

Mental health policy development in Africa

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Mental health issues are usually given very low priority in health service policies. Although this is changing, African countries are still confronted with so many problems caused by communicable diseases and malnutrition that they have not woken up to the impact of mental disorders. Every country must formulate a mental health policy based on its own social and cultural realities. Such policies must take into account the scope of mental health problems, provide proven and affordable interventions, safeguard patients' rights, and ensure equity.

Keywords: Africa; mental health; health policy; policy-making; access to health care.

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Introduction

Africa is a large continent, prone to strife, especially south of the Sahara. Most of its countries are characterized by low incomes, high prevalence of communicable diseases and malnutrition, low life expectancy, and poorly staffed services (1, 2). Mental health issues often come last on the list of priorities for policy-makers (3). Where mortality is still mostly the result of infectious diseases and malnutrition, the morbidity and disablement due to mental illness receive very little attention from the government. Health in general is still a poorly funded area of social services in most African countries (1), and compared to other areas of health, mental health services are poorly developed. Indeed, most African countries have no mental health policies, programmes or action plans (4, 5).

In 1988 and 1990 the Member States in the African Region of WHO adopted two resolutions (AFR/RC39/R1 and AFR/RC40/R9) to improve mental health services, and each state was expected to formulate mental health policies, programmes and action plans. A survey was conducted two years later to see if the countries that had adopted these resolutions had done anything to implement them. Despite some modest achievements, the situation of mental health programmes in most countries was found to be unsatisfactory (4). In addition, compelling evidence shows that a large proportion of the global health burden is due to mental disorders, and this proportion is projected to rise in many African countries (6). What does this mean for policy?

Policy goals

The development of mental health policy in Africa should be guided by a set of goals. These goals must

aim to change the negative perception of mental disorders by the public, reduce the incidence and prevalence of mental disorders, including those associated with inappropriate use of addictive substances, and provide adequate care for the mentally ill. Policies must aim to maximize scarce public resources and support families in the provision of the best possible care for the mentally ill. The goals must recognize the need for clear strategies to reduce the disablement associated with mental illness and to promote research on mental illnesses and how to prevent or treat them.

Attitudes to mental illness

In most parts of the continent, people's attitudes towards mental illness are still strongly influenced by traditional beliefs in supernatural causes and remedies (7). This belief system often leads to unhelpful or health-damaging responses to mental illness, to stigmatization of mentally ill persons and those who attempt suicide, and to reluctance or delay in seeking appropriate care for these problems (8). Such beliefs also affect the provision of mental health care services for the needy; thus, policy-makers are often of the opinion that mental illness is largely incurable or, at any rate, unresponsive to orthodox medical practices (3).

The education of the public should be given prominence in the development of mental health policies in Africa because many aspects of mental health care require the active collaboration of the community. Community rehabilitation of the mentally ill is an important example. Community understanding is also important in actions aimed at reducing stigma and discrimination. In most parts of the continent, the family remains an important resource for the support and care of patients with mental disorders (9). Families with mentally ill persons can only be strengthened in this role if they are not made to suffer rejection and lack of understanding by the community.

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Provision and delivery of health and social services

An important consideration in the development of mental health policy in Africa is the close relation between the level of mental health in the community and the general level of social well-being. In this regard, mental health policies need to recognize and stress the importance of other areas of the social services and health services which have strong implications for mental health. Issues relating to unemployment, homelessness and poverty are important in the primary prevention of mental illness. Policies aimed at improving these social factors will inevitably have a bearing on the mental health status of the community. The same is true of policies or strategies aimed at improving perinatal care. The high perinatal morbidity that exists in many African countries has direct implications for the prevalence of mental retardation, epilepsy, and possibly even psychotic disorders (8). Abuse of psychoactive substances is a mental health problem with strong social origins. In particular, the sources of problems due to the use of alcohol and the means of curtailing them are often to be found in social factors (10). Even though primary preventive measures of proven applicability to mental illness are few, policy developments should emphasize the available measures and provide scope for research aimed at finding others (see below).

