“WE ARE DROWNING”

MENTAL HEALTH AND PSYCHOLOGICAL NEEDS STUDY IN THE FOUR EASTERN PROVINCES OF KUNAR, LAGHMAN, NANGARHAR AND NURISTAN

Première Urgence - Aide Médicale Internationale
Sarah van der Walt
February 2022
The four provinces of the study are,
1. Nangarhar
2. Laghman
3. Kunar
4. Nooristan (Nuristan)
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<td>Action against Hunger</td>
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<td>American Psychology Association</td>
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<td>Afghan Symptoms Checklist</td>
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Executive summary

The mental health and psychosocial support research outlines the existing mental health and psychosocial wellbeing needs, obstacles in accessing Mental Health Psychosocial Support (MHPSS) and provides recommendations in the four provinces of Eastern Afghanistan, Kunar, Nuristan, Nangarhar, Laghman. The research also assessed how are mental health problems and psychosocial distress experienced and addressed these communities.

Both qualitative and quantitative tools were used in the research; as the data was gathered using Key Informant Interviews (KII), focus group discussions, Survey and a Health Care Questionnaire and Survey. The KIIIs took place with both key stakeholders as well as community leaders, in total there were 20 KII, 40 focus groups with adolescents and adults, 26 focus groups with children, and 17 health care assessment and 1522 respondents for the survey.

The findings of the research reiterate the importance of taking into consideration the lived experiences of those living in Afghanistan. Where the day to day living of people is stressful and contribute to the overall wellbeing of people. Supporting the findings in the literature cultural and social understandings shape how mental health problems and psychosocial distress are described and identified.

Stressors as identified by the population were similar across area, gender and age. The top stress factors, of the surveyed population were, first, poor living conditions (53%), followed by war (25%), no job (25%) closely followed by violence, conflict and killings (24%), money problems (21%) and explosive devices/bombs (17%). This was reiterated in the focus group discussions and the key informant interviews with women being stressed due to the living conditions, no job, poverty, the insecurity and violence in the community. Men were stressed due to the disunity in the community, poverty, unemployment, living condition, family problems (domestic violence), poor economy, helth problems and violence in the community. In turn children sad and scared because of the violence, insecurity, fighting in the homes and the community, poor living conditions, not meeting their basic needs and not feeling safe at home. When asked to draw what made them scared, children from all areas in Kunar and semiurban Laghman mostly drew something relating to violence and war, such as guns, bombs and insurgents.
Anxiety and depression as well as trauma symptoms appeared to impact the respondents the most with respondents reporting difficulty in coping with daily stressors and being unable to continue with daily tasks. Women scored above men on all the symptoms of the WHO-UNHCR (2012) Assessment Schedule of Serious Symptoms in Humanitarian Settings (WHO and UNHCR WASSS). However, the same symptom was scored the highest for females (75%) and males (63%), being unable to carry out essential activities for daily living because of feelings of fear, anger, fatigue, disinterest, hopelessness and/or upset most or all of the time in the last two weeks before participating in the study.

Using the Afghan Symptoms Checklist (ASCL) males, across the four provinces reported that on average, over three or four days a week in the last two weeks, they have shown symptoms of distress such as they thought too much, felt sad and had headaches. While females, in turn, experience slightly more symptoms of distress. On average, women show the following symptoms of distress between three and four days a week: feeling sad, headaches, thinking too much, becoming jigar khun, trouble remembering things, asabi, loss of appetite, insomnia, feeling hopeless, crying, and/or intrusive, unwanted memories.

Similarly symptoms of mental health problems and distress in the focus group discussions and key informant interviews were described as “sleeping, thinking too much, shying away from the community, bad behavior, not normal mentally, being flurried, look yellow, being tired, thinking negatively, weakness of the mind, tension and heart beating, anger and impatience”.

Coping and support were internal in the community with women, men and children all finding support either through community leaders, spiritual leaders, elders in the community and family and relatives. In addition, the family and the community leaders are most often the way in which people provided support and resolved problems in the community.

Faith was a dominant form of coping based on the perception of key informants for people with mental health disorders making amulets, recitation of the holy Qaran and going to the shrines to pray for help. This was mentioned in Nuristan, remote and semiurban areas, Laghman areas, and semiurban and semiurban and urban areas in Nangarhar. However this was not cited by Kunar key informant respondents. It was noted in the focus group discussions and the key informant interviews that accessing health services and centres were difficult, either due to
distance, safety and/or road damage. In some cases the key informants mentioned they and the community do not know how to assist rape survivors, people with mental health problems, family problems and drinking and drug problems and did not know who to go to for help.

Gender Based Violence (GBV), Sexual Gender Based Violence (SGBV) and family problems (domestic violence) are taboos in the community with some key informants requesting to not answer these questions or declaring these problems don’t exist in the community. Those who did respond to these questions mostly said how these would be resolved in the community. The rape survivor would experience shame in the community and some would commit suicide. Many in the community would isolate these people due to their bad character. While domestic violence was a private matter, which was resolved either by family elders or community leaders.

From the health care assessment, it appears as if doctors, midwives, nurses are well trained in core support and response to mental health disorders and distress. However, they did not appear to have received much training in bereavement support.

The findings point to the need for a community response to ensure the success of humanitarian interventions and mental health and psychosocial support interventions. Community and family support were the main ways in which different genders and ages coped with the distress and mental health symptoms. While this could promote the resiliency and long-term coping, it can also perpetuate harmful practices. Also, it was important to acknowledge how the community and family responded to people’s distress such as rape, disabilities and mental health symptoms had a direct impact on either promoting recovery or increasing distress. Identification of positive and negative coping mechanisms could be included in needs assessments and through the development of relationships with community leaders such as elders, spiritual leaders and health shuras. Positive coping mechanisms should be encouraged while negative coping mechanisms can be addressed through psychoeducation and psychoawareness campaigns.

The recommendations follow the Interagency Standing Committee (IASC) intervention Pyramid for mental health and psychosocial support in emergencies.
Recommendations

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<td>Culturally relevant approaches following the principles of value-based counseling (Missmahl, 2018)</td>
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Section 1: Introduction

Living conditions in Afghanistan have been eroded by years of war and disaster, with the consequences of the crisis limiting civilians’ ability to meet their needs and improve their quality of life. Further, the constant exposure to conflict, in combination with poor living conditions and daily frustrations, has resulted in many Afghan people suffering from mental health and psychosocial issues (National Editorial, 2019). The number of Afghans suffering from mental health issues still needs to be identified, as well as the barriers they face to accessing adequate services (United Nations Office for the Coordination of Humanitarian Affairs, 2020).

Objectives

1. To understand the condition of mental health in communities in four eastern provinces of Afghanistan - Kunar, Nangarhar, Laghman and Nuristan;
2. To better understand the main challenges communities face in accessing high quality MHPSS services; and
3. To provide recommendations on the most suitable and relevant interventions in the mental health sector.

Section 2: Methodology

The research used a mixed-methods approach: data was gathered using qualitative KII, Focus Group Discussions and a Health Care Questionnaire, as well as a quantitative Survey. These tools were finalised using:

- Ken Miller’s 2005 Afghan Symptoms Checklist, and
Survey tools

When the study was first designed, the WHO-UNHCR (2012) Assessment Schedule of Serious Symptoms in Humanitarian Settings (WASSS) questionnaire was to be used as the survey tool. The WASSS is designed to measure needs at a household level; but, due to the instability and insecurity of the context, the survey was conducted with beneficiaries at the PU-AMI project locations. Some questions had to be excluded in order to protect the confidentiality of beneficiaries; therefore, the research team could not ensure that beneficiaries were from the same household.

