

Developing basic mental health modules for health care workers in Afghanistan¹

Peter Ventevogel & Frank Kortmann

In this article we describe our experiences with the development of mental health training modules for doctors, nurses, midwives and village health volunteers in the context of a general basic health care programme in Eastern Afghanistan. The article contains references to resources to be used by developing mental health care training modules for health workers.

Keywords: mental health, training.

Introduction

Afghanistan's health statistics are striking, with a life expectancy of 47 years, an infant mortality rate of 145 per 1000 live births and the second highest maternal death rate in the world. Amidst this array of health problems one could easily overlook mental health problems, and this is indeed often done. We argue that mental health problems should have their due place within the health care system (cf Saraceno 2001, Baingana 2003b, Patel and Kleinman 2003,). Worldwide neuro-psychiatric disorders account for 11% of the Global Burden of Disease, second only to infectious disorders (World Health Report 2001). Mental disorders are disabling and costly. Basic health care doctors often do not recognise mental disorders, and prescribe non-specific treatments such as analgesics, vitamins,

and hypnotics. Effective and relatively cheap treatment methods for these disorders do however exist. The mental health needs of the population in Afghanistan are high, but exact data is lacking. The few available sources indicate that depression and anxiety disorders are highly prevalent, particularly among women and children. The high level of exposure to war-related violence has led to high figures of physical disability among men and can be expected to have profound effects on their mental health status.

Mental health care facilities

A mental health care system is virtually non-existent in Afghanistan. The World Health Organisation (WHO) estimates that the country has eight psychiatrists, 16 psychiatric nurses and 20 psychologists for a population of more than 25 million. It is however doubtful whether these professionals are all still in the country, but it is certain they are not working in Eastern Afghanistan.

The Afghan Ministry of Health has included mental health in its 'Basic Package of Health Services' (BPHS 2003) defining the medical interventions to be made available in all districts of the country. The BPHS will be pivotal in the Afghan health care

policy that is to be developed and implemented in the coming years. The document identifies the interventions and services to be provided in each level of health care, with a strong emphasis on the basic health care level. Mental health is included in the BPHS as one of the seven priorities. Central issues for mental health in the BPHS are the identification of mental disorders in the community and management of these cases at the basic health care level. The WHO world-wide promotes the inclusion of mental health care components in the national basic health care structures of developing countries (Mohit 2001b, Wig 2001). A report by the mental health specialist of the World Bank on Afghanistan also powerfully advocates the integration of mental health in basic health care (Baingana 2003a). An integrated approach can reduce stigmatisation and strengthen the use of the social support system (family and community) as an important resource for healing and rehabilitation of mentally ill patients. Community-oriented mental health care programmes address prevention, treatment, care and rehabilitation of mental disorders and psychosocial problems, in order (1) to reduce the number of people who develop mental health problems, (2) to assist those with mental health disorders to improve their overall quality of life, (3) to eliminate the stigma associated with mental and psychosocial problems, (4) to provide effective interventions to all needed, and (5) to promote ongoing research into the causes and treatment of mental disorders and psychosocial problems.

In the 1980s Afghanistan made an early attempt to establish community mental health centres in Kabul, but due to the decreasing security, the project ended prematurely and never managed to expand to other parts of the country. A few years ago

the WHO tried to tackle the shortage of qualified personnel by organising a mental health training for primary health care physicians in Northern Afghanistan (Mohit et al. 1999). The results were satisfactory and some of the trained doctors are still practising. Unfortunately this initiative has not been followed up, due to the political instability in the country and the unwillingness of the Taliban regime to invest in health care.

