HNP DISCUSSION PAPER

Mental Health in Afghanistan

Burden, Challenges and the Way Forward

Ghulam Dastagir Sayed

August 2011

MENTAL HEALTH IN AFGHANISTAN:

Burden, Challenges and the Way Forward

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Health, Nutrition and Population Discussion Paper

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FOREWORD

When we think about the damages caused by conflict, a lot of images come immediately to our minds: destruction, casualties, collapsed infrastructure, devastated cities and communities, broken families and pain. But we tend to pay less attention to other invisible wounds that last for years and cause deep scars on people and on development: those caused by conflict on mental health.

During the last 30 years, Afghanistan has been impacted in many ways by conflict. One can hardly find an Afghan family which has not lost one or more members in this period due to conflict. Over one million people have been killed, one million are disabled and millions either migrated abroad or are internally displaced. Conflict and other factors such as unemployment, general poverty, breakdown of community support services, and inadequate access to health services have not only damaged the social infrastructure of the nation, but also caused mental health disorders mostly in vulnerable groups like women and disabled people.

Half of the Afghan population aged 15 years or older is affected by at least one of these mental disorders: depression, anxiety and post traumatic stress disorder. These disorders contribute to community and domestic violence and to the high levels of malnutrition in the country as they adversely affect maternal care giving in diverse ways. In addition, social restrictions and taboos are big challenges for women's access to mental health services in Afghanistan.

Mental health in the country is a topic that needs to be better understood. This policy note *"Mental Health in Afghanistan, Burden, Challenges, and the Way Forward"* aims to contribute to the debate on this development priority and explores some options on how mental health challenges could be addressed.

The Government of Afghanistan and the Ministry of Public health are committed to address the major public health challenges that the country faces. The country has made significant progress in order to provide a quality package of basic health services to Afghans. This note is a contribution to those ongoing efforts.

Isabel M. Guerrero
Vice President, South Asia
The World Bank

ABBREVIATIONS

AADA	Agency for Assistance and Development of Afghanistan
AKU	Aga Khan University
APA	American Psychiatric Association
BPHS	Basic Package of Health Services
CHC	Comprehensive Health Center
CHS	Community Health Supervisor
CHW	Community Health Worker
CRW	Crises Response Window
DALY	Disability-Adjusted Life Year
DCPDC	Disease Control Priorities in Development Countries
DRA	Democratic Republic of Afghanistan
DSM IV	Diagnostic and Statistical Manual of Mental Disorders
EMRO	Eastern Mediterranean Regional Office
EPHS	Essential Package of Hospital Services
EQUIP	Education Quality Improvement Program
EU	European Union
GCMU	Grants and Contracts Management Unit
GOA	Government of Afghanistan
HDN	Human Development Network
HealthNet TPO	HealthNet Trans-Cultural Psychosocial Organization
HMIS	Health Management Information System
HNP	Health Nutrition Population
HOSA	Humanitarian Organization Support Afghans
HSSP	Health Service Support Project
IAM	International Assistance Mission
ICD	International Classification of Diseases
IEC	Information, Education, Communication
LSHTM	London School of Hygiene and Tropical Medicine
mhGAP	Mental Health Gap Action Program
MHD	Mental Health Department
MOE	Ministry of Education
M&E	Monitoring and Evaluation
MOPH	Ministry of Public Health
MOWA	Ministry of Women Affairs
NGOs	Non-Governmental Organizations
NSP	National Solidarity Program
PHC	Primary Health Care
PHO	Provincial Health Office
PTSD	Post Traumatic Stress Disorder
SASHN	South Asia, Health, Nutrition and Population Sector
TB	Tuberculosis
UN	United Nations
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

Health, Nutrition and Population (HNP) Discussion Paper

Mental Health in Afghanistan
Burden, Challenges and the Way Forward

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Abstract: Afghanistan has been in internal and external strife for more than thirty years. Prolonged conflict and civil war have left millions dead, thousands with disabilities and massive internal and external population displacement. The situation has contributed negatively to every aspect of the country and society as the majority of the population has been traumatized by constant conflict, natural disasters, and the difficult Taliban years. There is ample evidence that these calamities have contributed to an increase in mental health problems and has been further complicated by growing level of drug abuse.

As Afghanistan rebuilds itself, it is critical to understand the challenges and develop workable solutions. The paucity of high quality data on mental health problems and the lack of qualified human resources have hampered the development of cost-effective strategies and interventions to address the growing challenge of mental health in the country. There are few mental health facilities, and these facilities are scattered across the country with limited capacity and low levels of coverage. In addition, the population continues to face the main stressors with ongoing conflict in various parts of the country. To address mental health issues on a larger scale, this paper recommends public awareness-raising campaigns as a foremost prerequisite. It also proposes to draw on existing resources efficiently.

Achieving the aforementioned objectives require political support by the Government of Afghanistan along with technical and financial support of the development partners. This will allow necessary expansion of mental health services and will build the capacity of mental health clinicians and public health experts in the country.

Keywords: mental health, Afghanistan, basic package of health services, psychosocial

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This HNP discussion paper was written by Ghulam Dastagir Sayed (SASHN), with active support and guidance by Julie McLaughlin (Sector Manager, Health, Nutrition, and Population Unit, South Asia Region). The paper received valuable inputs from Kees Kostermans and Inaam ul Haq (World Bank). The peer reviewers for the paper included Alia Ibrahim Zai (Ministry of Public Health, Afghanistan), Willem van de Put (HealthNet TPO), Dr Khalid Saeed (WHO EMRO) and Homira Nassery (World Bank). The peer reviewer's critical contributions are highly appreciated. Comments and suggestions from Abeyah Al-Omair, Asta Olesen (World Bank) are also acknowledged. Amna Mir (World Bank) edited the report and got it ready for publication. Mariam Haidary and Muhammad Asif Qureshi provided robust administrative and logistical assistance.