Additionally, from the key informant interviews and the literature review, to understand mental health conditions and psychosocial needs in Afghanistan, one must take into consideration the cultural and social nuances. The research team recognized that Western concepts and measurements of mental health and psychosocial wellbeing capture core human psychological responses, but do not always adequately capture culturally specific indicators and idioms of distress, which are often more disruptive to the wellbeing and daily lives of individuals and communities (Miller et al., 2005). To address this gap and consider the full cultural and social context of wellbeing and mental health, the research tools were adapted to incorporate the ASCL and Bragin et al.’s (2021) categories of wellbeing into the survey questions. Meetings were hosted with the authors of these tools and study, who granted permission to use them.

Qualitative tools

Focus group discussions with adults and adolescents were based upon the WHO and UNHCR (2012), Participatory Assessment: Perceptions by General Community Members with additional questions about whether adolescents were attending school and how they perceived the future. These questions were designed to better understand the perceived problems and coping strategies in the communities. Questions on the future were asked to identify if people were hopeful and if they could envision themselves in a different space and time other than the present.

Focus groups were done with children, asking them to draw what made them feel unsafe, sad, sacred and happy. Facilitators asked if the children could explain what made them choose these
different things. To find out the different types of support and how these children typically cope with feeling scared, we asked them to tell us who they go to for help.

Key informant interviews were based upon the WHO and UNHCR (2012) Participatory assessment: Perceptions by community members with in-depth knowledge of the community. This tool allows a deeper understanding of the local perspectives on problems, symptoms of distress and how communities cope with problems.

Checklist for integrating mental health in primary health care (PHC) in humanitarian settings (WHO and UNHCR, 2012) was used in health centers, across the four centers, to identify what mental health conditions were being treated, the capacity of staff to respond to the needs of beneficiaries as well as identifying what are the barriers to providing MHPSS.

Study ethics
Permission was granted by the Afghanistan’s Ministry of Public Health Institutional Review Board to conduct the study, after review of the project research proposal. Before implementing the study, the project team met with the Public Health Directorate of each of the four provinces, and received permission to conduct the study in each of the locations. The Directorate’s Letter of Permission was provided to each health center prior to the start of the fieldwork.

Research team
Two local Research Assistants were hired at the beginning of November 2021; each supervised two provinces. For the field work, there were a total of 80 Numerators, with 16 Numerators in each province. The Field Numerators lived in the respective provinces of the study and were identified through either local NGO partnership or PU-AMI community liaisons. The numerators worked in male and female pairs to ensure that females interviewees were interviewed by female numerators, while ensuring the project abided by the local custom of having a male chaperone with women.

Each research team received a three-to-five-day training, with an introduction to mental health and psychosocial support, the research methodology and approach of the study, and research
ethics, such as consent and confidentiality. Included in the training were PFA principles and how to identify and refer someone in distress. Standard Operation Procedures were developed and shared with the numerators, to use when collecting data. To ensure adherence to the research methodology, weekly supervision sessions were hosted by the Research Assistants. Any issues were reported to the Research Lead who, with the Research Assistants and Project Team, resolved any challenges.

Identification of participants

The study sample size was calculated using a representative sample with a 5% margin of error and a confidence level of 95%. Due to the environmental and security constraints the study used a convenient sample where participants were conveniently identified at pre-selected health facilities, to compare urban, semi urban and remote experiences. The selection criteria were designed to reach a representative sample of gender, age and location. Initially, the selection criteria included ethnic representation; however, experience from previous studies has shown that this criterion could put the Numerators and Beneficiaries at-risk, so it was not used. The KII included local Shura (community members who form a community council), community leaders and health centers staff. Focus groups will also include Shura members as well as local members of the community who are accessing the health facilities.

Table 1. Survey sample calculations

<table>
<thead>
<tr>
<th>Location</th>
<th>Population total</th>
<th>5% margin of error</th>
<th>95% confidence level</th>
<th>Female</th>
<th>Males</th>
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<td>234,753</td>
<td>384</td>
<td>188</td>
<td>198</td>
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<td>Laghman</td>
<td>249,505</td>
<td>385</td>
<td>189</td>
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<tr>
<td>Nangarhar</td>
<td>544,717</td>
<td>386</td>
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<tr>
<td>Nuristan</td>
<td>15,547</td>
<td>375</td>
<td>188</td>
<td>198</td>
<td></td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>1,044,522</strong></td>
<td><strong>1530</strong></td>
<td><strong>748</strong></td>
<td><strong>785</strong></td>
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Limitations
The study took place during a major event in the history of Afghanistan, the withdrawal of international troops and the return of the Taliban to power and that impeded the macroeconomic collapse coupled with a rapidly aggravating humanitarian crisis. In addition, with the upcoming winter and the current drought people’s ability to meet their daily needs are hindered. While this is a stressful context for anyone, this study was a snapshot of a moment in time in Afghanistan and not only shows peoples levels of stressors, but also their resiliency.

Gender considerations were taken in the study to ensure that there were women in the research team as well as an equal representative sample. Even though the study reached this goal in the survey respondents, for the focus group participants and key informant interviews with community leaders it was difficult to find women who were able to participate.

Section 3: Background and context

Historical and geopolitical background
Two features underlie the experience of those living in Afghanistan. The first is the development of cultural and social norms based upon longstanding traditional beliefs and religion. The second is war, conflict, and violence. Both these features have historically been present in the country and have shaped almost all aspects of Afghan lives.

Afghanistan is one of the oldest societies and was part of the highly sought-after Silk Route. 330 – 327 BC Alexander conquered this region and the following decades were a chain of multiple conquests and divisions between Islamic rulers, Mongols, the Mughals of Northern India and the Iranian Safavid Dynasty (Library of Congress, 2008). From 1747 until 1978, the Pashtun ethnic group maintained power through a succession of Pashtun leaders (Library of Congress, 2008).

It is important to acknowledge these years of history within the wider geopolitical positioning of Afghanistan. Iran and Pakistan continue to assert their influence within the country, both directly and indirectly, as well as providing refuge for Afghans during the multiple years of war (Library of Congress, 2008).
While these close neighbours, Iran and Pakistan continue to maintain influence, Afghanistan has also been greatly influenced by other political powers further afield, such as the United Kingdom (UK), Russia and the United States of America (USA) (source: Britannica). The period of 19th Century and the beginning of the 20th Century was a period characterized as the “Great Game” as the British and Russian Empire engaged in political and diplomatic rivalry over Afghanistan and other areas in central Asia. (source: Library of Congress). This period came to an end with the 1907 Anglo-Russian Convention in Saint Petersburg and the 1911 Treaty of Rawalpindi. The 1907 Anglo-Russian Convention demarcated the Britain and Russian Empire areas of influence within Afghanistan and the surrounding areas. This convention formed the current borders which continue to define Afghanistan and Central Asia relations. The next period was a succession of Afghan rulers which eventually led to the alignment of Afghanistan with the Soviet Union to protect themselves from the tensions with Pakistan (Nations Online, 2017). However in 1978 Communist factions in Afghanistan overthrew the then president, Mohammad Daoud. What then followed was guerrilla warfare where the Soviet Union attempted to establish the principles of communism, which rejected religious beliefs and land ownership (PBS News Desk, 2021). Following a series of violence between the Russian communist regime and local warlords, Russia was defeated and the Taliban moved into power in response to the lawlessness caused by the civil war that erupted among different militia in 1992 (BBC, 2019).

