemiological study is going to be fraught with difficulties. One is struck by the relative youth of those affected by Parkinson’s disease in this study, and for the most part old people seem to be hardly visible in the studies that have been carried out. Most old people live in extended family structures in Tanzania and in 1988 only 4% of the 23.3 million population were over 60 [4]. The poverty is striking, with the choice patients must make between medication and food. The life expectancy for patients with Parkinson’s disease in Europe was severely limited before the introduction of levodopa, and that is essentially the situation that still exists in sub-Saharan Africa, so it is perhaps unsurprising that the truly elderly are unrepresented in the studies that do exist.

There have been major improvements in Parkinson’s disease care in the last 35 years in the developed world, including the introduction of levodopa and the dopamine receptor agonists as well as specialist nurses and a group of physicians who have developed a major interest in Parkinson’s disease. Levodopa is not regarded as an expensive medication in the United Kingdom but it is unaffordable in much of Africa, though one suspects its affordability could be increased by negotiation with pharmaceutical companies, similar to the successful arrangements that have brought about an improvement of access to anti-retroviral treatment in that population.

The theme that stands out in this paper is the different perception of illness in these societies where sufferers may be perceived as ‘bewitched’ or merely suffering from the effects of ageing. With treatment being unaffordable and unavailable, and with a complete discontinuity of medical care, it is unsurprising that patients turn to traditional healers.

Tanzania is one of the poorest countries in the world and faces overwhelming problems in health provision. Only 4.3% of gross domestic product is spent on health and almost half of this is private rather than government funded. Access to basic facilities such as clean drinking water remains a problem. While local resources and international aid are focussed on conditions such as infections and malnutrition, neurodegenerative disorders will not be perceived as a high priority. Life expectancy at birth is 46.5 years and
the incidence of HIV/AIDS in adults (15–49 years) is between 6.4% and 11.9% [5]. Africa, like Europe, has an ageing population but with a biphasic age distribution, the old and the young. The strong and economically active have been removed in large numbers by HIV/AIDS. The elderly are thus economically and socially important in these societies and yet treatments for the neurodegenerative diseases they are inevitably going to suffer are out of reach economically.

Dotchin and co-workers’ paper, however, does remind us of the opportunities that exist in Africa for our understanding of Parkinson’s disease. Some of the rural communities are stable over long periods of time and in Tanzania 62.5% of the population live in rural areas [6]: there are fewer pollutants and potentially less compounding variables in terms of understanding the epidemiology of Parkinson’s disease. We have learnt much about the nature and causation of the disease by examining populations in which disease prevalence is very different from the western world, and there is an urgent need to study Parkinson’s disease and other degenerative disorders in these populations. A more urgent need however is to address the humanitarian aspects of an untreated but treatable disease, which is often forgotten in the context of overwhelming numbers of infectious disorders. The effects of medical migration that have resulted in many African doctors emigrating to wealthier countries such as the United Kingdom [7], results in the grossly inadequate number of neurologists and the virtual absence of geriatricians. This issue affects specialists [8] from many countries, and needs to be urgently addressed by the western world.

References