In Afghanistan's neighbouring countries, recent experiences with the integration of mental health care in primary care yielded promising results. In Pakistan a community mental health project produced a sustained increase in the detection and treatment of common mental disorders in primary care (Mubbashar & Saeed 2001, Saeed et al. 2001). The Iranian national mental health programme has been able to integrate some mental health services in the majority of the countries rural districts (Mohit 2001a). According to recent estimations 15 million Iranians in the rural areas have now access to primary care workers who are trained in mental health skills (Yasamy et al. 2001). Worldwide, several other projects for the integration of mental health services in the primary care system by non-governmental organisations (NGOs) or national governments have been documented: Nepal (Ackland 2002), Cambodia (Van de Put & Eisenbruch 2002), Guinea Bissau (de Jong 1996), Nicaragua (Byng 1993) and India (Murthy 1998).

The mental health project of HealthNet International

The Dutch nongovernmental organisation HealthNet International has been active in health care in Afghanistan since 1994. The *Health Care Support Project* started in 1996

and now supports the primary health care services in seven districts in Nangarhar Province. It aims at strengthening a network of basic health facilities in the rural areas, a rural hospital, and links to the University Hospital of Jalalabad. The programme covers 382.000 people. The project provides comprehensive and diverse training programmes, covering various needs of the staff. Training of Traditional Birth Attendants and female Village Health Volunteers gives access to women and children. It promotes effective and active role for female health workers, and has good cooperation with other NGOs.

As in all provinces in Afghanistan, mental health care was almost non-existent in Nangarhar Province. To provide the project area with some basic mental health care, Dr. Frank Kortmann, mental health consultant of HealthNet International, made a needs assessment in January 2002 and wrote a project proposal to demonstrate the effectiveness and feasibility of a basic mental health training programme in primary health care (Kortmann 2002). The outcome of this pilot-project was the basis for implementing mental health care in all districts of the Health Care Support Project. Later on this programme could serve as a blueprint for the introduction of basic mental health care in primary care in other Afghan provinces. The mental health care approach of HealthNet International is fully in line with the policy of the Afghan government (Ventevogel et al. 2002). The local health care authorities of the province actively support the project and issue certificates for the trainees who have successfully completed the mental health courses. In fact, nearly all trainees in our programme are employees of the Ministry of Health.

A core element in the mental health project was the development of training modules

for health care workers in the existing health care system. A carefully prepared curriculum is the basis for an effective training. Ideally a training curriculum should consist of a clear overall aim (what do we expect participants to have learned at the end of the course), specific learning objectives (what should the students have learned at the end of each session), a description of the educational materials and teaching methods to be used, and finally the means of evaluation (Prideaux 2003). Below follows an account of our experiences with developing the training modules.

Training topics

The wish to include as many topics as possible in the schedule can lead to an encyclopaedic curriculum that is a more of an overview of the state of the art in a certain specialty than a course tailored to the needs of the participants. It is necessary to limit the number of topics. We selected schizophrenia, depression, anxiety, epilepsy, mental retardation and substance abuse. In the selection of the topics we have been guided by the following guiding principles: prevalence, clinical relevance and availability of easily administered treatment options. Prevalence figures of mental disorders among Afghans are scarce. Early in 2003 the University of Amsterdam, in collaboration with HealthNet International and the Centers for Disease Control in Atlanta, conducted a population-based epidemiological survey in Nangarhar Province, the province in which the project described here is situated (Scholte et al. 2003). The study uses a cross-sectional two-stage multi-cluster sample survey with a total of 1013 participants aged 15 years and older. Among the instruments used were Pashto versions of the Hopkins Symptom Checklist- 25 (HSCL-25) and the Harvard

Trauma Questionnaire (HTQ). The results of this study give some indications of the prevalence of common mental disorders in Nangarhar Province. Data on prevalence in Afghanistan of severe neuro-psychiatric conditions such as schizophrenia and epilepsy is not available, so we use figures from other countries.

Schizophrenia. Based on results of surveys in other low-income countries, we estimate the prevalence of schizophrenia between 0.14 to 0.46% (Jablensky 2000). The treatment of schizophrenia is relatively easy when the right medication is available. A schizophrenia treatment with chlorpromazine costs around US \$ 2 per month in Afghanistan. In focus group discussions about mental problems, case histories were invariably told of patients with chronic psychosis.

