Comorbidity: the African perspective

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Comorbidity in the developing world is a poorly researched harsh daily reality that compounds diagnostic problems at many levels. Allan German (1) described a group of people in Uganda as being in a state of subclinical malnutrition. In this group any insult, either physical or psychological, led to very severe forms of affliction. It is upon subjects of this level of weakness that a variety of mental disorders are superimposed. In rural Africa, over and above the AIDS pandemic, the people have to struggle with traditional infections, including typhoid fever and tuberculosis. Indeed, in many parts of Africa, psychosis is called 'the big malaria', a term that recognises the link between fever and psychosis. Epilepsy due to trauma at birth and head injury in later life is common in Africa. Childhood infections, including measles, are other common causes of epilepsy, a condition that is comorbid with mental illness in some cases.

Pincus captures the dilemma of the developing world most graphically when he states "Many information systems (especially in developing countries) do not have the capacity for incorporating all comorbidities. Individuals use clinical judgment to prioritize diagnoses, and may fail to account for diagnostic complexity where it exists".

The pressure becomes intense where the ratio of doctors to the population is 1:20,000, whereas that of the influential traditional healer is 1:25. In Tanzania, with a population of 30 million, there are only ten psychiatrists, four of whom work in the capital city (2). In these circumstances, the purpose and utility of remaining faithful to classification systems that have no bearing on the available interventions becomes the subject of legitimate debate. After all, goes the argument, classification systems exist, at least in part, to inform treatment. With the currently available numbers of mental health workers (psychiatrists and nurses), it seems futile to engage in detailed systems of classification.

Recent correspondence in the British Journal of Psychiatry (3) acts to fuel the sense of hopelessness experienced by lonely African scholars, who live without the luxury of intellectual communion with their peers. When Tyrer (3) proposes a trial marriage between depression and anxiety rather than a life of indefinite nosological sin, the African is left wondering how interesting the debate would have been in real life! It however remains clear, at the end of the debate, that nothing is clear beyond the fact that a system of classification, however imperfect, must remain in place.

Many questions arise from this conclusion, including that of the complicating role played by social cultural factors in the causation and perpetuation of common psychiatric disorders – poverty, internal and external displacement of people, refugee status, malnutrition and anaemia are but a few common conditions that could influence the way disease/health might be defined and classified. These considerations compound any attempt at clarifying the question of comorbidity.

As though to complicate things further, the majority of sub-Saharan countries do not have a mental health policy. A chicken and egg situation. In the absence of mental health policies, African governments do not see mental health as a priority issue worthy of funding. Kenya and Tanzania are good examples of countries in sub-Saharan Africa currently engaged in the development of mental health policy after the successful completion of baseline surveys of psychiatric morbidity in rural areas (4). During this process, it has become clear that comorbidity is a matter of concern at two levels. Firstly, the primary health care workers do not have the skills of identifying different psychiatric disorders. For this reason, the guidelines developed for the health information systems at primary care can only consist of a few disorders (eleven in Kenya), if a meaningful information system is to be planted in the country, in the hope that in time it could develop to the full ICD-10/DSM-IV level of complexity. In this way, Kenya recognises the importance of making the first step in this long journey towards harmony in classification systems.

Legitimate questions then arise from this decision. If there are only a few conditions recognised in this (most modern) African system, what is the scientific value of communication arising from Africa? Is research data from Africa to be respected/

trusted? Are Africans in fact talking the same language with the rest of the world when they discuss the challenges of comorbidity? Within the body of this questions lies the answer. Even as the Africans struggle to develop mental health policies, and even as they seem to be developing a parallel system, this is the reason for greater collaboration with the rest of the world.

The mental health policy support project in Kenya and Tanzania is funded by the British government through the Institute of Psychiatry in London, and with it have come many lessons and challenges. The project has exposed a critical mass of African scientists to the discipline of research, and the need to remain faithful to international systems of classification, while at the same time remaining grounded on the harsh reality of poor resources at their disposal, a fact that must drive their creativity.

Another challenge to the Africans considering comorbidity is the question of the prevalence of some psychiatric disorders common in the West, rare in Africa. These include anorexia nervosa and obsessive-compulsive disorder. Do they exist in a different form? Are they comorbid with other disorders? The issues raised by Pincus demand greater collaboration between the developing world and those responsible for harmonising classification systems.

References

1. German GA. Aspects of clinical psychiatry in sub-Sahara Africa. Br J Psychiatry 1972;121:461-79.
2. Ngoma MC, Prince M, Mann A. Common mental disorders among those attending primary health clinics and traditional healers in Tanzania. Br J Psychiatry 2003;183:349-55.
3. Tyrer P. The case for cothymia: an open verdict? Author reply. Br J Psychiatry 2001;180:380-81.
4. Njenga FG, Kigamwa P, Okonji M. Africa. The traumatised continent. The continent with hope. Int Psychiatry 2003;1:4-7.