Of particular concern to health care planners is the HIV/AIDS pandemic. The very high prevalence of HIV infection in some African communities, especially in southern Africa (11), makes it clear that the mental health consequences of AIDS will loom large in the overall psychiatric morbidity of these communities for many years to come. Some of the consequences may be direct effects of the infection or a reaction to the knowledge of being infected (12). However, others will be the indirect effects on bereaved families who have lost loved ones due to this disease. Mental health policies in such countries should take into account the demands of HIV-related mental morbidity on their services. They should also include a strong component of measures that can reduce behaviour and practices which foster the spread of HIV infection.

The proportion of mentally ill persons in African communities who visit their primary care clinicians in a given period has not been clearly calculated, but it is a common finding that most mentally ill persons receive care at the primary health setting (13). The realization that mental health services must be integrated into primary health care is now widespread, because WHO has been playing a major role in its promotion. African countries should emphasize this goal in their policies since primary health care provides a relatively cheap way of meeting the needs of their mentally ill citizens. The common problem of lack of adequately trained specialists in psychiatry makes this approach to the care of mental patients particularly important because of the easy access it provides for patients. However,

given the usual pathway that patients in Africa follow in their search for help, orthodox medical services are unlikely to be the only setting for care, or even the major one. Traditional healers and religious leaders (such as priests) provide a significant proportion of the care received by the mentally ill. For example, in Ethiopia about 85% of emotionally disturbed people were estimated to seek help from traditional healers (14) because there were only 10 psychiatrists for the population of 61 million. This reality has to be reflected in policy.

Many policy-makers in Africa talk about the need to integrate traditional health care into orthodox service delivery, but on the whole, little success has been achieved where such integration has been attempted. One possible reason for this is that the policy for integration has not been well articulated. Such policies have commonly failed to specify the service needs which can be met by the traditional approach, or to show how specific traditional interventions are to be assessed for efficacy, or to give some idea of how good standards in service delivery can be achieved and maintained. Only very few traditional methods have empirical databases to support their effectiveness and safety. In many cases traditional treatments are characterized by unhealthy and injurious methods, but practitioners cite patronage by the community as evidence of their effectiveness, a claim that is borne out by research. For example, an examination of the pathways followed by patients to a tertiary care setting in Nigeria shows that about 20% had previously consulted a traditional healer and that these subjects had a variety of psychiatric disorders (15). A much higher figure was reported by a similar study in Cairo, Egypt (16). It is essential that mental health policy-makers in African countries should grapple with the need to provide a sound and workable approach for integrating alternative medical practices into mental health service delivery. A policy of integration ought to have as one of its primary goals an examination of the nature of traditional practices. The scientific basis of the practice and a process of isolating and improving the more efficacious and safe components of this form of care, while removing those practices that do not meet the objective of efficacy without harm, must be pursued. The proof of evidence — applied before any pharmaceutical compound is adopted — is necessary before traditional herbs and practices can be accepted. Also, the policy of integration of such practitioners should include minimum specifications for qualified training, minimum practice standards, and adherence to a set of rules of practice and a code of ethics. Lists of approved practitioners should be kept and their areas of expertise noted.

Access to medication and community care

Effective treatment exists for many mental disorders. Drugs are not always needed, but when they are,

policies should aim to make them available and affordable. Drug treatment of a number of mental disorders is undergoing a revolution. In recent years, better medications have been developed for the care of persons with depression, schizophrenia, and dementia. Access to these medications is very limited in most African countries. While the issue of access to drugs in most developing countries is a difficult and complex one, the problems relating to medicines for mental illness are partly due to the poor purchasing power of these countries. Newer medicines are mostly developed by pharmaceutical companies based outside Africa. Because of patents on these compounds, companies in Africa cannot make cheaper forms for local use. As argued by Pecoul et al. (17), it seems that for the moment the only way to rectify this situation and provide essential drugs to patients in developing countries is for such countries to obtain compulsory licences. Such licences would "allow local manufacturers to circumvent patent rights with certain conditions and in return for the payment of royalties to the inventor" (17). Mental health policy-makers in African countries must tackle this important issue. It seems likely that joint international action between such countries, with the active support of WHO, will be required. Access to safer and more efficacious medications must be an important component of a policy aimed at providing care for the mentally ill which is shaped by the best standards of practice.

