

The Mortality of Serving Africa Presidents: A Lesson for the Health Profession and the Lay Public

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ABSTRACT

Background: Although Africa has the worst mortality data in the world, the picture painted by the high mortality rate of serving Africa leaders in the last five years suggests reasons and causes far beyond poor socio-economic conditions. This study examined the causes and age at death of serving African leaders, in the last five years, and draws out the lessons, for the health profession and the general public.

Material and methods: An internet search of creditable websites was carried out to determine the number, causes and age at deaths of the leaders, within the study period of 2008 to 2012. The life expectancy rates of the bereaved countries were also considered.

Results: A total of 13 presidential mortalities took place in the world during the study period, with 10 (76.92%) involving serving African leaders. The leaders died at an average age of 66.9 +/- 7.22 years, an average of 12.1 years above the life expectancy rate of their respective countries, but less than the world average of 68 years. Most (80.00%) of the leaders died from noncommunicable diseases; 3 died from cardiovascular diseases, 3 died from cancer, while two were known diabetics. The remaining two leaders were killed in a violent change of government.

Conclusion: The African leaders died mainly from noncommunicable diseases, at an age that is below the world average. Public enlightenment campaigns and greater emphasis on patient-centered chronic care of noncommunicable diseases are hereby

recommended.

Keywords: Presidential mortality; noncommunicable diseases; African leaders; patient-centered chronic care; screening.

INTRODUCTION

Mortality rate is an acknowledged proxy measure of the health and socio-economic condition of a community or country¹. Although Africa has the worst mortality data in the world, the picture painted by the high mortality rate of serving Africa leaders suggests reasons and causes far beyond its poor socio-economic condition. In the last five years, beginning from 2008, there have been a total of 13 presidential mortalities in the world, with serving African leaders accounting for 10 (76.92%) of the deaths². This is far beyond the expected, considering that leaders are the number one citizens of their countries, live a life far removed from those of the average citizens, and have access to the best medical care, without regard to cost or distance. This study examined the causes of the death of serving African Presidents in the last five years, and draws out the lessons for the health profession and the general public in Africa.

MATERIAL AND METHODS

An internet search of creditable websites was carried out on 9th September, 2012 to determine the number of deaths among serving African leaders, within the study period of 2008 to 2012; the age and cause of the death, and the life expectancy of the bereaved countries. Former leaders such as Frederick Chiluba who died within the study period were excluded from the

study.

RESULTS

A total of 13 presidential mortalities took place in the world during the study period, with 10 (76.92%) involving serving African leaders. Table I shows the age and cause of death of the leaders. The leaders died at an average age of 66.9 +/- 7.22 years, with a range of between 57 and 78 years.

The leaders died at an average of 12.1 years above the life expectancy rate of their respective countries, but none lived up to the 83 years life expectancy of Japan, the country with the highest life expectancy rate in the world.

Table I: Serving African leaders that died between 2008 and 2012, and the age and cause of death

Country	Leader	Age at death	Life expectancy	Cause of death
Zambia	Levy Mwanawasa	59	48	Stroke, hypertension
Guinea	Lansana Conte	74	52	Diabetes Mellitus? Leukaemia
Guinea Bissau	JB Vieira	69	49	Killed
Cabon	Omar Bongo	73	62	Heart Attack (official) Intestinal cancer
(Unofficial)				
Nigeria	Umaru YarAdua	58	54	Pericarditis, Renal ailment
Libya	Muammar Gaddafi	69	73	Killed
Guinea Bissau	Bacai Sanha	64	49	Diabetes Mellitus
Malawi	Bingu wa Mutharika	78	47	Heart Attack
Ghana	John Atta Mills	68	60	Throat cancer
Ethiopia	Meles Zenawi	57	54	Brain tumour

Most (80.00%) of the leaders died from noncommunicable diseases; 3 died from cardiovascular diseases, 3 died from cancer, while two were known diabetics. The remaining two leaders were killed in a violent change of government.

DISCUSSION

The study showed that the leaders died mainly from noncommunicable diseases. These diseases are often lifestyle related, and are also linked to environmental conditions that continue to exert their effects, even in the prenatal period, and long after the initial exposure³. A third of the leaders died from

cardiovascular diseases that can be linked to physical inactivity, obesity and consumption of western diet¹; and another third died from various types of cancers that can be linked to the environmental condition in which they lived, before the assumption of their leadership position^{1, 4}. These are recognized risk factors to the diseases that are often not amenable to medical treatment, but sadly not recognized and tackled, with the required vigor in Africa. Walking and other forms of physical activity is still being considered as “suffering”; obesity is still seen as a sign of affluence, in societies that associate asthenia with tuberculosis and HIV/AIDS; while fast foods are considered as treats to be enjoyed with relish⁵. Yet, physical inactivity alone was estimated to cause up to 1.9 million deaths every years and 16% of all the cases of breast cancer, colon and rectal cancers and diabetes mellitus; while BMI above 21kg/m² has been linked to 58% of all the cases of diabetes mellitus, 21% of ischaemic heart disease, and up to 42% of various types of cancers, including those of the breast, prostate, colon, endometrium, kidney and gall bladder¹.

