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Editorial

An Overview of Hypertension in the African Perspective: Are we on Course?

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The global burden of blood pressure disease by Lawes et al. found that 54% of stroke and 47% of ischaemic heart disease worldwide were due to hypertension [1]. The World Health Organisation estimated that > 175 million people at 25% + risk of a major CV event in the next decade [2]. There is evidence that the prevalence of hypertension and Cardiovascular Disease (CVD) is increasing rapidly in Sub-Saharan Africa and the majority of them had uncontrolled hypertension [3]. There are social factors affecting health in Africa which include urbanisation with increased slums, increased social disparity and urban crimes, civil strife, poverty and famine from climate change and droughts and shortened lifespan due to HIV/AIDS epidemic. Life expectancy is correlated with income. The Gini per capital yearly income in 2000 AD in Africa was only 470 US $. The global status of health according to WHO showed that in Africa (11% of the world's population had 24% of the world's diseases, but only 3% of the world's healthcare and just 1% of expenditure. There is a critical shortage of medical doctors in Africa [4]. The barriers to a prevention policy are competing priorities, technology-based interventions, inadequate epidemiological data, poor presentation of messages to policy makers and the media, failure to recognise the importance of prevention and cost effectiveness, anonymity, economic and social restraints, vested interests and lack of community mobilisation. Compliance with medication is a major problem. Compliance may be improved by 1. Good communication with the patient in his or her own language. 2. Socio-cultural factors. 3. Alternative medicine. 4. Difficulty in obtaining leave to attend the clinic. 5. Availability of drugs in clinics. 6. Access to health care providers. 7. Patient understanding of treatment goals. 8. Patient-physician interaction. 9. Inadequate monitoring of patient follow-up. 10. Medicine side-effects, including medicine interactions and effects on co-existing conditions. How can we prevent the majority of premature CVD? The current approach to CVD prevention is not to focus on high risk but to adopt a population focus on societal change and throughout a life course to concentrate changes in multiple risk factors. Whilst it is important to consider the science of medicine for the treatment of hypertension, particular attention should be given to cost-effectiveness as many countries in SSA have severe resource constraints. In some countries the health budget per capita does not exceed US 10 $ per year and is severely insufficient to address the needs posed by the double burden of non-communicable diseases and infectious diseases, including AIDS. Affordability is defined as the number of day's wages required for the lowest paid individual to purchase a 1-month supply of generic aspirin (100 mg), atenolol (100 mg), lisinopril (10mg), and simvastatin (20), daily for the secondary prevention of cardiovascular disease. The affordability of treatment for coronary artery disease in day's wages in six-low or middle-income countries was Bangladesh (1.6), Brazil (5.1), Malawi (18.4), Nepal (6.1), Pakistan (5.4) and Sri Lanka (1.5) [5].

In conclusion the basic underlying factor of hypertension CVD in Africa is poverty. This is discussed by Jeffrey Sachs in his book 'THEEND OF POVERTY. HOW WE CAN MAKE IT HAPPEN IN OUR LIFETIME' [6].

We should remember the wise words of the legend Nelson Mandela when he said "We must face the matter squarely that where there is something wrongs in how we govern known ourselves, it must be said that the fault is not in our stars, but in ourselves. We know that we sit in ourselves, as Africans to change all this. We must assert our will to do so-we must say that there is no obstacle big enough to stop us from bringing about an African renaissance".

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