Depression. The recent survey in Nangarhar Province (Scholte et al. 2003) showed that 16% of the male adult population had elevated scores on the depression subscale of the HSCL-25 (with the usual cut-off point of 1.75)). For women this figure was much higher: 58%. These figures are alarming, even bearing in mind that the HSCL-25 measures self-reported symptoms, and not mental disorders. Important contributing factors to the development of depressive and anxiety symptoms in Afghan women are probably war-related traumatic losses, sexual violence, and the culturally sanctioned social deprivation of women through a system of strict gender-segregation. In focus group discussions the participants mentioned *khafgan* (literally: 'sadness') as a condition that can refer to a person who has deep sadness and worries a lot, always thinks about the bad things of life, isolates himself, does not eat properly, and cannot sleep well. Somatic features are 'constrictiveness of the chest' (*jegar khonee*), 'heavi-

ness', and stomach problems. When the condition worsens it is thought to lead to 'craziness' (*levany*).

Anxiety. The study of Scholte et al. (2003) demonstrated elevated scores on the anxiety scale of the HSCL-25 in 22% of the male adults and 78% of the female adults (cut-off point 1.75). These dramatic figures do not indicate that the majority of the population is suffering from an anxiety disorder, but they do show that the self reported incidence of anxiety symptoms is extremely high. The rates of possible PTSD cases in the study of Scholte et al. (2003) is also high (7% for men, 32% for women). But in contrast to depression and generalised anxiety, these findings are not corroborated by the clinical impression of mental health team members and doctors in the basic health centres. They felt that post-traumatic stress disorders are relatively rare in this population. Nevertheless we decided to include post-traumatic stress disorder in our curriculum, since we could not exclude the possibility that this problem is under diagnosed.

Epilepsy. The prevalence of epilepsy in developing countries is estimated to be around 1% (Scott, Lhatoo & Sander 2001). In rural Pakistan a prevalence of 1.5% was found (Aziz et al. 1994). Effective and cheap medication for these conditions exist, but are often not available in the government-run clinics in Afghanistan. The stigma attached to epilepsy is considerable, and children with epilepsy are often excluded from school.

Mental retardation. As in most low-income countries, prevalence figures of mental retardation in Afghanistan are unknown, but the figure can be assumed to be high. In neighbouring Pakistan the prevalence of mental retardation was found to be considerably higher than in industrialised coun-

tries: nearly one in 50 children had severe mental retardation, and one in 15 mild mental retardation (Durkin, Hassan & Hassan 1998). Many of the risk factors for mental retardation in the Pakistan study are present in Afghanistan: perinatal difficulties, consanguineous marriages, high rates of neonatal infections, postnatal brain infections (cerebral malaria), malnourishment of pregnant women and young children, head trauma. Giving good instructions about the nature of the condition can help the family to focus on adequate training of the child, instead of spending endless sums of money in search of a cure that will never be found.

Substance abuse. Afghanistan is infamous for its poppy cultivation. The idea that the farmers only *grow* poppies, and do not consume their products is only partially true. In the heartlands of Afghanistan nowadays addicted patients roam around the trading places in search of opium and heroin. Use of cannabis is widespread. Alcohol abuse used to be a rare problem, but anecdotal reports indicate that its use is on the rise now that the severe restrictions imposed by the Taliban have been lifted. It is a great taboo, and people find it more painful to admit to using alcohol than to using cannabis or opium.

Participants and learning objectives

To assess the training needs we have done a baseline assessment among the health workers in the target area. We used a semi-structured questionnaire in which their knowledge and opinions were asked about the above-mentioned priority conditions. The conclusions were that the health workers were quite well aware of the high prevalence of mental disorders, but that they felt unable to diagnose and treat these cases themselves.

Based on the priorities as described in the last section and the results of the local assessment, we constructed different training modules for doctors, for nurses and midwives and for village health volunteers and traditional birth attendants. For doctors the scope of the training was more comprehensive, given the higher entry knowledge and their task as managers of rural basic health centres with an overall responsibility for treatment plans.

