EDITORIAL

Aging in Sub-Saharan Africa: Sub-par?

Although this sad tale describes a specific woman's story in Uganda, the focus of this editorial is on the case's sub-title: "Lessons for the Developing World."[1] Unfortunately, many of the issues addressed are generic, not only for parts of Africa but for much of the less developed regions of the world as well. While one size will hardly fit all, some principles that address these challenges are clearly generalizable.

The Bad News

To begin with Mdm. A's gender, the situation of women in many parts of the world is a real concern—primarily in Africa and the Middle East due to a combination of paternalism and absent, weak, or unenforced laws.[2] Many of this patient's woes were connected to her second-class status as a woman. She characterizes a typical tragic story, especially in sub-Saharan Africa, of early widowhood following HIV infection from the husband/partner and subsequently her own delayed death from the disease as well.

But Mdm. A's story is not only one of gender and AIDS; it is also the story of multiple marginalities, and the ways that these can shape health outcomes for the most vulnerable members of society. Any one of the characteristics used to describe a woman like Mdm. A (elderly, poor, widowed, residing away from her extended family network, HIV positive) would constitute a significant health risk. Put together, the totality of the hard knocks Mdm. A has suffered place her at an almost impossible position, far beyond her needs as a woman living with HIV-AIDS.

The treatment of this specific condition is beyond our scope but clearly much progress has been made over the past two decades. However, despite these improvements there are still millions in Mdm. A's doleful situation. No less important, the latest WHO treatment recommendation to "treat all" HIV positive patients regardless of the state of their illness[3] will result in an increase in the number of patients eligible for care. However, these new and much desired changes in treatment policy will put many more like Mdm. A in a similar position, in health systems that have yet to adapt to the growing, and complex, needs of their patient population.

To make matters even worse, the concept and development of palliative care services in many parts of the world, especially sub-Saharan Africa are still in their infancy.[4] The final clinical ignominy is the general lack of availability of medical narcotics, secondary to many cultural and bureaucratic blocks; this, despite the growth and use of illegal heroin in that part of the world.[5]

Connected to the second-class status of women, and so well delineated by this case, we also observe rapid changes in the traditional family structure—one that for millennia was the sole insurance support for those few who survived into old age. In this case, 8 of Mdm A's 11 children had migrated overseas, leaving only 3 to cope with her increasingly heavy needs. With state supported safety nets literally non-existent, the same mechanisms that pushed Mdm. A's children to migrate overseas in search of work are the ones that pushed her to move to the city, where her extended family support network was unavailable.

Again, the problem of migration is hardly new and not restricted to east Africa; compare with a similar phenomenon in a more economically successful China.[6] But this movement of people wreaks havoc with the traditional family—effecting both the very young and old.[7] Without the appropriate mechanisms to assume the roles previously undertaken by extended family networks, more people will find themselves in Mdm A's position.

Unlike the situation in more wealthy parts of the world, from the demographic point of view Africa is still relatively young—with Uganda being among the least aged. That being said, given the relative success in the field of maternal and child health, projections suggest a rapid aging of Sub-Saharan Africa. Again, a salutary comparison can be made with China, that for other reasons (primarily but not exclusively, the one child family policy) is just now entering a demographic catastrophe. Africa has more time but still, its aging is progressing.

Mdm. A was also a victim of a health system that while pushing hard to adopt new treatments and therapies is still severely challenged by limited resources. While many of these challenges are not directly health related, still they pose a major barrier to positive health outcomes. For example, Mdm. A's inability to access health services due to prohibitive transportation costs is one of the common barriers to care for those living with HIV throughout the region.[8]

Moreover, the health system that Mdm. A encountered in her time of need suffers from the fragmentation of care caused by weak primary health services, limited services for non-communicable diseases, and a reliance on vertical programs (silos) to treat infectious diseases such as HIV-AIDS. The lack of and disorganization of the medical services that do exist caused her to needlessly suffer the opposite of a "good death."

A final central issue, although not directly addressed in this case report, is the poaching of African physicians

DOI: 10.1111/jgs.14751

0002-8614/17/$15.00

primarily by four English speaking countries: the US, UK, Canada and Australia.[9] As pointed out over 10 years ago, while the US has only 5% of the world's population it enjoys the services of over double that proportion of the world's doctors with many of these international medical graduates coming from the poorer areas of the world.[10]

Although sub-Saharan Africa is not the prime source of this brain drain, given the extreme poverty of these countries and low absolute number of physicians within their borders, the relative losses here are significant. Specifically, with respect to Uganda, in 2005 14.2% of its 1,175 doctors were working in one of the above four abovementioned "Anglo-Saxon" countries.

