

## Burden of disease in francophone Africa 1990–2017: the triple penalty?



Recently, several francophone countries in Africa have become the epicentre of major infectious disease outbreaks. In 2014, Guinea contended with Ebola, and currently the Democratic Republic of Congo is facing the world's worst measles outbreak.<sup>1</sup> Given this situation, it is worth taking a look at potential differences between anglophone and francophone regions. Such reflection can serve as a first step towards attracting the resources, partnerships, and commitments necessary to mobilise attention to francophone Africa's disproportionately low rankings on all human development indices.

Health data, particularly on disease burden, remain scarce. The systematic analysis in *The Lancet Global Health* by Charbel El Bcheraoui and colleagues<sup>2</sup> is therefore welcome. It provides crucial information on burden of disease, allowing for a more targeted approach to seeking solutions and sharing resources between francophone countries to tackle common challenges.<sup>3</sup> Such focus is important in addressing what can be referred to as a triple penalty borne by francophone African countries.

The first penalty is reflected in the fact that these countries bear the highest burden of diseases in Africa. One key finding from El Bcheraoui and colleagues' analysis is a nearly 50% decline in mortality and morbidity between 1990 and 2017 in francophone countries. Although encouraging, the current number of deaths (779 per 100 000 population) remains remarkably high despite the heterogeneity between countries, with the Seychelles being the healthiest country with 29 200 disability-adjusted life-years (DALYs) per 100 000 population and a life expectancy at birth of 73.6 years, compared with the Central African Republic, which recorded the highest burden of morbidity with 89 700 DALYs per 100 000 population and the lowest life expectancy of 51.9 years. The high burden of disease was mainly due to malaria, lower respiratory infections, neonatal disorders, and diarrhoeal diseases. Unlike in anglophone countries, where HIV/AIDS has become the leading cause of death,<sup>2</sup> the top five killers in francophone countries remain diseases of poverty and other structural barriers. All are preventable diseases—for example, through

protection such as mosquito nets for malaria, vaccines for lower respiratory infections, or adequate hygiene for diarrhoeal diseases. As noted by El Bcheraoui and colleagues, the fact that years of life lost (YLLs) represent the majority of DALYs for the top five causes of death in francophone countries emphasises the weakness of the health-care system.

The second penalty lies in the fact that, despite carrying the highest burden of disease, francophone countries receive the lowest funds globally.<sup>4</sup> In fact, the ratio between their share of the burden of disease and their share of medical research funding is 29:1 for west African countries, compared with 16:1 for east African countries and 3:1 for southern African countries.<sup>4</sup> Most non-African public funding institutions (eg, the US National Institutes of Health, USAID, and the UK Medical Research Council), followed by philanthropic funding institutions (eg, the Wellcome Trust and the Bill & Melinda Gates Foundation), make particularly large contributions in eastern and southern African countries that are mostly anglophone.<sup>4</sup> However, some multilateral institutions, such as the Global Fund, are investing at least some resources in francophone countries, yet the ability of these countries to manage these funds is limited.

The third penalty is directly linked to the inequalities that arise from the dominance of the English language in global health. As English is the de-facto language of science, most funding opportunities and scientific papers are published in English. For the majority of non-English-speaking researchers, this situation is a real impediment to accessing these opportunities.<sup>5</sup> Even when they manage to perform crucial research that could impact the burden of disease in their countries, francophone researchers struggle to publish as first or senior authors because of this language barrier. They are therefore not telling their own story.<sup>6,7</sup> These limitations, coupled with the difficulties local actors have in accessing available health information in their own language, probably contribute to the disproportionate burden of disease seen in francophone African countries. A major contribution of El Bcheraoui and colleagues' study in this issue is that a full version of

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the Article is published in French alongside the English version, for which the authors and the journal should be commended. A more equitable publication system would—and should—make this format the norm for all research conducted in countries where English is not an official language.

60 years after their independence, it is remarkable that African countries are still distinguished on the basis of their colonial languages. And while a common language unites countries that carry this triple penalty, the challenges they face obviously cannot be attributed to language only, but also to poorer governance structures. Capacity building initiatives by anglophone institutions in francophone countries are taking place<sup>8</sup> and should be encouraged, as recommended by El Bcheraoui and colleagues. The high burden of disease and low funding create opportunities for new players, including African philanthropists particularly from the francophone world (sports stars, business leaders, corporates, and African diaspora), to catalyse public investments in health care. Start-ups, such as Nexakili are playing a pivotal role in building innovation ecosystems that catalyse knowledge circulation between anglophone and francophone countries and contribute effectively to making regional integration a reality. There is, of course,

a secret sauce: good governance, which is the key to coordinating the efforts of well intentioned actors involved in global health today.

We declare no competing interests.

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