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PREFACE

I. Mental health disorders appear to be widespread in Afghanistan. The majority of the population has experienced frequent traumatic events in recent times; resulting in a very high prevalence rate of mental health problems, as the evidence demonstrates from a number of recently conducted studies. Prevalence of mental health disorders is reported to be even higher among women and disabled people. Prolonged conflict and civil war have resulted in millions of deaths, thousands of people with disabilities and massive internal and external migrations. These are all the main stressors, which, coupled with the obliteration of existing cultural coping mechanisms and lack of proper mental health services, have led to increased prevalence of mental health morbidity. This situation is further complicated by growing number of people with drug abuse in the country. In fact conflict, illicit drug use and mental disorders are linked and reinforce each other.

II. Afghanistan is dealing with many competing health priorities in a constrained environment. Maternal and child mortality are among the highest in the world with a high burden of communicable diseases. To strategically and efficiently address priority health issues after the fall of the Taliban, the Ministry of Public Health developed a Basic Package of Health Services and an Essential Package of Hospital Services. Thanks to an innovative approach of contracting with non-governmental organizations (NGOs) on a large scale, the coverage of basic services rapidly expanded, and has currently reached more than 85 percent of the population. The provision of the Basic Package of Health Services (BPHS) has developed a good platform for any public health intervention in efficiently reaching the majority of the population.

III. A paucity of quality data on mental health problems and the lack of qualified human resources have hampered the development of cost-effective strategies and interventions to address the growing challenge of mental health in Afghanistan. There are few mental health facilities; and they are scattered across the country with limited capacity and low levels of coverage. Present levels of coverage do not reach even a small fraction of the population in need. In addition, the population continues to face the main stressors with ongoing conflict in various parts of the country. There is, however, a good experience of integrating mental health services at primary health care level by HealthNet TPO in the eastern provinces which could be replicated using the BPHS platform.

IV. To address mental health issues at a larger scale, this paper recommends public awareness-raising campaigns as a foremost prerequisite. It proposes to draw on available resources efficiently through:

- using a community based approach and defining an approach to mental health within the Basic Package of Health Services (BPHS), including basic psychosocial counseling at primary health care levels;

- using hospital services as defined under the Essential Package of Hospital Services (EPHS) for referral from the BPHS level, for the management of severe and acute mental health problems along with professional psychosocial counseling;

- developing technical capacity and expertise by engaging mental health experts/focal points at provincial level, both by MOPH and the implementing partners;

- supporting the Mental Health Department of the MOPH technically and financially so that it can adequately exercise its stewardship functions with regard to mental health programs in the country. The stewardship functions include: developing a mental health strategy, defining indicators of success, developing monitoring and evaluation tools, ensuring coordination of partners both at MOPH and at multi-sectoral level and facilitating and guiding implementation of the mental health strategy.

V. Achieving the aforementioned results requires political support by the Government of Afghanistan along with technical and financial support of the development partners. This will allow necessary expansion of mental health services and will build capacity of mental health clinicians and public health experts in the country.

INTRODUCTION

Mental health is a term used to describe either a level of cognitive or emotional well-being or an absence of a mental disorder. Mental health is an expression of one's emotions and signifies a successful adaptation to a range of demands. The World Health Organization (WHO) defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".[1] There are currently two widely established systems that classify mental disorders—ICD-10, part of the International Classification of Diseases produced by the WHO, and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) produced by the American Psychiatric Association (APA). These classifications encompass a wide range of mental health disorders. Since national and sub-national surveys in Afghanistan have found very high rates of depression, anxiety and post-traumatic stress disorders– with at least one of these affecting half of the population aged 15 years or older, for practical purposes in this paper the term mental health is restricted to these conditions plus epilepsy, the prevalence of which is also high. Prolonged conflict and civil war in Afghanistan have led to increased prevalence of the afore-mentioned mental health disorders. The purpose of this Policy Note is to inform the World Bank colleagues, development partners and potential financiers about Afghanistan's present mental health needs, the current state of the national response, and outline a way forward for scaling up the national response in collaboration with partners.

Background

1. The story of the last 30 years in Afghanistan is one of protracted conflict, social unrest, political instability and large scale internal and external migration. The country experienced the Soviet occupation followed by in-fighting among Mujahideen groups[2,] the harsh regime of the Taliban and now, the on-going military campaign of coalition forces against the Taliban and Al-Qaeda. Over one million people have been killed; one million are disabled and millions either became refugees or are internally displaced. One can hardly find an Afghan family that has not lost one or more members in the course of the last 30 years due to conflict. In addition, with easy access to relatively low-cost illegal drugs, a large number of Afghans have become drug users and are suffering debilitating mental, physical and social problems as a result. A United Nations Office on Drugs and Crime (UNODC) drug use survey in 2009 estimated one million adult drug users in Afghanistan[3]. Drug abuse and mental health disorders form a vicious cycle and are both cause and consequence of each other. Aside from the man-made disaster of conflict, in recent

[1] Promoting Mental health: Concepts, Emerging evidence, Practice: A report of the World Health Organization, in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne, 2005

2 The Afghan opposition groups which initially rebelled against the incumbent pro-Soviet Democratic Republic of Afghanistan (DRA) government during the late 1970s. At the DRA's request, the Soviet Union intervened. The Mujahideen then fought against Soviet and DRA troops during the Soviet war in Afghanistan. After the Soviet Union pulled out of the conflict in the late 1980s the Mujahideen fought each other in the subsequent Afghan Civil War.

3 UNODC, Afghanistan drug use survey 2009

times, the country has also been hit by a prolonged drought, which has severely damaged the food availability for households and has further aggravated both displacements of the population and further violence in the country, as well as a serious earthquake in 1998 in the northern Afghanistan. All of the above factors have badly damaged the social infrastructure of the nation.

2. Afghanistan has some of the worst health indicators in the world. Maternal mortality is the second highest in the world (1600 per 100,000 life birth)[4], while child and infant mortality are much higher than the average for low-income countries. Infectious diseases including respiratory infections and diarrhea also take a high toll. This disease pattern of preventable causes is further complicated by an increasing burden of mental health disorders. According to WHO, around 2 million Afghans suffer from mental health disorders, which could be one of the factors contributing to violence at community and household level.[5] The violence is not only husbands against wives, but also brothers against sisters, mother-in-laws towards daughter-in-laws and always against children. Due to socio-cultural context (very low marriage age, very high fertility rate and lack of control over own life), mental illness are higher among women, which is a likely contributor to the high levels of malnutrition among children in the country. It has been globally documented that mental health problems adversely affect maternal care giving, e.g., breastfeeding, responsive complementary feeding, thereby affecting child motor and cognitive development, and increased prevalence of stunting (chronic malnutrition), which could be a causative factor in the high levels of stunting in Afghanistan (more than 50 percent among children under five). In the meantime, due to social restrictions, social taboos and lack of female health professionals delivering services to female patients remains an important challenge.