The USA soon joined the fray, when the 2001 September 11th attacks by Al-Qaeda led to the invasion of Afghanistan by American troops. The American administration, under George W. Bush, united with anti-Taliban forces to begin a transitional leadership to establish a democratically elected government (BBC 2019). The subsequent years included years of violence, the return of warlords and continual, guerrilla-style attacks by the Taliban and al-Qaeda, resulting in high levels of insecurity, civilian causalities and compromised infrastructure development (Gobal, 2014).

A turn-around came at the beginning of 2020 under the so Called Doha Agreement began the peace talks between the Trump Administration and the Taliban which declared the withdrawal of American troops. The new US administration continued the peace talks and the renegotiation of the date that American troops would leave Afghanistan. During these developments, the
Taliban began a concise military take-over of Afghanistan, ending with the overthrow of Kabul. Since August 2021, the Taliban have established themselves as the Afghan government and attempted to appease the international community while maintaining their values and beliefs (World bank, 2021). Pressure has been placed on the Taliban to abide by human rights norms, as development funds have been withheld, mostly at the cost of civilians’ livelihoods and wellbeing. Following these devastating economic, political and social developments, the value of Afghani currency has dropped drastically; medical supplies are non-existent; and winter grips the heart of the country (World Bank, 2021).

Cultural norms

Centuries of Pashtun rule transformed Afghanistan’s societal and cultural beliefs, which continue to shape the social, political and cultural lives of people living in Afghanistan, even though there have been multiple attempts to counter these narratives. These cultural and social norms have been one of the main factors shaping the understanding of mental health and psychosocial wellbeing of people living in Afghanistan (Bragin et al., 2018, Ventevogel and Faiz, 2018 and Eggerman and Panter-Brick, 2010). As women’s lives have been restricted to their homes and girl children are valued differently than boy children, boy children continue the lineage of their families and are responsible for bringing in income. Men are expected to be the sole providers of their households and are expected to yield power over their homes and control all aspects of their families (Echavez et al., 2016).

Violence and conflict in Afghanistan

Afghanistan has been shaped and defined by multiple years of violence and war that have, through the centuries, formed its society. The last four decades in Afghanistan have been characterised by direct violence and war and not one generation has lived without war and conflict present in the country.

The invasion of the Soviet Union involved multiple massacres, which remain unaccounted for and the targeting of Afghan traditions and beliefs. The American takeover in 2001, direct
fighting continued through 2021, and when the USA withdrew, the Taliban once again took control of Afghanistan. While violence and conflict appear to have reduced in prevalence in the aftermath of the Taliban taking control, the socio-economic situation rapidly deteriorated, with humanitarian consequences as the country entered the winter of 2021/2022 (OCHA, 2022). The continual war has devastated the country’s social, economic and cultural infrastructure.

The National Mental Health Survey in 2018 found that 66% of Afghan’s had experienced, personally, at least one traumatic event and 77% witnessed a traumatic event. (2018:8). In addition, Afghanistan is also recognised as a trauma state stuck in a cycle of war and trauma, as war results in trauma, which drives more war, which in turn results in more trauma (Goepner, 2018). Social attitudes, beliefs, and behaviour shaped by war and its impact contribute to the continual violence and aggression that colour daily living, in combination with the daily stressors of a poor economy, poor living conditions, and inability to meet needs.

While one is tempted to focus primarily on the impact of war and conflict, which have shaped the political, economic and social landscape of Afghanistan and its prevalence of traumatic events, it is important to acknowledge the impact of everyday forms of suffering, violence and adversity within Afghanistan (Panter-Brick et al., 2009). As was found throughout the literature, many studies showed that daily stresses overlapped with war trauma to everyday violence such as physical and social stressors which negatively impacted the social fabric, access to basic needs, safety and security.

Section 4: Understanding Mental Health and Psychosocial wellbeing in Afghanistan

Defining mental health and psychosocial wellbeing

Mental health, as defined by the World Health Organisation (WHO) (2018), is a state of wellbeing where the individual can “realise their own abilities and can cope with the normal stresses of life, can work productively and is able to make a contribution to their community.” This is further supported by acknowledging that mental health is more than the absence of
mental health disorders or disabilities but a state of “complete physical, mental and social wellbeing” (WHO: 2018). The American Psychology Association (APA, 2020) definition of mental health includes these different aspects but takes it a step further, with the addition of emotional wellbeing, freedom from anxiety and disabling symptoms, and the ability to create constructive relationships.

*Psychosocial* refers more distinctly to the interaction of the social, cultural and environmental factors which shape and influence the mind and behaviour (APA, 2020). By compounding mental health with psychosocial wellbeing, mental health becomes more than a medical response but includes an ecological approach that defines the individual within a wider system of the social, economic and political environment. The IASC (2007) reiterates this; they define mental health and psychosocial support as any local or outside support to promote psychosocial wellbeing and/or prevent mental disorders.

The study of mental health and psychosocial wellbeing is vital in conflict settings as it recognises both the physiological conditions and factors and how wider social, political, and cultural factors combine to affect the ability of individuals and communities to cope with stresses and contribute to society.

**Mental health and psychosocial wellbeing in Afghanistan**

Key to understanding mental health and psychosocial wellbeing in Afghanistan is the position of the individual and the community within a wider context of historical violence, structural violence, cultural violence, individual and collective suffering and cultural beliefs and norms (Library of Congress, 2017).

Islamic culture and beliefs govern the way of life in Afghanistan; undermining these values and practices has been one of the main reasons foreign powers have failed to maintain their control in Afghanistan. Even though there are different sects of Islam, the foundation of Islamic beliefs and the religion’s conceptualisation of wellbeing is based on the Quran (Mohsen, 2012). Fundamental to Islam is the position of religion and spirituality in a person’s psyche, as one is born with a natural faith in God and the worship and serving of God is the sole purpose of one’s
existence and from this flows a happy life. Key to the conceptualisation of wellbeing in the Quran is obedience to the teachings and avoidance of sin, while focusing on the life hereafter (Eryilmaz and Kula, 2020). Central to the mental wellbeing of individuals is harmony between the individual and society; Islam promotes a collectivist society with each individual self as part of the community (Mohsen, 2012). Gratitude to God (shukr) and faith (iman) in God are central to wellbeing and life, with God being the provider of mental and physical health as well as consciousness (Pasha-Zaidi, 2021). During times of suffering and adversity, one accepts that it has occurred in accordance with God’s will.

Religious values and beliefs are central to the conceptualisation of wellbeing and giving meaning to adverse events (Ventevogel et al., 2013). These can be articulated in expressions of acceptance that God’s will shape all aspects of life and is ultimately beyond the control of the individual (Ventevogel et al, 2013; Eggerman and Panter-Brick, 2010). As one’s way of life is organised to the premise of Islamic values, beliefs and traditions, one needs to understand how this is used to address mental health and psychosocial problems.

The conceptualisation of mental health and psychosocial wellbeing in Afghanistan is a combination of Islamic traditions, beliefs and values, as well as cultural concepts and practices which often manifest in idioms. Idioms of distress are an attempt to understand or resolve a pathological symptom in a way that pays tribute to the surrounding culture; in many cases, this can include somatic complaints, spirit possession and culture-specific meanings (Bragin et al., 2021). Research by Miller et al. (2006) and Panter-Brick et al. (2006) concluded that, in Afghanistan, there are three ways psychosocial distress is explained. The three ways are categorised as,

1. biological mental disorders;
2. distress caused by djinns, spirits who take over a person’s mind and body for either good or ill; and
3. distress from adverse life experiences, including war, poverty, and violence (Miller et al., 2006).