The training for doctors consisted of (1) a general introduction to the basic concepts of mental health and mental illness and the effects of psychosocial problems on mental health, and to health education and health promotion, (2) the basic principles of diagnosis and (psychopharmacological) treatment of psychosis/schizophrenia, major depression, anxiety disorders, including post-traumatic stress disorders, substance abuse, mental retardation, epilepsy, and management of somatisation in a primary health care facility. After training, the doctors should be able to diagnose the above-mentioned conditions and to formulate a treatment plan according to the bio-psychosocial model.

The training for nurses and midwives consisted of the same topics, but with less emphasis on biological treatment options and with more emphasis on basic principles of non-pharmacological mental health care management, empathic listening skills, and counselling techniques. After training, the participants should be able to identify the six priority conditions and to use basic counselling skills in their daily work and be able to advise and educate patients and families regarding mental disorders.

The training for village health volunteers and traditional birth attendants consisted of (1) some very basic knowledge of mental health and mental illness, (2) identification

in the community of persons with a possible mental problem, (3) follow-up of patients with a chronic mental illness, based upon instructions of the doctors and nurses from the basic health centres.

The developed Training of Trainers consists of a 8-week programme, and focused on both increasing the training capacity of the participants and increasing the basic knowledge about mental health. We developed the following course, consisting of 5 elements:

- attending a training course for doctors (2 weeks)
- a detailed study of the training curriculums of doctors, nurses, village health volunteers and traditional birth attendants (2 weeks)
- teaching methodology, preparing power point presentations, technical aspects of lecturing (1 week)
- a clinical training in a psychiatric training hospital in Pakistan (2 weeks)
- participation in the training for the different groups, under supervision (1 week)

Training methodology and materials

The training courses were initially given in English, with a series of handouts that together constituted a core text. This text was initially written in English, then translated into Pashto by two Afghan doctors on the mental health team. The courses for doctors and nurses consisted of 30 1.5 hour sessions centered around one topic. In the case of 'depression', a whole session was devoted to 'diagnosis'. In this session a diagnostic video was shown. A second session consisted of an explanation of the treatment options, with a video about the explanation of the treatment to a patient and family. In the third session practical skills about com-

municating with a depressed patient were demonstrated by role-plays or real patients. To illustrate the clinical picture of the discussed diseases we used clinical example: videos made by the mental health team, or real patients invited into the classroom. Part of the exposure to a clinical setting comprised excursions to a clinical shrine or a school for mentally retarded children. Teaching communication skills and counselling was primarily done by probing, role-plays and group work.

We used several techniques to make the audience more active: buzzgroups (short exercises during a lecture in which groups of two or three trainees are requested to discuss the answer to a question), role plays, and group discussions (see Jacques 2003). In creating teaching materials one can use the ground rules (Farrow 2003) that materials should

- Have an obvious and direct link with the presentation
- Be easy to understand
- Be made in a consistent style
- Highlight the important issues or pivotal points
- Be targeted at what the trainees are supposed to learn

Since our project was in the fortunate possession of a multimedia projector and a generator we could use Microsoft Powerpoint, but of course slides and an overhead projector or flip-over papers can be equally effective.

Books and brochures about mental disorders and epilepsy can be found in abundance in the bookshops of industrialized countries. In developing countries, information about mental disorders which is both up-to-date and relevant for the local context is often extremely hard to find. In the appendix we have listed resources that we found particularly helpful in developing our

training courses. Most of these materials are available from the Internet or can be ordered directly from the publisher.

Evaluation

We evaluated the satisfaction of the participants using a 3-item questionnaire after each session, in which the participants were asked to rate the quality of teaching, the relevance of the topic for their daily work and the degree of difficulty. The topics most highly valued were the modules for 'depression' and 'psychosis'. As reason the participants gave the relevance to their daily work and the availability of treatment options in the first line. Least valued were topics related to substance abuse and anxiety disorders. The reasons given for the low ratings were the difficulties in understanding the concepts of anxiety disorders, in particular post-traumatic stress disorder, and the difficulty of effectively treating substance abuse in a primary care setting.

