Community Psychosocial Support in Afghanistan

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In 2001 Save the Children and UNICEF launched new programmes in Afghanistan. The emphasis was not on mental health service delivery, but on a community-based psychosocial support strategy. The article discussed the principles of the work undertaken by the two agencies. It also explores both these research and project planning which was carried out in Kabul between 2001 and 2002.

Key words: community based psychosocial support, qualitative research, child-to-child groups

Working with the children of Kabul to ensure psychosocial well being

There is no doubt that the constant war, insecurity and deprivation of the last twenty five years have taken a heavy toll on the emotional health of Afghans. Afghans often ascribe their frequent physical symptoms of sickness to psychological pain. Goitre (enlargement of the thyroid gland), for example, is said to arise from having too much grief to bear; thinness and stomach ulcers are seen to derive from stress; and aches and pains from depression. Afghan doctors, already overburdened by the ills of a poor population also face high demand to remedy these somatised emotions. This is in addition to the prevalence of more classic mental health conditions, for which local people also seek the help of their doctors and nurses since there are few mental health services. Mental health is rightfully a public health issue in Afghanistan but there is strong evidence to show that effective solutions may be other than medical ones.

This paper explores the work of UNICEF and Save the Children USA, two international child-focused agencies working for the well being and protection of children in Afghanistan. Aware of the impact of half a decade of conflict on the lives of young people and the level emotional suffering amongst Afghan children, in 2001 Save the Children, USA and the United Nations International Children's Emergency Fund (UNICEF) launched new psychosocial programmes in Afghanistan. Rather than concentrating on mental health service delivery, the emphasis of the new work was a community-based psychosocial support strategy.

There were several reasons for this emphasis on psychosocial support. First was the extremely weak capacity of the health and mental health services in Afghanistan and the already phenomenal level of demand placed upon them; the two agencies felt that

if they could provide alternative non-medical psychosocial support it might relieve some of this pressure. Secondly, it seemed appropriate to develop sustainable projects which would build on and support existing strengths in family and community life rather than relying upon resource intensive medical solutions. The third argument was the belief that recognizing the capacity that had allowed Afghans to confront, bear and survive the past quarter decade of loss and destruction would acknowledge the resilience and coping that already existed in Afghan social life. Building on this would prevent the portrayal of Afghans as in desperate need of specialized medical intervention to the detriment of acknowledging their ability to survive and cope.

To meet the aims for community-based psychosocial support, the Save the Children and UNICEF work received grounding in local level consultation, research and project planning. The article explores both the research and project planning which was carried out in Kabul between 2001 and 2002. It first, however, sets the policy context for the ethos and principles of work in Afghanistan undertaken by the two agencies.

Save the Children and UNICEF policy development

Shift in policy. In the last decade UNICEF and Save the Children (USA) have been large scale providers of psychosocial support for war-affected children across the world. The work in Afghanistan reflects the shift in policy that both agencies have made from health to community based interventions. To understand this shift in policy it is helpful to use a triangle diagram dividing the war-affected population in three groups of at-risk people. At the top apex of the triangle is a small minority of the population who will suffer severe and long lasting mental health consequences as a result of living through a time of war. At the bottom, widest part of the triangle is the majority of the population, affected by war and suffering its scars, but with the resources and health to recover. In the middle is a group of people who have been made especially vulnerable by war, they are in danger of severe mental health problems as a result but with some support and intervention can draw upon coping resources to heal their emotional wounds without seeking mental health care.

Early in the 1990's both UNICEF and SC/US focused intervention at the top apex of the triangle, targeting the most severely affected members of the population. In Rwanda and Bosnia agency staff used mental health checklists to diagnose psychological conditions, specifically of Post Traumatic Stress Disorder (PTSD), and set up large scale trauma counselling programmes as a healing intervention. Bosnia, in particular, proved a key learning moment both theoretically and practically for the two agencies dealing in such projects. Theoretically it became clear that the diagnosis of severe mental ill health was open to gross slippage. At a certain point many PTSD symptoms were diagnosed amongst a large percentage of the population. So, trauma counselling projects were installed providing specialized mental health services. But in time healing and recovery took place outside these programmes and only a minority was left with long term mental health conditions which required specialized intervention. Thus interventions which are appropriate for the minority severely affected part of the population triangle were being transposed into a wider client group. Next, this clinical policy was ignoring other simultaneous processes of people effecting

their own recovery through local resources and relationships.