In turn, treatment for mental health and psychosocial distress echoes these categories. A study by Alemi et al. (2018) on help seeking behaviour emphasised this; 30% of respondents went to
traditional healers, mental health professionals and primary care physicians, 21% sought help from family and friends and prayer and reciting the Quran, and 17% sought help from Imams.

One of the key findings from a school-based study in Afghanistan, which included caregivers and students, was the description of psychological distress (Eggerman & Panter-Brick., 2010). Idioms used were specific to the experience of distress within the body and differentiated between anger, stress, melancholy and anxiety.

Table 2. Idioms of distress as found by Eggerman & Panter-Brick 2010:75

<table>
<thead>
<tr>
<th>Cultural terms</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>Takleef asabi: disorder of the nerves</td>
<td>indicated irritability and anger</td>
</tr>
<tr>
<td>fishar payin/fishar bala: low/high pressure</td>
<td>described lethargy and agitation as well as blood pressure</td>
</tr>
<tr>
<td>Jighar khun: liver-blood – sorrow, regret, depression</td>
<td>referred to a state of acute dysphoria, often due to losing relatives as a result of war</td>
</tr>
<tr>
<td>tashwish</td>
<td>denoted everyday worry</td>
</tr>
<tr>
<td>delam naram hast</td>
<td>my heart is noisy</td>
</tr>
<tr>
<td>delam az-zindagi sard shoda hast</td>
<td>my heart has become cold from life</td>
</tr>
<tr>
<td>sharmandeh</td>
<td>tied to feelings of embarrassment</td>
</tr>
<tr>
<td>‘izzat</td>
<td>loss of honour</td>
</tr>
<tr>
<td>na`amedy</td>
<td>frustration</td>
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These findings support the notion that the body responds to trauma, psychosocial distress, and overall mental health. They are key to understanding mental health and psychosocial distress in Afghanistan and how it is expressed.

The Miller et al. (2006) study also sought to identify culturally relevant notions of distress and how to measure these within Afghanistan. This study led to the conclusion of the Afghan Symptoms Checklist, which identifies cultural terms detailing symptoms of distress. These symptoms can be categorised as relationships with others, psychosomatic symptoms and
emotions. Miller et al. (2006) simplified these symptoms into three factors reflecting the cultural expression of distress:

- Factor 1, Sadness with Social Withdrawal and Somatic Distress,
- Factor 2, Ruminative sadness without social withdrawal or somatic distress, and
- Factor 3, Stress induced reactivity.

A recent study by Bragin et al. (2021) identified categories of wellbeing for both men and women from four of seven regions in Afghanistan. The findings revealed categories of wellbeing which followed biological, psychological, social, and spiritual domains (Bragin et al., 2021: 10 -12).

Table 3. Domains and indicators of well-being across genders

<table>
<thead>
<tr>
<th>Women</th>
<th>Men</th>
</tr>
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<tbody>
<tr>
<td>Peace, security, justice</td>
<td>Peace, security, justice</td>
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<tr>
<td>Love/Support in the family</td>
<td>Economic security/Ability to provide for family</td>
</tr>
<tr>
<td>Freedom</td>
<td>Strong family relations support</td>
</tr>
<tr>
<td>Physical health</td>
<td>Independent power and authority</td>
</tr>
<tr>
<td>Economic security/access to resources</td>
<td>Friendship/solidarity outside family</td>
</tr>
<tr>
<td>Participation in cultural/religious practices</td>
<td>Religious observance</td>
</tr>
<tr>
<td>Friendship/support outside the family</td>
<td>Successful fulfilment of obligations</td>
</tr>
<tr>
<td>Self-efficacy/self-esteem</td>
<td>Leisure activities</td>
</tr>
<tr>
<td>Leisure activities or time to enjoy living</td>
<td>Participation in cultural practices</td>
</tr>
<tr>
<td></td>
<td>Personal Capabilities and attributes</td>
</tr>
</tbody>
</table>

MHPSS services

After the downfall of the Taliban in 2001, healthcare services were contracted out to NGOS by the government and international donors (Day: 2020). During this period, the need for MHPSS services were emphasised in statistics, which highlighted the mental health and psychosocial impacts of the previous years of conflict on the wellbeing of Afghans, especially women. Within Afghanistan, the provision of MHPSS services and care has been a gradual
development, beginning with the creation of strategic priorities in 2003 and the first regularly updated Mental Health Strategy from 2005 to 2009 (MoPH, 2005). This was followed by the establishment of the National Mental Health Programme in 2011. The foci of both the Mental Health Strategy and National Mental Health Programme are the integration of MHPSS into the healthcare system, awareness raising and referral through community health workers, and equipping health staff with trainings. The Mental Health Strategy 2019 – 2023 has the following strategic goals (MoPH, 2018: 12);

1. Improving governance and effective leadership.
2. Increasing access to basic packages of health service (BPHS) and essential packages of health service, including quality mental health and psychosocial services.
3. Human resource development and strengthening institutional training capacities.
4. Strengthening mental health promotion and capacity around prevention of mental disorders and suicide.
5. Strengthening emergency mental health interventions and psychological first aid (PFA) support.

Access and services available

In 2019, MoPH data showed that the integration of mental health and psychosocial support into the health care system has expanded to include health posts providing BPHS and EPHS as well as mobile teams and sub-centres providing PFA and basic psychosocial counselling. The expansions have resulted in:

- 19000 health posts and 38000 community health workers (CHWs) providing awareness, referral, and identification of mental health cases;
- 198 Mobile Health Teams and 807 sub-centres providing basic intervention;
- 830 Basic Health Centres providing basic counselling and medical treatment of mental disorders/problems;
- 430 comprehensive health centres providing advanced counselling with medical treatment of mental disorders;
- 83 district hospitals providing bio-psychosocial treatment of mental disorders;
- 27 provincial hospitals providing medical and psychosocial treatment with short-stay hospitalisation; and
Recent developments have seen changes in the governance and administration of health services. Whether these developments change the current local approach to mental health and psychosocial support remains to be seen. However, the integration of mental health into health services and the establishment of a community-based approach to mental health and psychosocial needs does take some of Afghanistan’s most pressing public health challenges into consideration.

**Challenges to MHPSS services**

One of the major difficulties Afghans face in accessing MHPSS is related to the district and level of security (Berdondini et al., 2019, Kovess-Masfety et al., 2021; International Medical Corps, 2021). Within Afghanistan, there are clear discrepancies in equitable access to care across rural and dangerous areas (IMC, 2021). The mental health needs and demands of rural and semi urban areas are often not met because Afghanistan’s mental health system is hospital-based, (Human Rights Watch, 2019). Kovess-Masfety et al. (2021) found that those who lived in highly dangerous areas had less available access to care.

The two most cited barriers to accessing MHPSS in Afghanistan are (1) knowledge and understanding of mental health and psychosocial wellbeing and (2) availability of services (Ayubi & Noori, 2018). This is highlighted by Dr Rohullah Amain who, after working with the youth of Afghanistan, realised that there is limited knowledge on mental health and psychosocial problems – many youths were confused by these problems; they did not know what to ask or where to go for the answers (Ayubi & Noori, 2018). This was reiterated in a study by Allan et al. (2018), which found that a lack of understanding of mental health issues makes it difficult for individuals to access the appropriate treatment. In turn, the Afghanistan Protection Cluster (2021) stated that 77% of children who needed psychological support services were not able to access them due to a lack of information. IMC (2021) also found that key stakeholders identified lack of awareness and knowledge of mental health problems,
combined with lack of facilities and services, as challenges to access. This can be twofold: local communities may have limited understanding, but the medical and international community using diagnostic psychotherapy and Western psychotherapeutic methods also often do not match local cultural beliefs, perceptions and symptoms of depression, fear and anxiety (Missmahle, 2018).