The knowledge of the participants was evaluated with a multiple choice pre- and post test, and showed a significant increase. There is a clear need for more elaborate evaluations of project such as that described in this article, since physician training itself does not necessarily improve the nature of care itself (Cohen 2001). Documented evaluations of training programmes for primary care workers will help policy makers to develop an evidence-based mental health care policy. The mental health programme of HealthNet International is ongoing, and more data are being gathered. Further evaluations are expected to be carried out in the future when the project is more firmly established.

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Case history from Afghanistan: a depressed farmer

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Mr M is a twenty-six year old married farmer with eight children (two sons and daughters). He lives in the mountainous district of Achin in Nangarhar province, about 100 kilometers from Jalalabad city.

The disease started about a year ago while the patient was working on the land and noticed pain in the back of his body and then in other parts of body, waist, and arms. The complaints deteriorated. The patient described burning sensations in his hands and shoulders. Sometimes he had a tremor in his hand or feet. He felt 'heavy in the stomach' after a meal. He had sleep problems, felt weak and tired, had no appetite, had lost weight, and had no tendency to have sexual intercourse. He felt so sad that he could not work anymore and stayed at home. He had no pleasure in anything, and preferred to be quietly in his room. There was no clear provoking factor for the disease, no bereavement or conflict in the family.

At first he had seen a local doctor who prescribed him anti malarial medication which didn't help at all. After that he went to different doctors in Jalalabad and Peshawar (Pakistan, about 200 km away). He has done many lab tests, mostly with private practices in Peshawar, Pakistan. The patient showed us a large file of medical tests: six blood tests, four urine two stool tests, and seven abdominal, kidney and pelvic ultra sonography scans. All results were normal except once a moderately elevated SGPT. The patient has been prescribed a large variety of medications ranging from anti helminthics, painkillers, antibiotics and sedatives. The patient estimates that this has cost him more than 30.000 AF (626 USD), equaling about 6 month wages. He did not see any enduring improvement in his complaints.

In July 2003 the patient was seen by the village health volunteer in his community. This village health volunteer had received a two day training to identify possible mental cases in the community. The patient was referred to the Basic Health Centre (about 5 kilometers away). The doctor in the clinic diagnosed a major depression and depressed and prescribed amitriptiline 75mg, and diazepam 5mg. After taking the medication for two months the sleep has improved dramatically, the sadness became much less, and the body pains improved. The patient has been advised to do some easy tasks and gradually return to his former job. He is now working 'on therapeutical basis' in the shop of his brother in the village.

Hafizullah Faiz (medical doctor), and Peter Ventevogel (psychiatrist) work for the Mental Health Programme of Health Net International in Nangarhar Province, Afghanistan.

Appendix

Books and brochures about mental disorders and epilepsy can be found in abundance in bookshops of industrialized countries. In developing countries information about mental disorders that is both up-to-date and relevant for the local context is often extremely hard to find. We have listed resources that we found particularly helpful in developing our training courses. Most of these materials are available from the internet or can be ordered directly from the publisher.

Manuals for mental disorders in primary care

- The manual '*mental health for refugees*' (WHO 1996) contains chapters on mental disorders, stress and substance abuse, and can also be used outside refugee settings. The book can be accessed from the webpage of the WHO Department of Mental Health and Substance Dependence (www.who.int/mental_health/resources/publications/en/) which has more valuable publications.
- The Amsterdam based Transcultural Psychosocial Organization published adaptations of the book in Khmer ('*Community Mental Health in Cambodia*') and Tamil ('*Mental Health in the Tamil Community*').
For information: www.tpo.pom.org
- The Institute of Psychiatry in Rawalpindi has developed modules for a one-week training course for basic physicians (Mubbashar 1998). For enquiries: Rawalpindi General Hospital (phone 0092519290299).
- The WHO educational package '*mental disorders in primary care*' contains diagnostic flowcharts and checklists for primary care physicians and educational material for their patients. The set focuses on minor mental disorders: depression, anx-

xiety, alcohol use disorders, sleep problems, chronic tiredness and unexplained medical symptoms. The whole package can be downloaded at www.who.int/msa/mnh/ems/primacare/edukit