3. The Government of Afghanistan (GOA) inherited a devastated health system in 2003 which needed bold and innovative initiatives to revitalize it. The GOA undertook a series of strategic steps to improve access to basic health services and enhance the performance of the health system by defining and developing the Basic Package of Health Services (BPHS) aimed at primary care service delivery and the Essential Package of Hospital Services (EPHS) aimed at secondary and referral care services - both package of priority health services. In addition, the GOA took a bold decision in large scale contracting with non-governmental organizations (NGOs) for the delivery of these services; and strengthening monitoring and evaluation of health sector performance via objective third parties. From among many competing priorities, the Ministry of Public Health (MOPH) made a strategic choice to focus on maternal and child mortality as its top priority. Mental health services were among the second tier of priorities. After initial expansion and increased access to basic services, a revision of the BPHS was undertaken in 2005. Mental health services were included in the first tier of priorities. However due to lack of clear implementation guidelines, lack of capacity and knowledge among implementing NGOs and the health workers, mental health related interventions did not receive due attention. The BPHS guideline was revised in 2009, and mental health services have been integrated at the basic level (see Annex I: Table of mental health activities at each health facility level as per the revised

4 http://moph.gov.af/en/page/2961

[5] The World Health Organization's *Country Cooperation Strategy* (CCS) *for Afghanistan 2006-2009*

BPHS guideline). A well-conceived implementation plan for the revised package will be the key to addressing the substantial burden of mental health problems in the country.

4. Investments in mental health services will not only contribute to reducing individual suffering, but will also contribute to reduction of the burden of domestic violence, alleviating societal fragility and tribal conflicts, and hence help the nation to move towards sustainable peace and development. In addition, improved mental health of mothers is likely to contribute to improved child care and may well improve the nutritional status of young children, thus resulting in overall reduction of child mortality.

MENTAL HEALTH STATUS

5. Due to a combination of high prevalence, early onset, persistence and disability, mental health disorders constitute a major part of the total burden of disease globally and even more so in conflict and post-conflict settings. There is no disagreement about the very high burden of mental health disorders in Afghanistan, much of which can be attributed to deep social trauma, over 30 years of armed conflict coupled with natural disasters, double-digit unemployment, acute poverty, dissolution of social capital, and inadequate access or lack of access to mental health services.

6. There is a dearth of quality information about mental health issues in Afghanistan -- both from household surveys and the Health Management Information System (HMIS) which does not adequately capture mental health disorders. According to a national survey conducted in 2004 by Lopes Cardozo *et al*, 44 percent of the respondents had experienced more than four traumatic events in the last ten years, 68 percent had some form of depression, 72 percent had anxiety and 42 percent had post traumatic stress disorders (PTSD).[6] These problems were even higher among female respondents and disabled people. In addition, 84 percent of the respondents reported to have feelings of hatred.

7. Given the conflict situation in Afghanistan, the proportion of people with PTSD appears to be lower than in other settings, which could be attributed to family and community support, religious beliefs and other social factors. However, one should be cautious, as the expression of distress related to psychological trauma in Afghans may be very different than the symptoms described in the usual psychiatric classification systems such as Diagnostic and Statistical Manual of Mental Disorders (DSM IV) (*Miller et al 2006*). The most common coping mechanisms listed by the respondents included reading the Quran (37 percent), praying (28 percent) and talking to family members (9 percent). (*Scholte et al, 2004*).

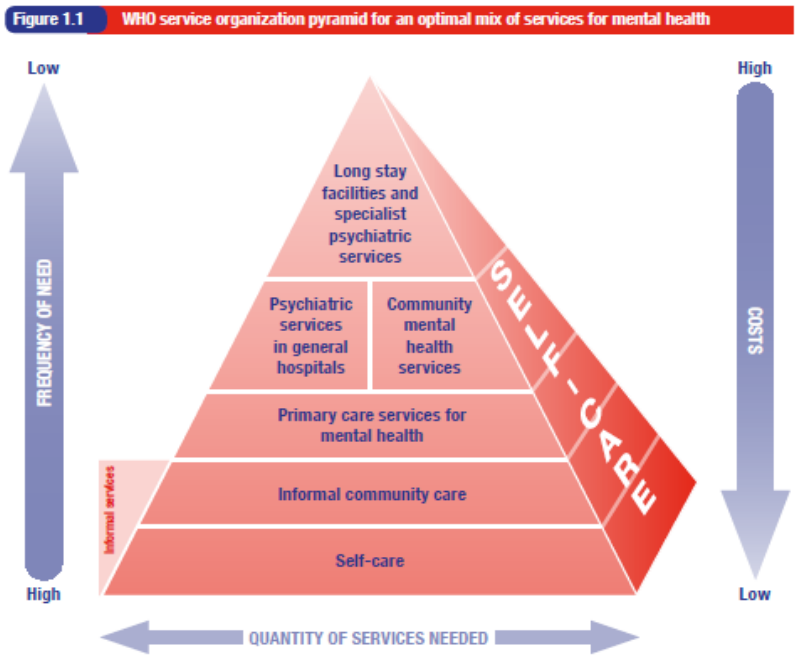
8. No reliable data exists on the prevalence of epilepsy in Afghanistan. There is, however, a huge stigma attached with epilepsy and society looks down upon epileptic patients. Due to associated stigma, epileptic patients tend to lose their self-esteem, avoid socialization and their

6 Lopes Cardozo, B. Et al. (2004). Mental health, social functioning, and disability in post-war Afghanistan. JAMA, 292(5), 575-584.

productivity decreases. Epilepsy is classified under the broader umbrella of mental health disorders. The epileptic patients not only need therapeutic treatment, but they also need psychosocial counseling to restore their self-esteem.