Another factor limiting access is gender: culturally and socially, women are not allowed to move unchaperoned, but must have either a male relative (Maharaam) or a female relative with them outside the house (Samuel Hall 2016; Berdondini et al., 2019; Allan et al., 2018). One health worker specifically noted this, mentioning, “Patriarchy and families that do not allow women to go to counselling centres” as a barrier to mental health care access (Berdondini et al., 2019). Other barriers to accessing overall health services for women include financial restraints, encountering community-based violence or armed conflict, not having access to mobile phones, and strict religious rules and observations (Tomlinson et al., 2020). Samuel Hall (2016) quantified this with the following statistic: one in 10 female youth in Kabul lacks sufficient support to be able to access medical treatment.

Contributing to this is limited trust towards confidentially within Afghan culture, where mental health is still highly stigmatised and women have limited ability to speak freely without a chaperone (Berdondini et al., 2019). The stigma of mental health has far-reaching consequences in Afghanistan, which prevent those who have mental health problems from seeking support, Afghan society from acknowledging mental health and psychosocial problems, and local leaders and decision makers from addressing the need (Samuel Hall, 2016).

While there have been attempts to integrate mental health care into the health system, one of the most challenging hurdles to overcome is the lack of mental health trainings for medical staff, followed by lack of knowledge by medical staff of psychotropic drugs and lack of space for mental health access (IMC, 2021 & Conseil Sante, 2018). The National Mental Health Survey and Assessment of Mental Health Services (Conseil Sante, 2018) found that 65% of Basic Health Care (BHC) had at least one member of staff trained in basic counselling, 71% of Comprehensive Health Clinics (CHC) had a person with advanced psychosocial training, and only 25% of community health workers had basic mental health training. The 2019 – 2023
National Mental Health Strategy (2019) also states that less than 10% of the population is even receiving available services.

Traumatic events and traumatic stress

It is tempting to emphasize the impact of war and violence and conflict on the people of Afghanistan by using Western concepts, such as trauma and post-traumatic stress disorder; however, it is important to recognize the ongoing social, political and economic impact of conflict and subsequent everyday violence. Western concepts don’t address ongoing trauma that is embedded in the day to day living of people, rather situating the traumatic event in the past and not an ongoing experience. Other concepts such as intergenerational trauma, continuous trauma, collective trauma and historical trauma would be more adept at describing the experience of those living in Afghanistan.

Focusing on continuous trauma as a concept that could be used to frame the lived experience of those living Afghanistan. Continuous trauma is a term used to recognize that trauma exposure can happen simultaneously where it is happening in the present and can be anticipated in the future as opposed to the idea that trauma is an experience assigned to past (Eagle and Kaminer, 2013). Characteristics of continuous trauma is “faceless” and unpredictable, pervasive, and substantive (Eagle and Kaminer, 2013). From the literature and the data findings war, conflict and killings were referred to as stressful events but so was the inability to meet basic need, the uncertainty of the social, political and economic situation as well as the high rates of violence such as domestic and collective violence.

Among studies that mapped the number of traumatic events experienced by study subjects, one study on children’s mental health, psychosocial wellbeing, and resilience found that 39% of children had been exposed to a war-related event (Ventevogel et al., 2013). Another study done in Nangarhar stated that, over the last 10 years, 44% of respondents had experienced between 8 and 10 traumatic events and another 14% experienced 11 or more (Scholte et al., 2004). The National Survey on Depressive and Anxiety Disorders in Afghanistan (Kovess-Masfety et al.; 2021) found 65% of the Afghan population had experienced at least one traumatic event and 78% had witnessed one such event. In addition, 61% of the sample experienced collective
violence in relation to war and 49% reported four or more events. These numbers echo statistics in an earlier National Mental Health Survey and Assessment of Mental Health Services (2018), which found that 66% of respondents had personally experienced at least one traumatic event, while 77% had witnessed a traumatic event. In total, 85% had either personally experienced or witnessed a traumatic event. This is 15% higher than what was reported in a study across 24 Countries as 70% respondents reported a traumatic event and 30.5% were exposed to four or more (Benjet et al., 2016). These high rates of exposure to traumatic events are to be expected, considering that Afghan people have experienced 40 years of war.

Even with these high rates of exposure to traumatic events, studies highlighted that respondents personally recognised that the traumatic stress of everyday violence and inability to meet basic needs characterised their lives. As put by Bragin et al. (2018:199), “the distress experienced by the majority of those seeking mental health treatment is the result of very real problems of daily living rather than any biologically based mental illness.”

Kovess-Masfety et al. (2021), who also found high rates of exposure to traumatic events, determined that events associated with higher post-traumatic stress disorder (PTSD) symptoms scores correlated to having experienced lack of food or water, lack of shelter, torture, having to flee suddenly, loss of property, kidnapping, and being close to death. Alemi et al. (2018) echoed that mental health problems of Afghans are influenced by the broken economy and poor living conditions.

A study by Miller et al. (2008) also found a higher correlation of daily stressors as precursors to PTSD. The Humanitarian Needs Overview (HNO) 2022 (United Nations Office for the Coordination of Humanitarian Affairs, 2022) supports this by recognising that poverty, family issues and socio-economic stress decrease mental health and psychosocial wellbeing, adding that; “Poverty, family issues and conflict or violence were the some of the major causes of behaviour change related to mental health” (OCHA, 2022). It is tempting to see these daily stressors and everyday violence as separate to traumatic events; but they demonstrate that years of conflict and war have wider social, economic, political, and cultural impacts which directly affect mental health and psychosocial distress. One such way is how the internal resources of
individuals are lowered to face traumatic events and increases the vulnerability to developing trauma symptoms.

**Depression, Anxiety and Stress**

A recent MHPSS Needs Assessment by IMC (2021) in the four provinces of Balkh, Nangarhar, Laghman and Kunar found that depression, anxiety and stress were the most mentioned mental health conditions. This was confirmed by the HNO (OCHA, 2022), which reported that depression, anxiety and stress were the most prevalent mental health problems. HRW (2019) noted that more than half of the Afghan population have symptoms of Depression, Anxiety and Post-Traumatic Stress. Afghanistan in comparison to the global scale of mental health disorders falls above the global average with 3.4 % of the world population experiencing depression and 3.8% experiencing anxiety (Dattani et al., 2021). Other studies found a high correlation between exposure to traumatic events and depression and anxiety symptoms (Conseil Santé 2018; Scholte, Alemi et al. 2018).

In contrast to Post Traumatic Stress Disorder (PTSD), depression is easier to understand as a symptom of traumatic stress in Afghanistan (Ventevogel & Faiz, 2018). This was highlighted in the 2018 study, which found that depression was mostly associated to severe or multiple loss and expressed through different cultural terms: asabi (irritability), goshagiry (self-isolation), ghamgeen (sadness), and jigar khun (sadness following interpersonal loss). Kovess-Masfety et al. (2021) explain that trauma is so frequently experienced by the Afghan population that trauma related symptoms do not prompt people to seek mental health consultations. In comparison, sadness, loss of pleasure, and other depressive symptoms are considered abnormal, with 65% of respondents in the Kovess-Masfety et al study requested help for sadness and 27% for anxiety (2021)

Most studies noted a marked gendered difference in the prevalence of depression, anxiety and stress symptoms. Paiman et al., (2019), using a hospital-based sample, found that 73% of females and 57% of males scored positive for depression and anxiety on the self-reporting questionnaire. Another study found that the prevalence of depression symptoms increased with
more exposure to trauma: among women who had no exposure to trauma, 12% reported depression; while among those with one trauma exposure, 16% reported depression; and of women who had between two and four trauma exposures, 17% reported depression (Jewkes et al., 2018). In a sample from Nangarhar, depression symptoms were prevalent among 16% of men and 58% of women; anxiety symptoms were prevalent among 22% of men and 78% of women; and the Harvard Trauma Questionnaire identified PTSD symptoms in 8% of men and 32% of women (Scholte, 2004). Explanations of the differences between men and women’s mental health include the social and political restrictions the patriarchal society places on women, normalisation of GBV and domestic violence, limited rights, the high burden of caring for their families, early and forced marriage, and current political uncertainty (CARE, 2020; Protection Working Group, 2021; OCHA 2022). In turn it is important to note the gendered differences of depression symptoms and how measurement scales could potentially ignore these differences.