The rehabilitation and long-term care of severely ill mental patients can be expensive. It is now generally accepted that while community care may be more humane, it is not necessarily cheaper than custodial care. Most African societies are fortunate in still being able to draw on the support of families for the care of the mentally ill. However, as urbanization becomes more widespread and the system of extended families breaks down, such readily available resources for the mentally ill may become scarce. Due notice must also be taken of the fact that, even in traditional communities, not every family is willing or able to care for their mentally ill members. The large numbers of vagrant persons with psychotic disorders or mental retardation in many African towns and villages attest to this. It is essential that policies for mental health care should recognize the important contribution of families and seek to support this resource. Policy goals may include bringing families with mentally ill members together, encouraging the creation of consumer groups, and supporting such groups. It is essential that policy-makers take a broad view of rehabilitation. The provision of day-care facilities, social support services devoted specifically to the long-term mentally ill, and living facilities in urban centres will be important. Most families are willing to support their sick members, but severe mental disorders may deplete the resources of even the most willing and able families (9). When one person has a chronic mental illness, others in the family may have to give up work and some of their social roles. Such family carers

often themselves suffer severe stress and their health may be compromised. Policy must also provide for the needs of such carers. Policy must identify a few disorders that make disproportionate contribution to health burden (such as schizophrenia, depression, epilepsy, and developmental disability) for special integrated control and management from primary prevention, where feasible, to rehabilitation.

The mentally ill and the law

In the early 1990s, only 23.4% of Member States of the African Region of WHO were reported to have mental health legislation that included alcohol and drug abuse control measures (4). Even where they exist, the legal provisions for issues relating to mental illness in African countries are often outdated and in need of revision. Most of these provisions were passed down by former colonial governments which have subsequently modified their own laws to reflect modern views on the nature of mental illness. The outdated legal provisions do not recognize the rights of the mentally ill, nor do they give consideration to the nature of their illness in regard to culpability for offences which may be committed. Mental health policy in Africa must be brought up to date. The human rights of the mentally ill must be given prominence with relevant legal provisions. While the safety and well-being of the society are to be protected, legal provisions must be explicit about the conditions to be met before a mentally ill person can be compulsorily admitted and treated. There is also a need to recognize and provide for a patient's refusal of treatment while recognizing that medical opinions on the need for treatment may sometimes overrule a patient's objection. Legal provisions for the protection of the mentally ill from unjust discrimination are becoming common in most developed societies. Such provisions ought to be adopted by African countries. In drawing up policies relating to the mentally ill, African countries should be guided by the principles for the protection of persons with mental illness as enunciated in the United Nations General Assembly Resolution 46/119 of 1991.

Training, research and human resources

Planning for mental health provision requires a credible information base. The prevalence and course of disorders must be studied, and the effects of various mental disorders on patients and their families must be assessed. Information on the efficiency and cost of various forms of intervention is needed to permit enlightened allocation of resources. While cross-sectional studies may provide much of the required information, monitoring the changes and trends in the occurrence and outcome of these disorders requires longitudinal studies. Most of

what is currently known about mental illness in most African countries is derived from small studies conducted in secondary or tertiary centres. Studies conducted on primary health care are rare, and those on health in the community fewer still. Community-based studies are expensive and require a relatively high level of research experience and expertise. The same is true of longitudinal and outcome studies.

Many industrialized countries, with existing information on the distribution of mental disorders, have recently sought to strengthen this information base by conducting large community-based surveys (18, 19). They have done so with the realization that a prerequisite of good public health policy, including one for mental health, must be based on reliable information. Most African countries still do not have a credible information base on which to erect an informed mental health policy (20). Questions about the prevalence in communities of common disorders of childhood or old age, or about substance use, or about factors associated with the HIV/AIDS pandemic are largely unanswerable in most African countries.