Environmental pollution such as improper solid waste disposal, noise and air pollution are still considered as mere inconveniences in Africa and leisurely tackled, even as it is estimated that Suspended Particulate Matter (SPM) in the air is directly responsible for 8% of all lung cancer deaths and 3% of all deaths from respiratory infection¹. The WHO Regional Office for Europe also estimated that excessive noise in Europe is responsible for the loss of 61 000 DALYs from ischaemic heart disease, 45 000 years from the cognitive impairment of children, 903 000 years from sleep disturbance, 22 000 years from tinnitus and 587 000 years from annoyance⁶.

This study also showed that the average age of the leaders at death was lower than the life expectancies in the developed countries. The average age of the leaders at death was 66.9 years, while a 2009 WHO estimate puts the life expectancy rate in the high income countries of the world at 80 years, and the world average at 68 years⁷. This shows that the best of medical care in the African countries was not good enough to

achieve the world average, let alone achieve the high life expectancy achieved in the high income countries, even when the diseases seem to be the same¹. This might not be entirely due to lack of expertise, but the inability of the African health systems to readjust and retool, to properly tackle the rising prevalence of noncommunicable diseases. The acute care philosophy is still being used in managing chronic diseases in Africa, with very disappointing results. A Nigerian clinic was only able to achieve good hypertension control for just 24.2% of the patients seen⁸, as much as 25.3% of all patients admitted to the medical ward of a Nigerian hospital die⁹, while about 45% of patients admitted for hypertension-related illness in another Nigerian hospital are likely to die¹⁰. These obviously are not good enough, and therefore call for urgent action, especially as the WHO has projected a further 24% increase in the prevalence of the non-communicable diseases, in the next ten years¹¹.

There is every need to move away from the acute care philosophy, in favour of the Innovative Care for Chronic Condition (ICCC) framework, recommended by the WHO¹². This framework specially called for the education of patients and other members of the community, especially as the risk factors of the non-communicable diseases are often lifestyle related. Had the leaders with known history of diabetes mellitus (Lansana Conte of Guinea and Malam Bacai Sanha of Guinea-Bissau) been better educated of their condition, the disability, political turmoil and frequent foreign trips, for medical treatment, caused by their health condition could have been significantly reduced^{13,14}. This is especially as diabetes education programmes have been found to add extra disability-free years to the lives of diabetes patients¹⁵. Studies have also shown that the brief advice and counseling delivered by a physician or nurse practitioner, as part of routine primary care can significantly reduce the amount of alcohol consumed by high-risk drinkers¹⁶, while a study in Lagos was able to achieve a 64% increase in hypertension control, through the counseling of market women¹⁷.

A third of the leaders died from cancer; their

deaths probably came shortly after the definitive diagnosis, because there are often no organized cancer screening programmes in Africa, even for the ruling class. Although African leaders have a tendency to hide their health problems, the experiences with the Latin American leaders with cancer amply demonstrate the importance of an organized cancer screening programme. The Venezuelan President is still alive several years after he was diagnosed with cancer; and in such a good health that he intends to run for another term in office. The cancer screening programme for the Argentine President Cristina Fernandez de Kirchner is so robust that even a slight dysplasia is detected and decisively treated¹⁸. It is not that there are no cancers screening programmes in Africa; what is often lacking is an organized system that ensures that healthy individuals come regularly, at designed periods, to be screened according to their age, personal and family histories, lifestyle and occupational and environmental exposures. Public enlightenment campaign is again required to ensure the uptake of the screening services, and it is in the interest of the health profession to encourage this uptake, to at least retain their relevance in the management of these health conditions. The lay public in Africa is used to the quick cure achieved with infectious diseases¹⁹; they have shown with medical tourism to India that they lack the patience to wait for the slow progress that characterizes the management of chronic diseases. They need to be told, at every point of contact that disease has changed, and that recovery is slow and better when discovered early.

CONCLUSION

The African leaders died mainly from noncommunicable diseases, at an age that is below the world average. This is probably due to poor risk perception of the risk factors of the emerging noncommunicable diseases, and the inability of the health system to effectively manage the health problems. Public enlightenment campaigns and greater emphasis on patient-centered chronic care of noncommunicable diseases are hereby recommended

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