The practical consequences of this intervention strategy became clear only months after the initial emergency responses had been established. As is common in emergency situations, after a first flood of funding it proved more difficult to access the same level of resources for ongoing work. It proved hard to sustain funding to maintain trauma centres, set up when money was abundant, and to pay trauma counsellors, trained in specialized techniques. UNICEF for instance then had to deal with large numbers of health professionals whom they had trained and guided as trauma professionals and for whom, after a while, they did not have money for salaries and support. At the same time UNICEF were aware of hundreds of children who had embarked on a process of talking through their appalling experiences and receiving support for processing them. Without funds to pay salaries, this process was stopped without sufficient attention to the emotional impact on children of starting on a process of therapy and not being able to see it through (personnel communications).

New approaches. As a result of this and other learning incidences, UNICEF and Save the Children have paid considerable attention to developing clear psychosocial policies for their own employees and partner organizations to follow. In 1996 the Save the Children Alliance launched a set of policy guidelines for providing support to war-affected children (Save the Children Alliance, 1996). These guidelines promote a community-based psychosocial approach for war-affected children. The basic premise of the approach is that Save the Children practitioners will start at the bottom of the triangle of the war-affected group. They will assume that the majority of the population has the resources to cope with their suffering. Amongst the vulnerable sector of the population these coping resources may, however, have been damaged or lost in war. Therefore a base line survey should identify weaknesses in coping resources and seek to improve these. Such an approach looks at identifying the positive, understanding and sustaining it and therefore avoids pathologising the population involved in the survey.

For example, for many children, their parents prove a key resource in helping them to come to terms with loss and grief. However, in times of war, care giving adults may be strained by economic responsibilities and have less time and energy to care for their children. Interventions would support parents in reaching economic security and to take the time and space to listen to and discuss their children's worries.

Research in Afghanistan

Late in 2001, there were new opportunities for wider scale psychosocial programmes in Afghanistan. Up to this point UNICEF and Save the Children had only very small scale psychosocial projects in Kabul (Arnston 2001; GMC 2001). In 2001 both agencies relaunched Child Protection sectors within which psychosocial care for children was the main priority. The launch started with a six month research project to ascertain a baseline of psychosocial needs and to set these needs in the context of local perceptions and cultural values of well being and child development.

This research looked far beyond the classification and prevalence of mental health and emotional distress symptoms amongst children. It also explored local understandings of what caused these symptoms, how they were experienced and what people did themselves to overcome their suffering (for

the full research report see Save the Children/UNICEF, 2003).

Therefore the symptoms of distress and the classifications of mental health disorders were not set in advance of the research as universal disorders. The research was different to a survey looking for the frequency of symptoms associated with universal mental health disorders to assess prevalence. In classical mental health research the question is not 'does this disorder exist' but 'how many people suffer symptoms associated with the disorder.' In contrast our research asked 'what disorders do Afghan people think exist?' The researchers relied on qualitative methods to elicit what the different states of mental distress are known as and referred to in Afghan culture.

The research project involved over 600 young people and adults in more than 238 focus group discussions. The emphasis was on qualitative research, with people responding to participatory activities and discussion prompts. Conversations revealed a rich language of emotional well-being amongst Afghans and nuanced descriptions of different conditions of distress. These conditions, which were identified by all those involved in the research, ranged from severe mental illness (*rawany taklef*) and 'madness' (*dewana*) to more commonplace feelings of sorrow and depression (*gham*), worry (*tashwish*), feeling strangled (*khafaquan*) and fear (*tars*). In almost all cases participants suggested that the conditions had physical expressions and symptoms. *Tashwish,* for example, was characterized by aging quickly, losing weight, having continuous aches and pains and teeth falling out.

Through many different case stories the researchers identified 17 conditions of mental and emotional distress, common to those in the discussion groups. The groups would then take each feeling in turn and explore how they would recognize that someone was afflicted with this emotion, what other situations may cause someone to suffer in this way and how it could be healed.