Other mental health and psychosocial distress

While depression, anxiety, and stress were the most mentioned mental health concerns in the studies above, other mental health disorders were also highlighted in the literature. Respondents from a recent IMC MHPSS needs and assessment study (2021), in the eastern provinces of Nangarhar, Laghman and Kunar and the northern province of Balkh, listed the following as mental health problems and distress: psychosis, the use of narcotic drugs, epilepsy, personality disorder, excessive anger, obsessive-compulsive disorder (OCD), general anxiety disorder (GAD), attention deficit hyperactivity disorder (ADHD) and loss of concentration issues, conversion disorder, sleeping disorder, grief, loss psychosomatic symptoms, suicide, and self-harm. Suicide often goes unacknowledged or reported in Afghanistan, due to social, cultural and religious taboos; however, recent studies show that there are cases of self-immolation, suicide, suicidal ideation, and self-harm (Thambu et al., Kovess-Masfety et al., 2021; Jenevieve et al., 2018). Multiple studies done in Afghanistan found emotional distress, anger problems, feeling unhappy, feeling afraid and losing interest in daily activities were also acknowledged as mental health and psychosocial problems (Bragin et al., 2021; Samuel ; IMC, 2021; Allan et al., 2018; IMC 2021). Although these symptoms might not necessarily include
clinically significant disorders, they still speak to high levels of psychosocial distress and the general wellbeing of those living in Afghanistan.

This was reiterated in the National Mental Health Survey (2018) which identified that 50% of Afghans are suffering from psychological distress and that 20% reported being impaired because of mental health problems. The Afghanistan Protection Analysis Update October 2021 (Protection working Group, 2021) found that 36% of household respondents are experiencing psychological distress. Poverty, family issues, and conflict or violence were some of the major causes of behaviour change related to mental health (OCHA; 2022). Bearing in mind that Western psychotherapeutic methods and measurements are not always applicable to the psychosocial and cultural situation of the local context, other non-traditional forms of mental health and psychosocial distress symptoms can be overlooked.

Women in Afghanistan

‘A woman is born with sorrow, married with sorrow, and will die with sorrow’ - 
Sanauddin, 2015

Using an array of indicators which included women’s inclusion and access to justice and security, Afghanistan was evaluated as one of the worst places to be a woman in 2021 (Women Peace and Security Index [WPS Index], 2021). Women’s identities and roles in Afghanistan are continuously shaped by traditional beliefs and ideals. Many women abide by these cultural norms based on patriarchal values which limit their freedom of movement and autonomy (Tomlinson et al., 2020) and increase the level of gender-based violence perpetrated against them (CARE, 2020). Further, the impact of these values on the relationships between men and women and the subsequent position of women in society must be noted. Women are perceived as objects or property to be honoured, further asserting the control of men over women and justifications for GBV (Action against Hunger ACF, 2018).

Education opportunities are low for women due to the previous years of Taliban rule which prohibited schooling for girls and women and promoted the subordination of women in social
and public life in Afghanistan (Scholte et al., 2004; Ventevogel & Faiz, 2018). While there were some attempts to counter these restrictions in the following years, from 2001 to 2021, cultural norms are entrenched and, with the Taliban’s return to power in 2021, the Ministry of Women’s Affairs has been replaced by Ministry of Vice and Virtue (Protection Cluster Afghanistan, 2021). These developments have increased the concerns of women and girls and limited their access to education, rights to work and freedom of movement. Many fear a return to the conservative and restrictive ruling that was seen in the previous Taliban years.

**Women’s wellbeing in Afghan culture**

In multiple studies, women showed higher levels of mental health symptoms than men (Scholte, 2004; Panter-Brick et al., 2009; Tomlinson et al., 2020; Kovess-Masfety, 2021). Kovess-Masfety et al.’s (2021a) national survey on depression and anxiety disorders in Afghanistan showed that women suffered more than men from psychological distress and impairment due to mental health symptoms, such as PTSD and suicidal behaviour and thoughts. Stressors found to impact Afghan women’s psychosocial wellbeing fell into two categories: war-related traumatic stress and ongoing daily stressors (Omidian & Miller, 2006).

Tomlinson et al. (2020) used the Patient Health Questionnaire (PHQ9) on a sample of women who had given birth in the last 12 months from Parwan Province. They found 87% of women presented some symptoms of post-partum depression. Of that 87%, 22% had mild depression, 20% had moderate depression, 27% moderate-severe depression and 19% had severe depression (Tomlinson et al., 2020). The same study noted that women whose children suffered from moderate or severe acute malnutrition were more likely to have depressive symptoms. Moreover, the study was done prior to the current political developments; attention must be made to how new restrictions on the social, political and cultural lives of women could undermine their mental health and increase the risk of developing mental disorders, such as depression (Silove and Ventevogel, 2022).

Acknowledging not only how culture positions women in Afghan society but also how women are culturally allowed to express themselves is important. A Pashto proverb, “A woman is born with sorrow, married with sorrow, and will die with sorrow,” clearly shows the acceptance of
women to display and feel sorrow in a context where they have very limited freedom otherwise (Ventevogel & Faiz, 2018). As women and girls have limited ways to protest and access support, health centres are often one of the few acceptable destinations for which they can leave the house and bring attention to their sorrows and frustrations (Ventevogel et al., 2013). Female interview participants from Kandahar reported feeling that they were under constant criticism and scrutiny of their behaviour, dress, or observation of their faith by family members, co-workers, or strangers in the street (Bragin et al., 2021).

Feelings of safety and GBV

“Gender-based inequality is extensive in the country – decades of conflict, food insecurity and conservative patriarchal norms limit Afghan women and girl’s freedom of movement, decision-making power and access to health, education, and other basic services and resources.” – CARE (2020)

Responding to the most recent nationwide Quarterly Protection Analysis (Protection Working Group 2021), 35% of women stated that they do not feel safe, citing cultural reasons, growing insecurity, GBV risks and armed groups. Women and girls have self-limited their movements and access to public space to protect themselves in the current uncertain context. However, it is not only the world outside of the home that is a hostile environment to women and girls.

Domestic violence is one of the main forms of GBV, with approximately 90% of women having experienced intimate partner violence with husbands as the principal perpetrators (Protection Cluster Afghanistan, 2021). A recent report by WHO (2021) identified that Afghanistan has a 46% prevalence of physical and sexual interpersonal violence. While sexual and gender-based violence (SGBV) are taboo subjects, with GBV often referred to as “family problems,” one can expect these numbers to be greater than what was reported - especially as honour killings of GBV survivors are pervasive (Afghanistan Protection analysis, 2021) and women survivors are sometimes pressured to commit suicide, often choosing self-immolation (Maniam, et al., 2021).
However, work by international NGOs to improve the rights of women and girls has, in some instances, caused tension and more harm than good, as cultural notions of womanhood are challenged (Ventevogel et al., 2013). The explanation is that, often, community leaders and men associate these ideas with imperialist powers (Echavez, et al., 2016). Key informant interviews with religious leaders emphasised how cultural norms and values may support GBV; for example, the beating of a wife is permitted if she is “nashiza” (rebellious/disobedient women). Similarly, feminity in Persian and Pashto literature is often attributed to manipulation, wrongdoing and lying (Maniam et al., 2021).