- Perhaps the best reader for primary care physicians and other health workers in low-income countries is Vikram Patel, *Where there is no psychiatrist* (to be ordered at Gaskell Publications: www.rcpsych.ac.uk/publications/gaskell/72_7.htm). This book is written in the style of the famous 'Where there is no Doctor' and describes clinical problems and treatment options in a non-jargon language.

Specialized topics

- For a more elaborate handbook the Oxford '*Psychiatry*' by M. Gelder, R. Mayou and J. Geddes (1998) is a good choice. This book is written for medical students and general practitioners in the UK. Though not written from a cross-cultural perspective it proved a very useful book in the Afghan context.
- The series '*ABC in psychological medicine*' in the British Medical Journal contains relevant articles about anxiety in medical patients, functional gastrointestinal disorders, and multiple chronic somatic complaints. The articles can be downloaded for free (bmj.bmjournals.com/cgi/collection/somatoform_disorders). All articles are collected in the book ABC of psychological medicine (Mayou et al. 2002).
- The American National Institute for Mental Health has a series of patients' educational materials with brief information in clear easy language, which make them of use for training health workers. (www.nimh.nih.gov/practitioners/pat-info.cfm)
- Downloadable, concise and up-to-date

information about epilepsy and its treatment can be found at the websites of National Institute of Neurological Disorders and Stroke in the USA (www.ninds.nih.gov/health_and_medical/disorders/epilepsy.htm) and Epilepsy Action in the UK (www.epilepsy.org.uk/info/medical.html). The book *'Epilepsy. A manual for medical and clinical officers in Africa'* by Dekker (2002) can be downloaded from www.who.int/mental_health/resources/publications/en/

- For information about counselling we refer to *'Training counsellors in areas armed conflict within a community approach'* (Van der Veer 2003) which is a practical manual with elements to be included in a training for psychosocial counselling. The book can be ordered at www.pharos.nl.
- Guidelines for training programmes for mental health and psychosocial interventions for trauma-exposed populations have been formulated by the International Society for Traumatic Stress Studies (Weine et al. 2002, available at www.istss.org/terrorism/guidelines_for_trauma_training.htm) and a group of Dutch organisations (available at the website of the Netherlands Institute for Care and Welfare: http://websrv1.nizw.nl/nizwic/_Werkdos/publications/guidelines.htm).
- Guidelines for development of mental health care development and training in the acute aftermath of disaster can be found in the WHO document *'Mental Health in Emergencies: Mental and Social Aspects of Health of Populations Exposed to Extreme Stressors'* (available in English and Arabic at the WHO website: www.who.int/mental_health/resources/publications/en/#catastrophe)
- The Refugee Studies Centre in Oxford

(UK) offers a 30-hours psychosocial training module to facilitate the training of humanitarian assistance workers in response to the psychosocial needs of refugees. The course can be ordered at www.forcedmigration.org/rfgexp.

Training methodology

- The British Medical Journal has recently published a collection of articles on medical teaching: www.bmj.bmjournals.com/cgi/collection/teaching. The articles about *'creating teaching materials'* (Farrow 2003), *'teaching small groups'* (Jacques 2003), *'teaching large groups'* (Cantillon 2003), *'curriculum design'* (Prideaux 2003), and *'evaluation'* (Morrison 2003) proved to be useful during our Training of Trainers sessions.
- For training of community health workers, traditional birth attendants and community leaders, the classical *Helping Health Workers Learn* by David Werner and Bill Bower (1995) is a great resource. This book contains methods and experiences from a wide variety of countries and suggests activities for community education such as theatre, drawing, flannel boards, and other low-cost, popular teaching aids. The book can be ordered at the website of the publisher, the Hesperian Foundation (www.hesperian.org/index.htm).

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