Mental Health Strategy, Global Principles

9. The basis of effective mental health programs is an emphasis on prevention and management of simple mental health disorders at the primary level with an emphasis on self-care. The World Health Organization (WHO), as shown in Figure 1, has developed a tiered pyramid approach for mental health programs. In this approach, the majority of activities take place at the community and primary health care level, with a focus on prevention and management of simple mental health disorders. As one proceeds through the referral system in more complex cases, the services become more specialized and the number of cases which need those services drops as one moves up in the pyramid.



As the figure illustrates, the majority of mental health care can be self-managed or managed by informal community mental health services[7].

10. WHO recommends integration of mental health services at the primary health care level. The key principles which need include:

- Policy and plans need to incorporate mental health in primary care
- Advocacy to shift attitudes

[7] The WHO Mental health Policy and Services Development Guidance Package (14 modules)

- Need for adequate training
- Primary care tasks need to be limited and doable
- Support from specialist at secondary care
- Access to essential psychotropic drugs
- Integration to be considered as a process, not an event
- Need for mental health coordinators at different levels of the health system
- Cooperation with non-health sectors, community development
- Need for additional financial and human resources.

11. The Disease Control Priorities in Developing Countries (DCP2), *2006 edition*, elaborates that the main challenge to deal with mental health problems is enhancing systems of care by developing effective local models and disseminating them throughout a country. [8] It also points out that basic psychological therapies can be effective and can be easily put to use at the primary level. Since DCP2, there is recent evidence on anti-depressants, which suggest that the pharmacological interventions for mild to moderate depression had no greater impact than a placebo. [9]However, there is good evidence that anti-depressants are helpful for patients with severe depression. Therefore, in line with the WHO mental health Gap Action Programme (mhGAP) intervention Guide, the prescription of anti-depressant medication should be restricted to the more severe forms.[10] In Afghanistan, as in many other Asian countries, many patients visiting health facilities expect to be prescribed some kind of medicine. In the training of health staff an important element is to assist patients in a satisfactory way, while preventing iatrogenic harm due to unnecessary prescription of psychotropic drugs. Alternatives for anti-depressant prescription can include psychosocial interventions and short-term prescription of symptomatic medication to restore sleep or reduce anxiety.

12. The DCP2 recommends building the diagnostic and treatment capacity at primary health care level along with sustained supply, access to supervision and incentivizing health care providers to see patients with mental illness. (*Hyman et al, 2006*). It further elaborates that community approaches using low-cost, locally available resources can improve adherence to treatment and clinical outcomes even in rural and underserved settings. The above approach is very relevant to the Afghanistan context due to the availability of strong BPHS platform which could be used to develop the community and primary health care basis for mental health interventions.

13. The WHO mhGAP aims at scaling up services for mental, neurological and substance use disorders for countries especially with low and middle-income. Part of this program was the development of new simplified diagnosis and treatment guidelines released in October 2010.

[8] DCP2 a publication written by more than 350 specialists in diverse fields from around the world, provides the results of in-depth research, offers insightful analyses, and proposes context-sensitive policy recommendations to significantly reduce the burden of disease in developing countries and to improve the quality of life for all people. It includes a chapter on Mental Disorders (*Hyman et al, 2006*)

[9] Fournier, J. C., DeRubeis, R. J., Hollon, S. D., Dimidjian, S., Amsterdam, J. D., Shelton, R. C., et al. Antidepressant drug effects and depression severity: a patient-level meta-analysis. *JAMA, 303*(1), 47-53.

[10] Mental Health Gap Action Programme (mhGAP) intervention Guide for Mental, Neurological and Substance use disorders in non Specialist Health Settings, World Health Organization

These evidence based guidelines have been designed to facilitate the management of depression, alcohol use disorders, epilepsy and other common mental disorders in the primary health-care setting. The Intervention guide extends competence in mental health disease diagnosis and management to non-mental health specialists including doctors, nurses and other health providers (WHO, 2010).

Hints From Global Evidence for Management of Priority Mental Health Problems in Afghanistan

14. ***Depression:*** From the literature it is evident that psychosocial therapy can be as effective as medications for the initial treatment of moderate to severe major depression (at 8 weeks, positive response rates to medications was 50 percent, and to cognitive therapy 43 percent; both response rates were superior to the response rate for the placebo [25 percent]), but this degree of effectiveness may depend on a high level of therapist experience or expertise.[11] Of the psychosocial treatments with demonstrated efficacy, the most widely accepted are cognitive-behavioral approaches. Alone or in combination, pharmaceutical and psychosocial treatments speed recovery from acute episodes[12]. The WHO mhGAP intervention guide recommends a combination of pharmacological and non-pharmacological interventions for moderate and severe depression, and psychosocial interventions for mild depression.

15. ***Anxiety***: According to DCP2, despite lack of sufficient evidence, the population-level impact of anxiolytic drugs (benzodiazepines) and psychosocial treatments is substantial. It can reduce the severity of panic attacks and improves the probability of making a full recovery. From an evidence-based perspective, cognitive-behavioral therapy is currently the treatment of choice for anxiety and depressive disorders in children and adolescents[13]. The WHO mhGAP intervention guide does not include a separate module on anxiety disorders but recommends some basic psychosocial interventions for people with 'other significant emotional and medically unexplained symptoms'.

16. ***Post traumatic stress disorder (PTSD)***: A review of the treatment research by *Susan Solomon et al* indicates that for reducing the symptoms of post-traumatic stress disorder (PTSD), psychosocial interventions are the most effective approach. It specifies that treatment should be tailored to the severity and type of presenting PTSD symptoms, to the type of trauma experienced, and to the many likely co-morbid diagnoses and adjustment problems[14].

17. The cost effectiveness of using local trained counselors to provide mental health services has been demonstrated in post-conflict areas. The results of an analysis at the level of six low and middle-income World Bank regions using the criteria of the WHO Commission for

[11] Robert Jeffrey Sternberg et al, Cognitive Therapy vs Medications in the Treatment of Moderate to Severe Depression
[12] DCP2
[13] *SCOTT N et al*, Cognitive-Behavioral Psychotherapy for Anxiety and Depressive Disorders in Children and Adolescents: An Evidence-Based Medicine Review
[14] *Susan D et al*, Psychosocial treatment of posttraumatic stress disorder: A practice-friendly review of outcome research

Macroeconomics and Health, indicates that interventions for common mental disorders (depressions and panic disorders) and epilepsy can be considered very cost-effective (each Disability-Adjusted Life Year [DALY] averted costs less than one year of average per capita income). These findings are highly relevant for community mental health care programs in view of the scarcity of mental health professionals in low and middle income countries and post-conflict areas.