Once the 17 states of emotional distress were identified, they were themes that were explored through the rest of the research. However, again in contrast with mental health research, rather than identification and prevalence of these states of distress driving the research, they were always placed in the context of people's comments on general mental, emotional, physical and spiritual well being. It soon became clear that emotional health was only one part of a much broader set of local understandings about children's ideal development and well being. Both parents and children stated that alongside positive feelings and the avoidance of emotional distress, it was equally important for children to also have religious faith, household and economic responsibility, physical well being, courage and morality as they grew up.

These attributes were not only important alongside emotional well-being but more than this, were actually inter-dependant with emotional well being. So, for example, having good morality based in religious knowledge and instruction was said to be vitally important to mental health. A child with good morality would be able to withstand traumatic events. For children with good morality can separate off the impact of conflict on themselves by having a clear dividing line between right and wrong, good and evil.

This interdependency of all aspects of well-being remained true when the research moved to look at the threats to children's well-being and causes of distress. When children were asked about the causes of emotional distress they identified the

following threats alongside conflict: displacement, poverty, family loss, family separation, family tensions such as domestic violence and drugs abuse in the home, lack of access to education, long term sickness, gender discrimination, early marriage, heavy and exploitative work, sexual abuse, threat of kidnapping, damaged, dirty and dangerous physical environments, busy traffic, as well as a fear of ghosts. There were thus a wide range of situations of social and economic stress, which Afghans experienced in terms of emotional suffering.

War was considered so harmful to emotional distress because it upsets the patterns of social relationships, moral development, physical strength and religious learning, which were perceived as so important to children's well-being.

For example, poverty was highlighted as particularly detrimental to emotional well being because it eroded away supportive social relationships in the family. Parents said that they became so busy and tired with basic survival requirements such as gathering food, water and fuel, that they didn't have the time to listen to their children's problems, resolve their arguments or comfort them through their worries. Nor did they have time to give to moral learning and religious teaching that would give children the resources to cope with difficulties. Poverty affected children's physical health, meaning they were more prone to disease, less able to get medicine and support when required and therefore weaker in their bodies and more likely to suffer physical manifestations of emotional distress.

When talking about the remedies for emotional grief, many participants stated that they did indeed turn to health professionals to offer relief of the symptoms and to promote healing via prescriptions. They often experienced the most immediate manifestation of negative emotions through bodily pain and weakness, which they sought to overcome quickly through palliative means. Equally, however, there was recognition that suffering could be eased through other non-medical solutions. This was parallel with the recognition that emotional well-being was reliant on social factors and that threats to mental stability worked through a web of physical, spiritual and social influences.

Having a safe home, a supportive and loving family, having a positive attitude to suffering, sharing suffering through talking with others in the same position, having caring friends, restored environments and political and economic security , faith and belief in God were all identified in helping heal pain and cope with adversity.

For example parents said that if their child was afflicted with grief and all the physical pain that goes with it, they would take them to a mullah in the mosque. The religious leader could give specially blessed amulets and extracts from the Koran to aid the child's recovery. The leader could also instruct the child in morality and belief, in being able to discern right from wrong and therefore build in the child the moral resources to understand and withstand risks and emerge with their emotional health intact.

All the discussions and understandings of the participants pointed to the need for a holistic picture of emotional and mental well-being, set in the context of their many diverse strategies for coping and healing. (Summerfield et al. 1995)

Interventions

Given that, through this approach, so many children and adults involved in the research identified social, economic and religious causes and solutions to mental suffering, it was clear that in order to do justice to the research findings, new psychosocial projects in Kabul were going to have a wide remit. Psychosocial programmes would have to

cross into other sectors such as education, shelter projects, livelihood support, and protection. They also had to touch on areas not usually in the field of humanitarian support, such as faith groups, social ceremonies, family relationships and environmental regeneration.

Save the Children and UNICEF devised a strategy of psychosocial programming with three main strands:

- Integrating psychosocial support into other programmatic fields,
- Single issue interventions to address major sources of risk for children's psychosocial well-being,
- A model for interventions aimed at issues linked to local conditions.

A decision to *integrate psychosocial* support into other programmatic field was supported by the research findings which showed how much distress was caused by factors outside the fields of child protection and psychosocial support, and the curative possibilities of strengthened coping within these areas.

