

Letter to the Editor

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Building a rheumatology team for Africa: enhancing the roles of patients and non-specialists

SIR, We are grateful to Genga *et al.* [1] for elegantly outlining the urgent need for improved rheumatology care in sub-Saharan Africa (SSA). The authors frame their discussion with the key observation that in many regions of SSA with ageing populations we have entered the era of non-communicable disease as the main driver of morbidity and mortality [2]. Rheumatic and musculoskeletal diseases (RMD) are the third most common cause of disability globally [3]. As Genga *et al.* observe, African specific risk factors, including the high frequency of manual occupations and increasingly western diets and behaviours, are poorly understood.

Nigeria alone has a population of over 180 million people; West Africa has a population exceeding 320 million [4]. Comparable to the data from East Africa quoted by Genga *et al.* there are currently 26 consultant rheumatology physicians in West Africa. Outside of South Africa, the only fully accredited rheumatology training programme in SSA awarding its own certificate of specialization is based in Lagos, Nigeria. Trainees on rheumatology specialist programmes in Ghana and Kenya must currently complete their specialist training in South Africa or outside the continent owing to insufficient numbers to provide domestic senior supervision. The West African programme was established in 2000 by Professor Olufemi Adelowo. At this month's American College of Rheumatology meeting (3–8 November 2017) Professors Adelowo and Oyoo presented data on behalf of the African League of Associations in Rheumatology reporting that the Nigerian programme has produced 12 consultant rheumatologists and 19 trainees with capacity for four trainees a year [5]. This programme provides a template for rheumatology training across the continent supported by the African League of Associations in Rheumatology and the International League Against Rheumatism [6].

We recently hosted the first rheumatology plenary session at the Nigerian Institute of Medical Research (NIMR) 4th International Scientific Conference (7–9 November 2017). It brought together rheumatology specialists and interested non-specialists from all over West Africa. Recently published data on behalf of Community Oriented Program for Control of Rheumatic Diseases suggest that musculoskeletal morbidity is high in Nigeria with 58% point prevalence of musculoskeletal symptoms in this population-based survey [7]. As alluded to by Genga *et al.*, the conference discussed the major problem of delayed presentation of RMD to specialist care

associated with increased morbidity and mortality from undiagnosed and inappropriately managed disease. Even in Lagos, where rheumatology provision is superior to other regions, the average time to specialist care from onset of symptoms exceeds 4 years [8]. Across West Africa presentations of SLE are often managed as infection given the perceived high prevalence of communicable disease: mortality is 48% in those admitted to hospital according to unpublished data (Dey *et al.* 2017). Specialist physicians cannot meet this adversity alone. Awareness of rheumatic conditions among both patients and non-specialist physicians is fundamental to improving care outcomes in SSA. Survey forms were given to 60 attendees of the NIMR conference at random with 53 respondents. Respondents were asked 'What is the single most important barrier to improving the care of patients with musculoskeletal disease?' Fifty-seven per cent reported either patient or non-specialist doctor awareness of RMD (see Fig. 1). Only 6% reported that availability or use of specialist treatments was the single most important barrier.

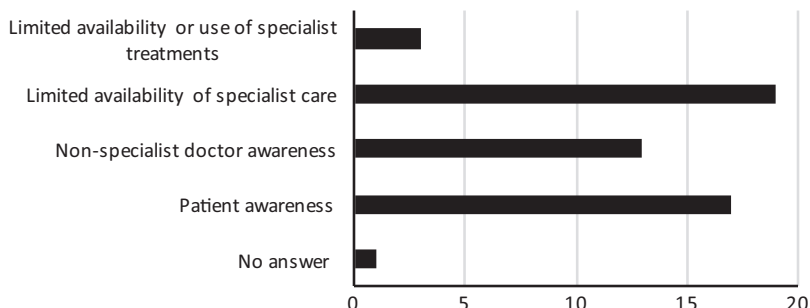
To address this gap in Ghana, Dr Dzifa Dey has pioneered a community-centred approach to improving rheumatology care. She founded tRi Ghana (The Rheumatology Initiative) as a non-profit organization to provide advocacy, education and research for autoimmune rheumatic conditions in Ghana [9]. tRi Ghana organize educational seminars for non-specialist physicians, support group meetings for patients and hold fundraising events that lobby for government support. This is an example that should be emulated across the continent and beyond: we plan to start this process by formally announcing the tRi International organization. We invite patients, non-specialist physicians and rheumatology specialists to join this movement to maximize available resources and knowledge.

Finally we would like to reiterate the absence of high quality population-based data relating to rheumatic disease in sub-Saharan Africa. As Genga *et al.* make clear, we must first define the problem before we can plan intervention and infrastructure development. Sharing available data should be a priority. Longitudinal datasets of patients with rheumatic disease exist in Ghana and Nigeria that we hope to formalize. We would like to invite other African collaborators to join this initiative. We would also like to highlight the paucity of data relating to RMDs in people living with HIV (PLWH). A collaboration between NIMR and University College London is making a contribution to address this specific knowledge gap.

Bringing together stakeholders from across SSA will continue to build the case for support of RMD care in SSA on the firm foundations laid by pioneers such as Adelowo, Dey, Moody and Oyoo. The case is more likely

Fig. 1 Nigerian institute of Medical Research 4th International Scientific Conference survey of attendees for rheumatology plenary session

What is the single most important barrier to improving the care of patients with musculoskeletal disease?



to be heard and action taken internationally if we join as many voices as possible to the chorus.

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