18. In summary, there is ample global evidence which indicates that a psychosocial approach at local level through Primary Health Care (PHC) is the best choice to manage wide-spread mental health problems in Afghanistan. From a programmatic perspective, it could be readily implemented through strengthening the BPHS in terms of its capacity to provide basic psychosocial counseling coupled with provision of the right medication.

Mental Health Program in Afghanistan

19. The Mental Health Department (MHD) was established in 2005 in the MOPH. The department consists of Mental health and Drug Demand Reduction sections. The mandate of the MHD is to ensure the continuing relevance, dissemination, implementation, and monitoring of the National Mental health Strategy (see Annex II: Summary of the mental health strategy). The department aims to ensure that the Government of the Islamic Republic of Afghanistan/Ministry of Public Health (GIRoA/MOPH) response to the mental health of the Afghanistan population is clearly identified in the policy and strategy, and addressed through medium and short-term plans, protocols, and practices. In other words, the aim of the department is to exercise the stewardship role of the MOPH in the area of mental health programs in the country. Some of the key positions such as the hospital mental health focal point, the PHC mental health focal point and the mental health technical officer positions are vacant in the mental health department-- limiting its technical ability to provide appropriate leadership for mental health interventions. Thus due to lack of technical capacity and shortage of financial resources, the department is not in the driving seat. It has often been bypassed by development partners, both donors and UN implementing agencies. There are many small scale mental health projects being implemented across the country, from the details of which the Department is not aware. There is no database of ongoing mental health interventions and mental health partners in the country.

20. A strategy paper on integrating mental health in PHC was developed in 2005 by a mental health task force. The strategy paper proposed three phases to complete the integration process. In the first phase, a mental health unit was to be established within the primary health care department. In phase two, a pilot program on a limited scale in selected geographic areas was to be implemented; and in phase three, based on the results of the pilot, nationwide implementation of mental health interventions was to be initiated. The paper was a good start, but mainly due to competing priorities in the health sector, it did not get fully implemented.

21. A more comprehensive Mental Health Strategy was prepared in 2009, and was recently approved by the MOPH. In addition, in line with the WHO essential drug list, an essential drug list of psychiatric pharmaceuticals has been developed. Mental health treatment and basic counseling training manuals for doctors; basic counseling manuals for nurses, midwives,

Community Health Supervisors (CHSs) and the Community Health Workers (CHWs) both in English and Dari have also been developed. The training manual for doctors and nurses has a specific Learning Resource Package for the facilitators. Furthermore, a one-year curriculum has been developed for training professional psychosocial counselors. Mental health related Health Management Information Systems (HMIS) reporting formats have been also drafted.

22. The Afghanistan mental health strategy 2010, envisions that all people in Afghanistan have access to a community-based yet comprehensive and coordinated system of mental health care support, treatment, and follow-up of mental illness and related disorders. It commits to promoting a system of recovery and mental wellness that is integrated with the other primary health care service and is promoted outside the health sector as an issue that requires multi-sectoral commitment and effort at the community level by the year 2020. The goals of the strategy are:

- to develop, introduce, and monitor a broad range of mental health initiatives to support individuals and families across the range of preventive interventions, primary and secondary service provision, referral and rehabilitation, with special focus on immediate delivery of the most essential services to those with the greatest needs;
- to introduce or strengthen legislation, regulation, organizational, and operational activities to support the delivery of interventions and services within the public and private health sectors plus related interventions within other sectors.

23. The European Union (EU) is currently the key financier of mental health programs in Afghanistan. In a phased approach, in the provinces being financed by EU, training of staff of both the BPHS and EPHS facilities has been initiated. In addition, EU is also financing some vertical mental health projects in the country. Other donors are: USAID which supports developing of guideline and training of mental health master trainers through the Health Service Support Project (HSSP); UNFPA which finances training of basic psychosocial counseling to BPHS implementer in Bamyan and Faryab provinces; Caritas which finances small mental health projects; WHO which provides technical support to MHD/MOPH; Aga Khan University (AKU) which provides scholarships to medical doctors to obtain health policy and management expertise (mental health track) and supports research activities; and CARE which runs some mental health projects for widows in Kabul city.

24. The main implementing agencies are: HealthNet TPO (conducts training for all EU-financed EPHS and BPHS implementers), International Assistance Mission (IAM), Medica Mondiale, Humanitarian Organization Supporting Afghans (HOSA), Window for Life, Agency for Assistance and Development of Afghanistan (AADA), and the implementing NGOs of BPHS and EPHS.

25. The mental health integration in BPHS has been tried in a number of places on a small scale, and the population coverage of these programs remains small. The key interventions being implemented include:

- In 2002, HealthNet TPO started a mental health pilot in three districts of Nangarhar province, with the objective of integrating mental health services at the primary care level. The project developed training manuals, Information, Education, Communication (IEC) materials and HMIS tools. The results of the pilot were promising in terms of detecting more mental health patients and providing mental health services at PHC level. Based on its findings, it was recommended to consider integration of mental health to BPHS.

- Based on the findings of the pilot project, HealthNet TPO expanded the mental health services to 12 provinces including ten EU supported provinces. The results indicated that after systematic training of health workers, the reporting of mental health related problems increased from 1–2% up to 10% of the total outpatient consultations, reflecting an increased awareness of health staff to identify, manage and report mental health disorders. Currently, HealthNet TPO with financing from EU is trying to further strengthen the integration of the mental health component at BPHS in EU funded provinces by training staff of the BPHS implementing NGOs to implement mental health services at the primary level.

- HealthNet TPO is also piloting basic psychiatry services at provincial hospitals in five provinces (Nangarhar, Kunar, Laghman, Logar and Daikundi) with EU financing. The objective is to introduce small scale services at provincial level and develop a multi-disciplinary approach. The project will be thoroughly evaluated and the results will be shared with all stakeholders.

