Teleneurology and COVID-19 in Sub-Saharan Africa: Capitalizing on the Need Now

Patricia Rigas *

Editorial Office, Journal of Neurology & Neurophysiology, Brussels, Belgium

Corresponding Author*

Patricia Rigas

Editorial Office

Journal of Neurology & Neurophysiology, Brussels,

Belgium

E-mail : neurophysiology@scholarlypub.org

Received: 2-Sept-2022, Manuscript No. jnn-22-79668; **Editor assigned:** 8-Sept -2022, PreQC No. jnn-22-79668 (PQ); **Reviewed**: 12- Sept -2022, QC No. jnn-22-79668 (Q); **Revised**: 18- Sept -2022, Manuscript No. jnn-22-79668 (R); **Published**: 30- Sept -2022, DOI. 10.35248/2471-268X.22.13.9.596

Introduction

Over 60% of the 1.3 billion people who call Africa home live in rural regions with little access to medical professionals. Few African nations now practise any kind of sustained and coordinated telemedicine, and even fewer provide specific tele-neurology services, despite having an absurdly large and underserved population. One of the most severe disruptions to important spheres of human activity in modern times has been the ongoing COVID-19 pandemic. Telemedicine is becoming more and more advocated for in the healthcare industry to provide non-urgent care. The current condition of tele-neurology practise and infrastructure readiness in sub-Saharan Africa was assessed in this research. Most countries currently have mobile phone penetration rates of above 70%, and almost all of them have mobile internet. services using various generations and technology. The required infrastructure is getting easier to find, but it still needs to be upgraded. The Access, Costs, Ethics, And Support (ACES) model has been suggested by us as a unique, all-encompassing approach for the development of tele-neurology in sub-Saharan Africa.

In December 2019, the Chinese province of Hubei had an outbreak of the coronavirus disease-2019 (COVID-19), which is brought on by the SARS-COV-2 virus. Since then, the disease has spread to over 200 nations worldwide. The United States of America (USA), a few Western European nations, and China have had the biggest loads from COVID-19, which has so far resulted in nearly seven million infections and over 400,000 fatalities globally . The disease's severe and difficult cases, which necessitate hospitalizations and critical care, quickly overwhelmed healthcare systems in many parts of the world as the epidemic spread. As a result, it became necessary in many countries to re-deploy healthcare staff and repurpose healthcare resources and infrastructure to confront the existential hazard that the infection poses .

Due to a lack of neurology specialists and the restructuring of existing healthcare systems, demand for neurology treatments during COVID-19 was quite high. Despite the disruption of the chronic neurology outpatient clinics, acute services continued in individuals needing urgent care under the supervision of the emergency department or neurosurgery. The problem was made worse by the broad implementation of lockdown procedures, which made it challenging for those who weren't COVID-19 patients to get medical treatments in locations where they were still offered. Additionally, the extreme susceptibility to COVID-19 of the elderly and those with underlying chronic illnesses, who make up a large portion of our neurology patients, created additional barriers and disincentives for this group of patients to seek medical attention, even when there were clear signs and symptoms. were clear and urgent signs that such. For instance, stroke centres in Europe reported getting significantly fewer occurrences of acute stroke at this time than they had in the past. Though the entire effects of the COVID-19 pandemic in the Sub-Saharan Africa (SSA) environment have not yet been assessed, empirical data points to a severe restriction of traditional service delivery and face-to-face consultations. Few facilities across the continent still offer tele-neurology services in neurology. Some clinics who lacked an existing tele-neurology programme were forced to create an impromptu system to accommodate their patient base . Given that there are significantly fewer neurologists per 100,000 people in Africa than in Europe, it is predicted that tele-neurology will continue to grow and be more widely used in SSA in the post-COVID-19 era. However, there are now limitations, including an estimation of the population who might benefit from tele-neurology expansion and a lack of proof of its cost-effectiveness. SSA is the region with the lowest degree of economic, technological, and internet development globally, in addition to its enormous healthcare burden, even though it is a part of the second-largest continent in the globe . The low-hanging fruit that, if addressed, will make tele-neurology practise a well-organized and appealing practise and service choice in SSA have been briefly highlighted in this work and grouped into Access, Costs, Ethical, And Support (ACES) issues. Due to a lack of neurology specialists and the restructuring of existing healthcare systems, demand for neurology treatments during COVID-19 was quite high. Despite the disruption of the chronic neurology services were provided as needed under the supervision of neurosurgery or the emergency department. The problem was made worse by the broad implementation of lockdown procedures, which made it challenging for those who weren't COVID-19 patients to get medical treatments in locations where they were still offered. Additionally, the extreme susceptibility to COVID-19 of the elderly and those with underlying chronic illnesses, who make up a large portion of our neurology patients, created additional barriers and disincentives for this group of patients to seek medical attention, even when there were clear and urgent indications for it. For instance, stroke centres in Europe reported getting significantly fewer occurrences of acute stroke at this time than they had in the past .

Although the COVID-19 pandemic's full effects have not yet been assessed in Empirical data points to a significant constraint on traditional service delivery and face-to-face consultations in the Sub-Saharan Africa (SSA) context. Few facilities across the continent still offer tele-neurology services in neurology. Some clinics who lacked an existing tele-neurology programme were forced to create an impromptu system to accommodate their patient base . Given that there are significantly less neurologists per 100,000 people in Africa than in Europe, it is predicted that tele-neurology will continue to grow and be more widely used in SSA in the post-COVID-19 age . However, there are now limitations, including an estimation of the population who might benefit from tele-neurology expansion and a lack of proof of its cost-effectiveness. SSA is the area with the lowest level of development despite being a part of the second-largest continent in the world. globalisation of economic, technological, and internet growth, as well as its enormous healthcare burden. In this paper, we have briefly outlined the low-hanging fruits and classified them into Access, Costs, Ethics, And Support (ACES) issues, which, if addressed, will improve tele-neurology practise and make it a well-organized and appealing practise and service option in SSA. We have also discussed the ACES model as a bespoke, holistic strategy for the successful implementation and advancement of tele-neurology in sub-Saharan Africa.

Cite this article: Rigas P. Teleneurology and COVID-19 in Sub-Saharan Africa: Capitalizing on the Need Now. J Neurol Neurophysiol. 2022, 13(9), 001