The paucity of empirical data on issues relating to mental disorders reflects the generally poor attention given to research and its funding in most of Africa. The collection of basic statistics as an official policy is often lacking or inadequately implemented. This results in unreliable data, which cannot form the basis for an informed and efficient policy. Research expertise in tertiary institutions is sparse and researchers often do not get the encouragement they need. The resulting gap in knowledge in regard to mental health issues indicates the need for a policy committed to the promotion of research. Research that will inform policy-makers about the extent of mental health problems, their causes, the associated disablement and consequences, and their outcome should receive priority attention. The challenge to African countries is to generate empirical evidence as a basis for policy formulation. In the allocation of scarce resources, prioritization is essential. A public health perspective in prioritizing activities relating to mental health has to involve some consideration of the disability associated with different diseases. The Global Burden of Disease (GBD) project is a bold attempt to provide information on the impact of diseases, including mental disorders, on society (6). Some of the major decisions in estimating such an impact are rooted in social and cultural beliefs. For this reason, local projects to complement the data derived from the GBD and to place the findings in the context of their immediate social and cultural environment are particularly urgent. These will allow policies that are driven less by advocacy, but more by the locally relevant body of evidence.

Equally important are studies designed to determine the best policy for the particular country concerned. Such studies should take into account the prevailing social and cultural circumstances, the main constraints, and the options for a viable model of care

within them. Other research activities should examine the efficacy of interventions and the efficiency of mental health policies. Evaluative research to promote and sustain the quality of care and provide reliable auditing of the service is essential. Policies that are not evaluated may be inappropriate or become outdated and inefficient.

There is a need for mental health policies to set targets and goals for achieving the objective of providing an adequate mental health service. This applies particularly to the area of manpower development. Policies must recognize the importance of primary care services both in prevention of some mental disorders and in early intervention for others. In this regard, the goals of training primary health workers to recognize common forms of mental disorder and provide the necessary intervention must be well articulated. The existing body of staff in each country should be the starting point for selecting and planning training activities. WHO has training packages specifically designed for primary care workers and focusing on such conditions as depression, anxiety, somatization disorders, and substance abuse. African countries should make use of such packages, modifying them as necessary.

The training of medical students should include sufficient information and skill-acquisition in mental health to reflect the importance of mental disorders in the work of physicians. A large proportion of the unmet need for mental health services stems from the often very limited ability of physicians in general health settings to recognize and treat psychological problems in their patients (21). The policy should aim at improving the efficiency of doctors in this area by providing adequate time for psychiatric training in medical education.

In 1975 a WHO report observed that “the most important constraint in meeting mental health needs in the developing countries is the extreme scarcity of mental health professionals. This situation is unlikely to improve within the next decades, because of the small numbers at present being trained in mental health care, and the migration of those who have completed their training to developed nations” (22). In 2000, the picture remains dismal. In many countries in Africa the ratio of psychiatrist to population may be as low as 1 per 5 million (5, 14) — compared with 1 per 1000 in European countries (23) — and reflects the requirements in other areas of mental health manpower as well. National policies must tackle this serious problem with a combination of training programmes, incentives and improved conditions of service for mental health professionals. Some of the training may be best organized and paid for by pooling national resources at the subregional level.

Funding of mental health services

Health is part of the social services, which consume rather than generate money. Public health services ought not to be run as a profit-making business or left

to the vagaries of market forces. Still, policies have to recognize the need for an efficient and effective service, and for this the participation of the private sector in the provision of mental health services may be encouraged. How a country organizes its health services will be dictated by political and economic views, but there is a need for provision of funds so that public mental health services do not fall below a given level. The World Health Organization's suggestion for a minimum level of national funding for health (24) provides a good basis for policy formulation. For mental health, the issue is how this amount should be shared among the components of the health service as a whole. Traditionally, mental health has been neglected in this context. Policy-makers must show where it fits in relation to other health needs. The fact that mental disorders are among the top ten causes of disability in Africa and the rest of the world, and that their contribution to the overall burden of disease is going to rise (6) makes a strong case for giving them the attention and resources they need. Adequate funding must be supported by information on the best standards of care and by local data on how mental disorders affect quality of life. Policy-makers need to stress the cost-benefit ratio of treating persons with mental illness and making them active participants in national economic activities.