- At the same time, HealthNet TPO is implementing a community based psychosocial program in 5 provinces (Kapisa, Nangarhar, Urozgan, Khost and Paktia) where the focus is on prevention of mental health problems and on solving psychosocial problems at the community level. This program is focusing on women and children through a number of innovative community based approaches in coordination with MOPH, Ministry of Women Affairs (MOWA) and Ministry of Education (MOE).

- Since August 2008, the Humanitarian Organization Support Afghans (HOSA), an Afghan local NGO with financing from EU, is implementing a mental health project in Bamyan, Balkh and Herat provinces, where two professional psychosocial counselors have been deployed in selected Comprehensive Health Centers (CHCs) to provide one-on-one psychosocial counseling for mentally ill patients. The project duration is two years and could be a good source of information on integrating professional psychosocial counseling at BPHS facilities.

26. In addition to the above interventions, there are around 11 mental health counseling facilities across the country with almost no community contact or after-care services, and no services for children and adolescents. These facilities, including the mental health hospital in Kabul, have no linkage or formal reporting contact with MHD at the MOPH.

Gaps, Challenges and Opportunities:

27. Afghanistan faces a high burden of mental health problems, persistent stressors and limited mental health services. There are critical gaps in the response:

- access and availability of mental health services remains limited
- available services are of low quality mental health services
- lack of trained skilled manpower for service delivery, (there are only two internationally recognized psychiatrists in the country, and both of them do not practice). There are no trained clinical psychologists or psychiatric nurses
- lack of competent leadership and technical capacity to implement the mental health strategy
- lack of proper Monitoring and Evaluation (M&E) system and indicators to measure success of mental health services
- medicalisation of mental health problems, combined with poor quality of mental health services has lead to irrational use of anti-depressants and benzodiazepines
- inadequate financing of mental health and psychosocial interventions

28. The present vertical health facility based approach is insufficient and inadequate to provide services. Lack of services for children and adolescents is another major shortcoming of the approach. However, experience has shown that BPHS forms an excellent platform for the provision of basic health services in the country. With 85 percent coverage in the country and good community linkages, effective inclusion of mental health interventions in BPHS programs would ensure good coverage of primary mental health care with minimal cost (about .36 USD) per capita per year, according to HealthNet TPO's experience in Nangarhar province) across the country to all population groups, including children and adolescents. The National Tuberculosis program is a good example, which has successfully exploited BPHS as a vehicle to expand the TB DOTS coverage to more than 90 percent of the population.

29. The mental health strategy is somewhat general and envisages implementing a comprehensive program. But in an attempt to be comprehensive, it fails to identify key mental health priorities which need to be addressed in the country as a starting point. For implementation purpose, it would be appropriate to concentrate on 3–4 major mental health problems, such as depression, anxiety, and PTSD, as priorities, and focus on developing ways and means to build adequate capacity for delivering services and monitoring progress in the first phase.

30. As yet there is no published evidence about the effectiveness of deployment of two professional psychosocial counsellors at CHC facilities and many partners (WHO, HealthNet TPO and some other NGOs) have concerns about cost-effectiveness of this approach. The Mental

health Strategy proposes this approach should be included in the revised BPHS. This recommendation may be premature at this point. It might be advisable to start with basic psychosocial counseling through existing staff in the BPHS level. This approach would benefit from a well-designed large scale pilot in a few selected provinces with rigorous monitoring and evaluation to collect lessons learned and good practices for wider replication.

A WAY FORWARD FOR THE FUTURE

31. There is a general consensus among all stakeholders on the high burden of the mental health problems in Afghanistan. However, the question is what would be the proper and most effective and efficient response, i.e., which mental health interventions need to be supported and how, at what cost, and how to measure their performance; and which alternatives exist to reach masses with mental health disorders due to persistent conflict and violence in the country.

32. To maximize access and outreach to mentally ill patients with limited resources in politically fragile countries such as Afghanistan, the evidence from the literature indicates the following approaches: (a) community-based interventions to strengthen resilience[15]; (b) group based interventions to reduce moderate level psychosocial distress; and (c) focused interventions to address severe distress and high-risk populations. [16]

Community-based Versus Facility-based Approach:

33. Afghanistan has a collective and traditional culture (in contrast with western more individualistic and progressive culture). Coping mechanisms should be seen in this context; for example, in a study in Eastern Afghanistan, 98 percent of the respondents mentioned "Allah" as the main resource for emotional support when feeling sad, worried, or tense. Traditionally the Sufi gathering places are locations for men and in some places for women, to sit together and perform certain Sufi rituals which are a kind of meditation and relaxation exercises. This is reported as extremely helpful for relieving stress and sorrow[17.] An effective MOPH response to mental health morbidity will have to take this context into account, and invest in the community based approaches. In this view, it would also be very helpful if the MHD could work closely with the "Department of Islam and Health" in the MOPH and with Ministry of Religious Affairs.

34. Afghanistan is still very much in the middle of a conflict -- though some people classify it as post-conflict—in this context, it is even more relevant to focus the mental health activities on strengthening existing cultural coping mechanisms and strengthening resiliency, which heavily relies on community based approaches.

15 Resilience in psychology is the positive capacity of people to cope with stress and adversity.

16 Jordans, M.J.D et al, *Development of a multi-layered psychosocial care system for children in areas of political violence*

17 Sufi Meditation (Muraqiba), Wikipedia, the free encyclopedia

35. A community-based approach is essential, especially for women. Access to health facilities is very limited for women and more so in the case of access to mental health services, due to the high degrees of stigma attached to the problem. Hence establishing community female *shura* and self-help groups would be a feasible approach. It could encourage isolated Afghan women to get in touch with other women in the neighborhood and sharing their problems and sad experiences. This would also help in following up on the adherence to treatment of mental health problems -- important as treatment is often of long-term nature. As indicated by the global experience, the community based approaches are of low-cost and the locally available resources can improve treatment adherence and treatment outcomes.

36. Facility-based approach would require more medically qualified human resources and more financial resources. This is a big challenge for resource constrained Afghanistan, which is dealing with many competing priorities. Also, through a facility-based approach and individual counseling, it would be very difficult to reach the majority of the patients in the country. Hence, a practical and feasible option to address the widespread mental health disorders in Afghanistan would be to use a combination of both approaches with a main focus on the community-based approach.