Men’s mental health

“Our talks and discussions about women’s rights are all as slogans but nothing in action. Why? It is because our masculine honour and bravery are more than their rights. The life in the village is different from the city. Here, if a stranger bothers my wife or sister as he stares at them on their way home, I cannot tolerate that; I would have to kill him, or else I am not called a man in my community” - Baf, Mature Man, Kabul Rural - Focus Group Discussion Participant (Echavez, et al., 2016:4)

The identity and position of men in Afghan society is strongly tied to cultural and religious beliefs and values. This is especially true in the eastern region of Afghanistan, where Pashtun culture is dominant and Madrasa schools (Quranic schools) are considered compulsory to the education of boys. Men are perceived as the “nan avar” (ultimate breadwinner), domestic figureheads whose responsibilities encompass the overall family (Echavez, et al., 2016). In addition, fundamental to being a man are characteristics of bravery and honour (Ayubi & Noori 2018). However, in Echavez et al;’s (2016) study, many noted that many men feel a loss of integrity and worth when they are unable to meet these expectations due to the political, social and economic climate. Because of this, many said they experienced great dishonour (beghairat-I) and shame. Many studies have found that, when men experience shame, there is a need to regain respect through violence, especially if the surrounding social and cultural context is one of historical violence and promotes a masculinity of dominance and power (Gilligan,
Devakumar et al. (2021) state that armed conflict challenges the dominant masculinities that cast men as providers and head of families in ways that contribute to family violence.

Missmahl (2018) noted that memory flashbacks and hyperarousal caused many men to experience the fear of losing control of the situation and their own feelings. This was often disguised by exerting compensatory control within the social space of the family, affirming their place in society and the cultural notion of being a man and controlling and protecting the family. This was reiterated by one of the male participants in Echavez et al. study (2016:41).

“Violence is more likely to happen when frustrations piled up as after-effects of the inability to fulfil the expected role of being a nafaqah provider and the inability to control their spouses and other members of the family.”

Understanding what it means to be a man in Afghanistan is vital to understanding men’s mental health problems and psychosocial distress symptoms and response. For men in Afghanistan, distress symptoms are stigmatised as weakness (Alemi et al., 2018), especially the display of sadness, fear, jealousy, or tenderness (Ventevogel and Faiz, 2018). Even so, in a recent MHPSS needs assessment by IMC (2021), mental health problems and psychosocial stress were identified as symptoms being experienced by men. These included family conflicts, child abuse, addiction to drugs, depression, anxiety, insomnia, mania, epilepsy, psychosis, PTSD, personality disorders, excessive anger, Obsessive Compulsive Disorder (OCD), Generalised Anxiety Disorder (GAD), Attention Deficit and Hyperactivity Disorder (ADHD) and loss of concentration. The Humanitarian Needs Overview (OCHA 2022), found that 22% of men suffer more from excessive worry with no hope for the future than women (16%).

Children’s mental health

Children in Afghanistan are forced to navigate their emotional and physiological developmental stages in a world characterised by limited access to basic needs, conflict, violence and uncertainty. In the literature, many studies found that children showed signs of
psychological distress and mental health symptoms. This was attributed to an array of factors, such as:

- prolonged exposure to toxic stress of caregivers,
- deprivation of nutrition,
- lack of stimulation and health care,
- closure of schools,
- movement restrictions,
- increase in child labour and child marriages - as a coping response to socio-economic issues,
- risk of death of serious injury as a result of Explosive Remnants of War, and
- multiple exposures to adverse and violent events (Save the Children, 2019; Protection Cluster, 2021; Panter-Brick et al., 2009).

Additionally, there is a strong link between adult mental health and children mental health, not only when it comes to past experiences of conflict and the presence of a mental disorder in the adult in general, but also in terms of the impact of everyday stressors on the psychological balance of the family system, such as domestic violence and inability to access basic needs and services (Eggerman & Panter-Brick, 2010; Panter-Brick et al., 2009; IMC, 2021). Many children expressed concern about socio-economic, health and financial problems and on how they impacted their lives and their family lives (Eggerman & Panter-Brick, 2010). Panter-Brick et al.’s (2009) study of children’s mental health and psychosocial wellbeing in Afghanistan highlighted several variables which influenced their mental health: primarily, exposure to multiple traumatic events, being a girl, residence in Kabul and caregiver’s poor mental health.

The Protection Working Group reported in their 3rd Quarter Analysis of 2021 that 24% of respondents said that conflict was the leading reason for children’s psychological distress. While noting that exposure to conflict resulted in a change in children’s behaviour, these changes included violent behaviour, eating disorders, self-harm, and suicidal tendencies (Protection Working Group, 2021). Ventevogel et al. (2013) also found changes in children's behaviour linked to violence as street games included violent enactments of war and children’s drawings show images of armed conflict, death and injury (Ventevogel et al., 2013).
It was noted in the National Mental Health Survey (2018) that children have high levels of symptoms which are mostly different to adults. These included emotional problems (39% of children), conduct disorders (41%), ADHD (15%) and problems with peers (52%). A study conducted by Samuel Hall (2016) of urban displaced youth in Kabul, found that symptoms of trauma and an overall lack of coping mechanisms made it difficult for youth to do daily tasks, keep a personal routine, sleep and eat well, concentrate, control their anger and avoid tensions with family and friends.

Child labour also poses a risk to children’s mental health in Afghanistan. A child is traditionally seen as an adult when they reach puberty and are moved directly into the adult world (Ventevogel et al., 2013). For boys, this is between 10 and 12, when they start working. For girls, they are given in marriage once they reach puberty. This is especially true in non-urban areas, where children assume social responsibilities with limited time for play. In addition, social life for children is strictly gendered and often includes systematic exposure to violence (Ventevogel, 2013).

Different studies reiterated that Afghanistan is one of the most dangerous countries for a child to live and grow (Save the Children, Stop the War, & OCHA, 2022). A study done across Afghanistan found that 77% of children reported they had experienced at least one type of family violence (Devakumar et al., 2021). Violence directed towards children is a major problem within Afghanistan, with many reporting this as a common occurrence. Catani et al.’s (2008) study in Kabul found that, of the children interviewed, 54% reported three or more violent incidents in the home.

A recent study found that boys suffer family violence more than girls, with 81% of boys and 71% of girls reporting at least one type of family violence event (Devakumar et al., 2021). Another study using the Strengths and Difficulties Questionnaire (SDQ), (a rating tool for emotional disorders) showed a high prevalence of emotional and behavioural problems for boys (Panter-Brick et al., 2009). The boy child is exposed to high levels of violence not only in the house but outside the house. one such practice is the sexual abuse of the boy child. This practice of bacha bāzī (literally meaning in the Dari Persian boy play) allows for an older man to have sexual relations with a boy (Ghorbani et al., 2021).
One of the major concerns of young girls is early marriage, with many being forced into it. A household survey found that 42% of households had at least one incident of child marriage (UNICEF, 2018). One married girl said that she was between the age of 7 and 8 when she got married, but it is more common for girls to marry age of 14 or 15 (Echavez, 2016). If girls get married later, there may be talk in their communities about whether they are sick or have problems at home (Echavez, 2016). In addition, new restrictions on the movement of girls and their access to education has caused additional stress and limitation of the Afghan girl child to the domestic world (Samuel Hall, 2016; Protection Cluster Afghanistan, 2021)

People with disabilities

Findings indicate there has been an increase of people living with disabilities in Afghanistan over the last 15 years (The Asian Foundation, 2020). In 2005, 3% of Afghans lived with severe disabilities; in 2019, a study found that number had increased to 14% (The Asian Foundation, 2020). This increase affects at least one in five Afghan households with either an adult or child with a serious physical, sensory, intellectual, or psychosocial disability (HRW, 2020). This number positions Afghanistan with the largest population per capita of people with disabilities in the world (HRW, 2020).