Equity in the provision of mental health services

Since mental illness is so closely related to vulnerability, both in its causes and in its effects, its sufferers are at a severe disadvantage in expressing their needs and having them met. They are easily marginalized by the social services, including health care services. Mental health policies ought to take particular note of this, and set guidelines to counteract it. Shortages of money, staff and facilities make unequal access to care more likely, but equity is about the way the available resources are distributed, however inadequate they may be. The most disadvantaged economically have the least access to services and are likely to experience social isolation and low self-esteem. The peculiar nature of mental illness dictates that mental health policies should be specific in recognizing the possibility of such inequities and seek to prevent them. Establishing a mental health desk in the Ministry of Health — in those countries where such units do not exist — with the responsibilities of planning, implementing and monitoring the mental health services may help to ensure equity for the mentally ill. Policies that empower consumers and family support groups will also help to expose and counteract inequities.

Creating an environment for good mental health

The social environment in many African countries is unlikely to nurture good mental health. Wars and

internecine strife disrupt social and community life and spread hunger, disease, and homelessness. These disruptions lead to psychological disorders in large numbers of people. It is often not sufficiently realized that psychological morbidity accompanies and outlasts the physical morbidity of war. Even the problems in normal life associated with the loss of a husband, a father, or a family breadwinner are commonly of mental health importance. Policy-makers must be aware of the impact of social upheavals and, even when they are not directly able to prevent them, make whatever provision possible to reduce their negative effects on the psychological health of the victims.

One mental health policy or several?

Given the general tendency in the general public to regard mental illness as being synonymous with severe (mainly psychotic) disorders, should policy-makers produce one policy for mental health or several, reflecting the dichotomy between severe and common disorders? In general, the needs of a psychotic patient are different from those with a neurotic disorder. On the other hand, the differentiation of mental disorders into severe and mild is often arbitrary, and not based on the experience of suffering or disability among the victims. Also, the move towards 'mainstreaming' mental health services with those of general medicine goes with the effort to reduce the stigmatization of mental illness. Having separate policies for severe and common disorders could run counter to this effort.

It seems that what is needed is a broad view of mental illness as a major cause of morbidity and a burden to the victims, their families, and society. An integrated mental health policy would aim to reduce this morbidity and burden by emphasizing primary and secondary prevention of all forms of mental illness and by making provision for the tertiary or rehabilitative care of the more severe cases. Such a policy will draw on the epidemiological knowledge of the clustering of mental disorders in the most vulnerable groups of society and provide for the varying levels of disability that may be associated with different disorders.

Conclusion

The massive burden attributed to mental disorders globally, and specifically in Africa, is a challenge for health planners to rethink the customary ways of viewing the health needs of their communities. The increasing need for mental health programmes has been underestimated, and disruptive events such as wars and the HIV/AIDS pandemic are further adding to the need. While new challenges are emerging, old enemies like communicable diseases and malnutrition are not likely to disappear soon, as poverty and lack of training persist. These facts call

for a well-articulated plan of action which sets achievable goals and targets to reduce the burden associated with mental disorders within the prevailing constraints.

As a programme of action, a policy should be seen not as immutable but as a set of strategies to deal with identified problems and needs. Such problems and needs will inevitably change with changing social and cultural circumstances. A policy for mental health must be flexible enough to respond to such changes. In particular, it must designate bodies that will be responsible for each aspect of its implementation. There must also be a clearly identified process for evaluating the effectiveness of such a policy and making changes dictated by empirical needs. It is essential that policies are evaluated not just when they

are newly introduced and being implemented under relatively controlled circumstances, but also at intervals later when the dynamics of bureaucratic and other activity may influence their effectiveness.