One major area was education. Children identified education as key to their psychosocial well-being. Children said how lack of access to education, discrimination in school, the use of heavy punishments, cruel and abusive teachers could cause them to develop symptoms such as worry, grief and resentment. These worries were compounded because children set such great store by education, seeing it as a way to qualification and a better future, which might, in turn, lead them out of poverty. At the same time children said how kind and listening teachers could help them not just in their school work but also to cope with domestic disputes and other worries. Children often saw teachers "like a parent," with the potential to listen and take action on their behalf.

In response to this, Save the Children and UNICEF made a decision to integrate training on psychosocial support into all primary school teacher training. UNICEF liaised with the Afghan Ministry of Education and secured approval for a training module on how teachers could offer psychosocial support to pupils and could take measures for the protection of children. The message, supported by the government, was that teachers had more than a duty of academic instruction and should also be responsible for the social and emotional development of children. A consultant with long term knowledge of Afghan culture devised the training module, exploring how teachers could integrate traditional Afghan coping strategies for emotional well-being into the class room. A group of master trainers from the Ministry of Education took responsibility for the training package and for rolling it out to every primary school teacher in Afghanistan. This process is currently under way.

Similarly Save the Children and UNICEF highlighted the links between Early Childhood Development (ECD) Programmes and psychosocial support for children. In the research parents had decried the impact of poverty on their family lives, meaning that they often did not have the time and energy to be as good and supportive parents as they would like to be. At the same time children explained how play was so important to their enjoyment of life and sense of happiness.

Both these issues were met in existing Save the Children ECD programmes whereby mothers in a local community would meet together to discuss parenting problems and how to reach solutions. Alongside this the group was equipped with play materials for their children to enjoy and learn from whilst their mothers talked. By highlighting the links between ECD and psychosocial protection for children, UNICEF and Save the Children could advocate for the continuation of this important education project.

The research proved that it was vital to have psychosocial support integrated into public health and medical sectors in Afghanistan. Whilst people tried to turn to the medical profession for assistance with emotional and mental health stresses, lack of access to medical facilities was likely to increase levels of anxiety and feelings of powerlessness. Improved diagnosis amongst medical practitioners made them able to recommend the use of non-medical and rather social, religious and economic solutions to emotional problems, thus keeping scant resources available for the minority of severely affected patients.

Using a similar formula to that devised for teachers, UNICEF negotiated with the Ministry of Health for acceptance of a training module for health professionals. This training encouraged health staff to turn to non-medical solutions for psychosocial problems and to draw upon traditional Afghan coping and healing resources. At the same time the training built skills of listening and referral. Through these health staff could learn as much as possible about a source of distress and could turn to other key players who might have a role in assisting the patient. The training module also aimed for technical improvement in the recognition of severe mental health distress such as trauma and depression, thus tightening diagnostic procedures and knowledge of the symptoms of these states.

At the same time, the two agencies decided on a number of *single-issue interventions* around decreasing the risks to children's psychosocial well-being. *For example, children in Kabul had come up with the surprising conclusion that road conditions and traffic accidents were one of the greatest threats to their physical safety and emotional calm.* Not only were children terrified of busy roads and careering cars but busy traffic was also putting a strain on their school journeys or domestic activities such as fetching water and firewood. With the intention of preventing psychosocial distress, UNICEF and Save the Children secured funding from USAID for a city-wide road safety campaign. This included designing child-focused road safety material and working with local communities to address particularly dangerous intersections and road crossings. Similarly, given that children had identified the physical environment as having a major influence on their psychosocial well-being, with destroyed houses and rubble making them feel depressed and sad, and parks, trees and flowers making them feel glad about life, the agencies lobbied for child-friendly cities where physical reconstruction would take into account the needs of children and make allowances for children's parks and playgrounds.

Finally, the two agencies worked on delivering programmes that focused more on a *model of providing community psychosocial support and risk prevention*. The research showed that particular risks to children's psychosocial well-being were often linked to very local conditions. *For example one group of children might identify a local pack of rabid dogs as causing them harm and distress, whereas others might point to a nearby mine field as causing them concern when they had to cross it to get to school or fetch water.* Children identified common resources for addressing these problems, they said they would ideally turn to their parents and community leaders to tackle the problem and also to talk over their fears and worries with reassurance. Building on this pattern Save the Children established local child-to-child groups across Kabul city. A facilitator helped children identify and talk through their concerns and then to think about action they could take to solve the problem. At the same time Save the Children mobilized parents and community committees.