Service Delivery:

37. To make these recommendations happen, major donors of the health sector (the World Bank, EU, and USAID) could provide financial and technical support to the MOPH to strengthen the MHD and revise the NGO contracts to make sure mental health activities are taken care of, as envisaged in the newly revised BPHS guidelines.

At Community Level:

38. Community psychosocial support could be strengthened via training of CHWs, creation of self-help groups and support groups. More investment should be made on the public awareness raising through development and distribution of brochures, leaflets, radio and TV talks on mental health issues and utilization of other community trusted channels such as Mullahs and prayer gatherings, etc. To carry out effective public awareness campaigns, public health experts ought to create words for better expression of mental health related feelings, emotions and problems. This is an important task, since due to huge stigma and taboo, it is difficult to find proper words within the ordinary local languages vocabulary. People need help to express their emotions and painful experiences to relieve their stress. They ought to be provided with enough information to comprehend that it is the circumstances which are abnormal and not their reactions (normal reactions against abnormal circumstances).

At the BPHS Facilities:

39. Through proper integration of primary mental health care at the primary health level, BPHS facilities could provide basic psycho-social counseling and manage common mental health disorders. All doctors, midwives and nurses working in the BPHS facilities should receive basic training in identification and management of common mental disorders, including training on basic psycho-social counseling. This not only will increase the knowledge of the health workers in terms of helping mentally challenged patients, but, as experience shows, will have a positive

externality in the form of improved behavior of the health workers towards all patients in the clinic.

40. The supply of essential psychotropic drugs to all BPHS facilities is an important activity factor to be ensured by all implementers across the country. The mental health related services of the BPHS should receive enough supervision by the implementers. Based on the revised BPHS, the HMIS formats need to be revised, so to adequately reflect mental health problems.

At the EPHS Facilities:

41. In line with WHO recommendations, every general hospital should have a (functioning) mental health ward. It is advisable to secure some beds in EPHS hospitals for management of acute/severe mental health problems. One could start with professional psychosocial counseling at the EPHS level. Like the BPHS, the concerned staff at EPHS facilities should be trained, required medicines should be supplied and proper supervision ensured. As a logical step, the EPHS guideline also needs to be revised to keep its complementarities and relevance with the BPHS guideline.

Recommendations for Capacity at Various Levels:

At the NGO level:

42. All BPHS/EPHS implementing partners should appoint a staff member to take responsibility as a mental health focal person or advisor, who will make sure the mental health component of the BPHS/EPHS receives proper attention and gets adequate supervision. Contracted NGOs could strengthen mental health service delivery through adequate implementation of the recently revised BPHS.

At the PHO Level:

43. One of the PHO officers could take the responsibility of the mental health issues at the provincial level. This person will make sure that the mental health agenda is being implemented at the provincial level and that the implementing partners are providing mental health services according to MOPH strategy. The long term vision could be recruitment of a dedicated mental health officer at the PHO level.

At the Central MOPH Level:

44. MHD should be fully staffed and appropriate training programs should be developed for the team, if the department is to assume its intended role as the steward of the mental health programs in the country. Necessary guidelines and protocols for implementation of the mental health interventions at different level of the health system along with proper HMIS and monitoring tools need to be developed and improved by the mental health department in collaboration with the relevant departments. MHD needs to be functionally linked with the Grants and Contracts Management Unit (GCMU), the Islamic, nutrition, reproductive health and IEC departments. Recruitment of a mental health advisor in the GCMU will ensure the NGOs contracted for BPHS/EPHS service delivery fulfill the recommendations of MOPH's mental health strategy is essential. This person will also serve as liaison between MHD and the GCMU.

45. The MoPH should ensure continued coordination to harmonize approaches. All mental health projects in the country should be mapped, which will constitute a starting point for development of a mental health partners' database. It would be very helpful if the MHD could maintain the database and update it bi-annually. There is a 60-bed mental health hospital in Kabul. This hospital consumes the bulk of the mental health budget of the MOPH. The hospital faces a severe shortage of qualified staff, for example there is no clinical psychologist in this hospital. The long term vision for this hospital could be enhancing it to a mental health teaching hospital for the whole country. Currently the hospital is totally disconnected from the MHD; it would be advisable to create a functional relation between this hospital and the MHD.

At the Multisectoral Level:

46. Mental health National Steering Committee needs to be established and chaired by a senior official from the Ministry of Public Health which could lead to the creation of a multi-sectoral action plan. Besides MOPH, this committee must include a representative from each relevant Ministry (Ministry of Culture and Information, Ministry of Labor and Social Affairs, Martyrs and Disabled, Ministry of Women Affairs, Ministry of Education and Ministry of Religious Affairs), as well representatives of the concerned development partners and implementing NGOs.

47. The steering committee, for example, could facilitate collaboration between MOPH and Ministry of Education on mental health curriculum development for school teachers and creation of linkages between schools and mental health activities in the community as well as with available mental health services in the area. It could also influence the curriculum revision of the Kabul Medical University to include a special focus on priority (acute and severe) mental health disorders in the country.

Recommendations for the World Bank:

48. The Bank could support the government to look at mental health issues in detail, help develop mental health interventions, and foster a multisectoral response. The Bank could facilitate this through all or some of the following:

- Facilitating/financing training of front line health workers in the area of mental health and financing both short-term and long-term technical and managerial training in the field of mental health.
- Along with other partners, supporting the design and implementation of large scale pilots to test different approaches for operationalizing mental health services delivery in few selected provinces with an in-depth evaluation.
- Providing extra funding for mass IEC to raise awareness about mental health issues in the country as a part of the pilot project.
- Financing implementation of mental health services within the revised BPHS.
- Mainstreaming the mental health agenda in major Bank financed projects, such as NSP and EQUIP.
- In order to provide a clear and updated picture of the mental health situation in Afghanistan, a mental health survey should be carried out in the country. Given the

concerns of partners about the validity of the previous surveys using un-validated brief self reporting questionnaires, this will be a good opportunity for the health sector to get quality data of the mental health situation in the country. The Bank could also support such a survey with a clinically valid instrument.