In many countries, mental health services are placed on the political agenda by a combination of pressures from advocacy groups and enlightened citizens. In many African countries, groups with a particular interest in the care of the mentally ill — such as professional associations, consumer groups, and nongovernmental agencies — will need to exert pressure on government to put mental health on the political agenda. They should ensure that, once policies are developed, they do not become just another set of documents left to gather dust on the shelf of a government department or ministry. ■

Résumé

Mise en place de politiques de santé mentale en Afrique

Les problèmes de santé, dans la plupart des pays d'Afrique, restent liés à la forte prévalence des maladies transmissibles et de la malnutrition. Ces pays manquent de ressources humaines qualifiées. Les économies nationales se caractérisent généralement par des revenus faibles et une base industrielle naissante. Nombre de ces pays connaissent également des troubles sociaux et des conflits dont le mobile est la destruction réciproque et, souvent, ils sont en outre gravement affectés par la pandémie de VIH/SIDA. Les dépenses de santé nationales sont d'ordinaire inférieures aux niveaux recommandés. La santé mentale intéresse rarement les responsables politiques et, par rapport à l'ensemble des priorités sanitaires, les crédits alloués aux services de santé mentale ont toujours été bien en-dessous de la moyenne. Rares sont encore les pays qui ont une politique reconnaissant clairement l'étendue des problèmes de santé mentale dans la population et visant à définir des stratégies pour y remédier.

Les politiques de santé mentale dans les pays d'Afrique doivent s'appuyer sur la reconnaissance de l'ampleur des problèmes, y compris la consommation de substances dépendogènes, et l'évaluation de la charge de morbidité due à ces problèmes. L'étude de 1996 sur la charge de morbidité mondiale peut servir de cadre à ce travail de reconnaissance mais des études locales devront compléter les données résultant de cette étude. Des stratégies devront être élaborées pour faire mieux connaître les maladies mentales au public et réduire la stigmatisation des malades et de leur famille. Un programme destiné à améliorer les services pour les malades mentaux doit privilégier le dépistage précoce au niveau des soins primaires et l'accès aux médicaments, éventuellement en obtenant, à titre préférentiel, des dérogations aux droits de brevet pour faciliter la production de médicaments meilleur marché par les laboratoires pharmaceutiques locaux. Les politiques doivent trouver les moyens d'aider les familles à soigner leurs membres atteints de maladie mentale. Les

communautés africaines recourent abondamment aux pratiques traditionnelles et les responsables politiques évoquent souvent la nécessité d'intégrer ces pratiques dans la médecine occidentale. Il convient toutefois de s'interroger sur l'efficacité et l'innocuité de nombre de ces pratiques, spécialement en ce qui concerne le traitement des malades mentaux profonds. Certaines pratiques, en effet, sont clairement inhumaines. Une politique d'intégration de ces pratiques dans les soins pour les malades mentaux doit reconnaître les aspects positifs et déconseiller les aspects dangereux.

Les politiques de santé mentale devront prévoir la révision et la mise à jour de la législation existante sur les maladies mentales. La plupart des pays d'Afrique ont encore des lois que leur ont léguées les colonisateurs il y a plusieurs décennies et qui ne correspondent ni à nos connaissances actuelles de la nature des troubles mentaux ni aux normes actuelles applicables aux droits de l'être humain. Les nouvelles lois devront prévoir le traitement humain des malades mentaux qui ont commis un délit et protéger le droit des malades mentaux à refuser certaines formes de traitement, tout en reconnaissant la nécessité de protéger la société et de prendre soin des personnes qui ne sont pas en mesure de faire des choix éclairés.

Les politiques doivent s'attacher à assurer le financement adéquat des services de santé mentale, l'objectif étant de veiller à ce que le niveau des soins corresponde aux meilleures pratiques possibles, malgré l'insuffisance des ressources. Le souci d'équité doit toujours inspirer la fourniture des services. Les politiques doivent également s'attacher à promouvoir la recherche et la formation. Les recherches sur la distribution et l'évolution des maladies mentales et les incapacités dues aux maladies mentales doivent être assorties de politiques visant à concevoir les meilleurs soins possibles pour les malades mentaux et de recherches servant à évaluer l'efficacité et la pertinence de ces politiques.