The children presented their discussions to the adults and together the children and adults were supported to come up with action plans to solve the problem. In this way the risk to children's psychosocial well-being would be overcome whilst at the same time promoting spaces where they could talk over fears with adults. They acquired the support of the community to listen and take action - the very resources that children said they already used for psychosocial comfort and support.

This model of intervention using local level community structures produced some immediate and powerful results. In 2003 Save the Children received funds from both UNICEF and USAID to roll out this model of local level child protection and psychosocial support across Kabul and Mazar-i-Sharif, in the north of Afghanistan. The aim was for 60 child-to-child groups across 6 districts. At a mid-way evaluation of the project, the children involved said overwhelmingly that the child to child work was helping them to feel better, and empowered them within their community.

For example, in one community, children identified road safety as their main psychosocial concern. Busy roads and dangerous driving was giving them sleepless nights as they contemplated getting to school in the morning or venturing out of their houses to fetch water and wood. Numerous children recalled loosing their parents in a road accident (in fact more children in the research said that they had lost parents due to traffic accidents than through war). During the child-to-child process the children identified one particularly busy corner in their community as being particularly risky to their physical safety and therefore also to their mental calm. They drew maps of the corner and devised plays which expressed how terrified they were at the prospect of crossing it every morning. These they presented to their parents and local community leaders. The adults elected a committee to work with the children in devising action plans to solve the problem. Amongst the group was a local teacher and leader of a Scout organization. He suggested that the Scouts be mobilized to provide a rota in order to help young children cross the road every morning and lunch time. This was set up. The parents also decided to write to the local municipality to complain about the traffic intersection and ask for a traffic warden to be placed there. Save the Children then supported the groups with money to act on their suggestion to place a warning sign post at the intersection.

Psychosocial and mental health service provision

The research and intervention strategy outlined above started at the bottom base and the middle segment of the possible intervention triangle. Yet even with all possible emphasis on a holistic and local level strategy for psychosocial support in Afghanistan, there are still those Afghans who fall into the top minority apex of the intervention triangle, for whom social support and general community approaches will not be enough and who require specialized mental health assistance. The research project also made specific recommendations for the improvement of mental health provision in Afghanistan:

1 Strengthen Afghan health professionals' capacity to recognise and treat psychosocial needs by encouraging social or religious coping mechanisms and not prescribing drugs - especially for children.
2 Study the practice of self-medication, which many Afghans undertake for psychosomatic symptoms, and work for responsible drug prescription and use.
3 Improve links and dialogue among agencies offering psychosocial support and those offering mental health services.

4 Research and share information on how mental health is experienced, diagnosed and labelled in Afghan society.
5 Review existing mental health treatment capacity in Afghanistan and seek to upgrade specialized services for the seriously mentally ill.

These recommendations that Save the Children and UNICEF make for improved mental health care in Afghanistan come with three important provisos. Firstly, Save the Children and UNICEF believe that they are not the agencies best placed to provide specialised mental health support. They see themselves as specialising in generic community-based psychosocial support, leaving specialised intervention for specific affected individuals for others. Secondly, the agencies suggest that a mental health strategy must always be placed in the wider context of non-medicalised psychosocial support. Save the Children and UNICEF working in Afghanistan strongly advocate that as much intervention as possible be given as social, economic and religious assistance, through building on local community-based coping mechanisms. This establishes and strengthens the specific clinical assistance provided to those who need it. The provision for the needs of the few also will not be diffused and weakened by over-exaggerating the scale of the problem amongst the majority. Thirdly, Save the Children and UNICEF advocate for strong collaboration in Afghanistan between mental health provision and psychosocial support provision. Both communities have much to learn from each other in the recognition of how psychosocial well-being and mental health is experienced and can best be bolstered for Afghans. In Afghanistan mental health and psychosocial strategies can learn from each other in order that both can be part of the same continuum of giving well-informed assistance to people who have suffered such oppression and violence over the last quarter of a century.

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