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Annex I : Mental Health Services by Type of BPHS Facility

(BPSM = biopsychosocial management; PSM= psychosocial management)

Interventions and Services Provided	**Health Facility Level**					
	Health Post	**Health Sub-Center**	**BHC**	**MHT**	**CHC**	**District Hospital**
Mental health awareness	Yes	Yes	Yes	Yes	Yes	Yes
Mental health education	No	No	Yes	Yes	Yes	Yes
Identification of suspected cases	Yes	Yes	Yes	Yes	Yes	Yes
Diagnoses and classification	No	No	Yes	Yes	Yes	Yes
Psychosocial problems and stressors	PSM	PSM	PSM	PSM	PSM	PSM
Common Mental Disorders (mild-moderate depression, anxiety disorders, unexplained somatic complaints):	Refer suspected cases	PSM	BPSM	BPSM	BPSM	BPSM
Severe Mental Disorders (psychosis, severe depression, bipolar disorder, schizophrenia):	Refer suspected cases	Refer suspected cases	BPSM *	Referral	BPSM	BPSM
Substance Abuse:	Refer suspected cases	Motivation, referral, follow up	Motivation, referral, follow up	Motivation, referral, follow up	Motivation, referral, follow up	Detoxification, Referral to specialized services
Childhood mental disorders (including enuresis)	Refer suspected cases	Referral	BPSM *	BPSM	BPSM	BPSM
Learning difficulties : Identification and education for parents and teachers	No	Yes	Yes	Yes	Yes	Yes
Epilepsy	To be referred	Referral	Yes *	Yes	Yes	Yes

Interventions and Services Provided	Health Facility Level					
	Health Post	**Health Sub-Center**	**BHC**	**MHT**	**CHC**	**District Hospital**
Self harm	Identify, and referral	Identify and referral	Identify and referral	Identify and referral	BPSM	BPSM
Community based rehabilitation (linked to disability component)	Yes	Yes	Yes	Yes	Yes	Yes
Inpatient treatment	No	No	No	No	To be referred	Yes
Monitoring and follow up	Yes (treatment compliance)	Yes	Yes	Yes	Yes	Yes

* BHC staffed by doctor, otherwise only follows up

Funds will be provided for mental health training, drugs and psychosocial counselling in a phased manner

ANNEX II

SUMMARY OF THE AFGHANISTAN MENTAL HEALTH STRATEGY

The mental health strategy envisions that all people in Afghanistan have access to a community-based yet comprehensive and coordinated system of mental health care supports, treatment, and follow up of mental illness and related disorders. It will promote a system of recovery and mental wellness that is integrated with the other primary healthcare service provisions by the year 2020.

The main aims of the National Mental Health Strategy are:

- To promote mental health of the people of Afghanistan;
- To minimize the stigma and discrimination attached to mental disorders ;
- To reduce the impact of mental disorders on individuals, families, and the community;
- To prevent the development of mental health problems and mental disorders, wherever possible;
- To provide quality, integrated, evidence and rights based care for individuals suffering from mental disorders at all levels of health system.

STRATEGIC GOALS

The following best describe the two key strategic goals of service and support on which this National Mental Health Strategy is based:

- To develop, introduce, and monitor a broad range of mental health initiatives to support individuals and families across the range of preventive interventions, primary and secondary service provision, referral and rehabilitation, with special focus on immediate delivery of the most essential services to those with the greatest needs
- To introduce or strengthen legislation, regulation, organizational, and operational activities to support the delivery of interventions and services within the public and private health sectors plus related interventions within other sectors.

Strategy components

The NMHS is designed to build a comprehensive mental health system that will contribute to key areas of prevention, identification and referral, care and treatment if required plus the creation of a robust functioning support system, including legislation and regulations, oversight, and resource availability, including human resources.

The national mental health program has the following six components:

Component 1. Provision of preventive, gatekeeper, and maintenance initiatives

This component includes monitoring, school health, health promotion, and psychological first aid, working with community organizations, non-health gatekeeper organizations (police and other social services).

Component 2: Provision of primary care interventions and services

This component includes assessment, counseling, first line treatment and drug use, psychotropic drug availability, chronic care, referral and rehabilitation at Community-based level, Primary mental health care and Monitoring of Private Mental Health Provision

Component 3: Provision of Referred Tertiary Secondary and Forensic Medicine

This component includes secondary acute mental health car, tertiary acute mental health care and attention, chronic care and rehabilitation, Forensic Psychiatry and services for Prisoners.

COMPONENT 4: STRENGTHEN NATIONAL STRATEGIC INTERVENTIONS

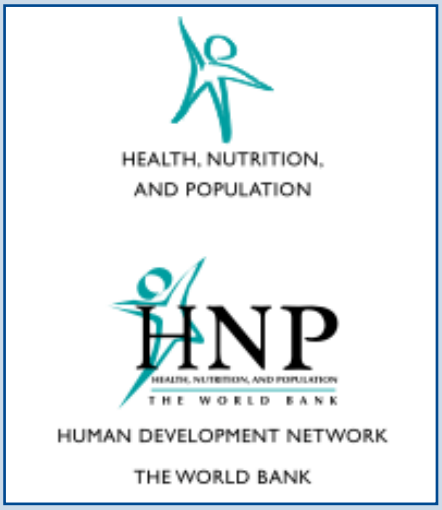
This component includes oversight of national strategy, inter-sectoral collaboration (national level), inter-ministerial collaboration, direction and support for provinces, mental health funding, program monitoring, research, legislation and regulation

COMPONENT 5: STRENGTHEN PROVINCIAL STRATEGY OVERSIGHT AND IMPLEMENTATION

This component includes Service delivery monitoring and quality improvement, Strategic implementation planning, Inter-sectoral collaboration at provincial level, Regulation compliance (public and private sector).

COMPONENT 6: STRENGTHEN PREVENTIVE INTERVENTION AND SERVICE DELIVERY RESOURCES AND INFRASTRUCTURE

This component includes human resource planning, pre-service and in-service training, coaching, and mentoring, specialist training, inter-sectoral staff training, mental health worker supervision (MOPH and supporting sectors) and Infrastructure development.



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