Resumen

Desarrollo de políticas de salud mental en África

La mayoría de los países africanos siguen afrontando problemas sanitarios relacionados con la alta prevalencia de enfermedades transmisibles y de malnutrición. Sus recursos humanos están poco desarrollados. La mayoría de las economías nacionales del continente se caracterizan por unos bajos ingresos y una base industrial incipiente. Muchos de esos países están sufriendo además conflictos sociales en forma de guerras intestinas, y muchos se han visto gravemente afectados por la pandemia de VIH/SIDA. El gasto nacional en salud es por lo general inferior al recomendado. Los problemas relacionados con la salud mental rara vez tienen trascendencia política, y la financiación de los servicios de salud mental suele ser bastante inferior a la media en el conjunto de las prioridades sanitarias. La mayoría de esos países no disponen aún de una política claramente articulada que reconozca la magnitud de los problemas de salud mental entre sus poblaciones y que procure identificar estrategias para afrontarlos.

Es preciso que las políticas de salud mental de los países africanos estén basadas en el reconocimiento de la magnitud de los problemas, en particular del consumo de sustancias adictivas, y en una evaluación de la carga sanitaria atribuible a dichos problemas. El estudio de 1996 sobre la carga mundial de morbilidad proporciona un marco para ese reconocimiento, pero es necesario complementar los datos de ese estudio con otros estudios locales. Es preciso formular estrategias para fomentar y ampliar el conocimiento de las enfermedades mentales entre el público y para reducir el estigma que afecta a quienes las padecen y a sus familias. Un programa de mejora de los servicios prestados a los enfermos mentales ha de hacer hincapié en la detección precoz en el nivel de atención primaria y en un acceso adecuado a la medicación, basado tal vez en una renuncia preferencial a patentes que facilite la producción de medicamentos más baratos por las compañías farmacéuticas locales. Las políticas deben ofrecer fórmulas apropiadas para ayudar a las familias a cuidar a los miembros afectados por trastornos mentales. Importantes sectores de las comunidades africanas

recurren a prácticas de curandería, y los políticos señalan a menudo que es necesario integrar esas prácticas en la atención médica ortodoxa. No obstante, la eficacia e inocuidad de muchas de esas prácticas, sobre todo en lo que respecta a la atención dispensada a las personas con graves trastornos mentales, son cuestionables. Es más, algunas de esas prácticas son claramente inhumanas. Toda política que aspire a integrar esas prácticas en los sistemas de atención a enfermos mentales deberá identificar los aspectos positivos y disuadir de los perjudiciales.

Las políticas de salud mental tendrán que prever la revisión y actualización de la legislación existente sobre las enfermedades mentales. La mayoría de los países africanos todavía tienen en sus códigos de leyes medidas que, heredadas hace varias décadas de quienes les colonizaron, no reflejan ni nuestros actuales conocimientos sobre la naturaleza de los trastornos mentales ni las ideas hoy imperantes sobre los derechos individuales. La nueva legislación deberá asegurar un trato humano para los delincuentes afectados por trastornos mentales, y proteger el derecho de los enfermos a rechazar determinadas formas de tratamiento, reconociendo siempre la necesidad de proteger a la sociedad y de cuidar a quienes no pueden tomar decisiones informadas.

Un objetivo de las políticas ha de consistir en proporcionar fondos suficientes para los servicios de salud mental, con la finalidad de garantizar un nivel de asistencia que refleje las mejores prácticas posibles dadas las limitaciones de recursos existentes. La necesidad de garantizar la equidad debe ser siempre un principio orientador en la prestación de servicios. Otro componente de las políticas debe ser la promoción de actividades de investigación y de formación. Las investigaciones sobre la distribución y evolución de los trastornos mentales y las discapacidades por esa causa deben complementarse con políticas orientadas a determinar la mejor manera de atender a los enfermos mentales y con investigaciones que permitan evaluar la eficacia y pertinencia de esas políticas.

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