The Good News

Despite all of the above, the news is not all bad. For example, with respect to the overall economic situation of Africa, a recent special report in the Economist was upbeat, pointing out that "[while] the commodity boom may be over, and barriers to doing business everywhere…Africa's market of 1.2 billion people still holds huge promise." Specifically East Africa, including Uganda, boasts an average annual increase in GDP of between 6% and 7.9%. Should this economic progress be maintained, and even if only some of these resources are directed towards health, the situation of people such as Mdm. A should improve.[11]

Even without economic growth, as has occurred in much of the developing world, Africa has taken advantage of technological "leap frogging." For example, it has little need of investing in landline telephony given the astronomical growth of cell phone penetration (36.7 million subscribers by mid-2016 and growing).[12] With respect to energy, the growing use of solar power, at least in part obviating the need for expensive investment in traditional energy infrastructures, should also garner savings.[13] Again, one hopes that some of these resources can be redirected towards health in general and to the elderly in particular.

This "leap frogging" in technological innovation has already resulted in the adoption of e-Health and m-Health solutions throughout the region, that while may not be costly, have been shown to improve the quality of healthcare services.[14]

What is to be Done?

Given all of the above, what steps can be taken to improve the situation of the elderly in the less developed regions of the world? Firstly, we need more data. Even though the piece on which we are commenting is a case report, the decision to publish it reflects the Journal's policy of welcoming more papers from around the world. Within the developing world itself the relevant medical and social disciplines will need to invest more of their efforts in motivating and training young people to become interested in gerontology and geriatrics. Although traditional deference towards the elderly is eroding due to the pressures of globalization, industrialization, and migration, the wellspring of respect for "the elders" still exists in many parts of the world and especially in East Africa. This social capital needs to be maintained.

With respect to the lack of and disorganization of primary care services, which can so adversely affect elders like Mdm A, things need not go that way. Clearly, much of the medical solution lies with the development of good primary care services rather than expenditures on costly "white elephants." Moreover, Mdm A's story is a painful reminder that our tendency to rely on "vertical" programs (e.g., HIV-AIDS, malaria, etc.) may be harmful not only to the ones excluded from care, but also to those whose needs will not be comprehensively served by disease-specific programs. Mdm A, after all, was eligible for the existing AIDS treatment programs, and yet the failures of the system as a whole prevented her from receiving the care she needed.

Efficiency and flexibility in the development of appropriate services for the elderly can also be encouraged. Facing a devastating shortage in human resources, many countries struggling with resource-poor health systems have explored task shifting as a tool to augment health services. In Mdm A's case, as in many others, a network of community health workers could have replaced (at least in part) her weak family support system, and provided linkage to much needed care.

Although there are various models from around the world, the Israeli NGO *ESHEL* has helped develop services for the elderly in Israel, a country that went from developing to developed status in just a few decades.[15] It has accomplished much on a very modest budget by acting as an honest broker linking other NGOs, volunteer associations and so forth with the relevant governmental ministries in Israel. Many of these strategies and programs could be adapted (not necessarily adopted) to the East African context.

Efforts made by local national health systems not withstanding, it would also be hoped that the large development agencies (both government and NGOs) would also begin to shift some of their focus from a nearly universal concern with children and acute disease to one which recognizes the ongoing demographic and health shifts described here. For example, a quick perusal of the Gates Foundation website could find nothing specifically devoted to either the elderly in general or those in the developing world, although ample examples of programs dealing with poverty (with possible tangential benefits to older persons), children, and acute illness were easily located.

For their part, relevant organizations in the industrialized countries, such as the American Geriatrics Society and its cognates in other countries could be more welcoming towards members of the developing world, e.g., offering subsidies for membership and grants to attend annual meetings. Laudably this journal is already signed on to the WHO's Hinari system of providing free access for scientific journals to readers in poor countries (ref: http://www.who.int/hinari/en/; Accessed October 8, 2016) and the AGS offers discounts for membership; but more can be done.

This case history describing one old lady's dire situation, poor medical care, family disintegration, and in the end, her "bad death" can help us all to focus on the growing phenomenon of aging in the developing world. Tomorrow's elderly, in Africa and around the world, have already been born. It behooves us all to prepare for their care which will be on us soon enough. We can do better and there is still time to prepare—but not all that much.

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ACKNOWLEDGMENTS

Conflict of Interest: Neither author has any conflict of interest to declare.

Author Contributions: Both authors contributed to the writing of this manuscript.

Sponsor's Role: There are no sponsors of this manuscript.

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