People living in with disabilities in Afghanistan not only need to navigate physical obstacles to reach services, but also face stigma and entrenched discrimination (HRW, 2020). Many of those living with disabilities live in rural areas, where cultural beliefs and traditions are more entrenched and health services are difficult to come by. Some of these stigmatising beliefs include seeing people with disabilities as cursed or in inferior social positions (Trani et al., 2016). Children with disabilities are especially vulnerable: traditionally, they are categorised as less worthy of social investment, which further excludes them from much-needed services (Ventevogel et al., 2013). Girls living with disabilities must overcome the stigma and discrimination of living with a disability, but they are also forced to negotiate what it means to be female in Afghanistan (HRW, 2020). For example, girls with disabilities are 2.7 times less likely to attend schools than boys with disabilities (Whittaker & Wood, 2022). Confirming the findings from the IMC assessment, children felt feelings of disrespect and difficulties in making
friends and mental distress in the form of sadness, anger and worry (IMC, 2021; Whittaker & Wood, 2022).

A study done by Ventevogel and colleagues (2013) found that children and adults living with disabilities show more signs of mental distress than others. People living with disabilities in the IMC Mental Health and Psychosocial Needs Assessment (2021) reported they would often avoid gatherings due to feelings of guilt and embarrassment. These individuals listed their mental health problems as depression, anxiety, stress, PTSD, sleeping disorders, and GAD. Some also mentioned they experienced low self-esteem, loss of memory and concentration, and lack of appetite, while others said that feelings of neglect and working under difficult conditions led them to acquire hypertension (IMC, 2021).

Coping mechanisms

Most of the coping mechanisms uncovered in the literature review were rooted in traditional beliefs and values. The family and the community are seen as the main sources of support, with traditional, community and religious leaders central to treating mental health disorders and psychosocial distress. It was noted that in some cases when the individual had severe symptoms, doctors and health centers were also accessed for support.

The National Mental Health Survey and Assessment of Mental Health Services (2018) found that people first go to a mental health professional, followed by the community health worker, and then by the Imam. Scholte et al.’s (2004) study of mental health symptoms following war and repression in eastern Afghanistan found that 98% of respondents mention Allah as their main source of emotional support when feeling sad, worried or tense. Seeking religious help also includes the use of amulets, prayers and reciting the Quran (IMC, 2021). Nangarhar women said they would go to a shrine and talk to the mullahs; this was reiterated by a minority of Kunar Males, who also said they would go to the shrine (Bragin et al. 2018). Youth also quoted religion and community elders as sources of support (Samuel, 2013). It is important to note that traditional and religious services are often free of charge and are not as stigmatised, allowing individuals to freely access this support (Alemu et al., 2018). Hope is
also seen as closely linked to the social and moral organisation of life (Alemi et al., 2018), which is embodied in the cultural expression of faith, family unity, service, effort, morals, and honour (Eggerman & Panter-Brick, 2010).

A supportive family and community are essential to the help-seeking behaviour of those suffering from mental health and psychosocial problems (Alemi et al., 2018). This was especially true when it came to women, (Eggerman & Panter-Brick, 2010; Protection Cluster Afghanistan 2021); however, this could reflect the cultural beliefs and traditions that women cannot leave the house without a *Maharam* (chaperone). Speaking to family members and neighbours is also an important way to stay included in society, being encouraged and motivated (IMC, 2021). Accessing this support could be challenging, as some Afghans experiencing mental health symptoms do not want to be a part of society any longer and rather isolate themselves (HRW, 2019), while others find that their depression symptoms make participating in society difficult (Allan et al., 2018).

In another study, some participants mentioned they would get angry and use violence towards their children and families to feel better (IMC, 2021). In the IMC (2021) assessment, females mentioned they would either beat themselves or their children and fight with family members to feel better. Miller et al. (2006) found that women beating themselves was a symptom of distress rather than a coping mechanism and was reportedly enacted roughly once a week.

The use of narcotics was also mentioned as a coping mechanism (IMC, 2021) and is often prescribed to children to help them sleep (Ventevogel et al., 2013). Opium is often the choice of drug to forget one’s pain and fears and overcome daily stresses;

“[I] cannot find a job and sometimes I don’t have enough money to eat. Today, I cannot survive without opium, it helps me forget (Basir, 22 years old)” (Samuel Hall, 2016:22).

“For us (girls), it is difficult to play a role in this society. My brothers do not even want me to go to University. So with my friends, we sometimes smoke to relieve pain and forget our fears (Rashid, 17 years old)” (Samuel, 22 years old).
As noted by UNODC anxiety, depression and PTSD are common risk factors to drug use and the development of drug use disorders (2021). In 2015 it was found that 11% of households surveyed had at least one or more person tested positive for at least one drug. The same study found that a biological sample of two-thirds of children from rural areas were found to contain opium.

Many Afghans accept self-medication using psychopharmacological drugs, such as antidepressants and mood stabilisers (Alemi et al., 2018). While this is not necessarily a problem, as these drugs - when they are actually indicated and with the right dosage - can assist people in coping with the stress and symptoms of mental health disorders and psychosocial problems, they can cause dependencies and adverse effects if they are not regularly used as prescribed or when incorrectly prescribed. This is often the case because access to medicine is not guaranteed in Afghanistan, and providers have limited knowledge on psychopathology, psychotropic drug administration, and pharmacotherapy training is absent from most public health facilities (IMC, 2021).

Conclusion

The literature clearly identifies the prevalence of mental health conditions and the importance of providing Mental Health and Psychosocial Services. Of the conditions identified, the most prevalent appears to be depression, anxiety and trauma-related disorders. This is not unexpected as the impact of war, conflict and violence in society is known to cause symptoms of depression, anxiety and PTSD. However, what was emphasised in the literature was the impact of living conditions and the pervasive nature of all forms of violence in Afghan society and how this was a casual factor on the development of mental health conditions. Idioms of distress and cultural connotations of mental health and psychosocial distress need to be taken into consideration in Afghanistan and need to be included in any mental health response.
Section 5: Data Findings

Health care centres mental health service delivery

Training and skills in health centers across all four provinces revealed a majority of healthcare staff such as midwives, doctors and nurses, have had at least one training on core topics. The only area where there appears to be limited training is in bereavement support. The below tables show the level of training and skills for midwives, doctors and nurses.

Table 4: Communication skills training of healthcare providers

Table 5: Clinical skills training of healthcare providers

Table 6: Mental health disorders and service delivery in health care centres.

<table>
<thead>
<tr>
<th>Province</th>
<th>Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nuristan</td>
<td>all 3 facilities were CHC</td>
</tr>
<tr>
<td>Nangarhar</td>
<td>2 facilities were CHC, followed by 1 UTH, 1 DH and 1 FTZH</td>
</tr>
<tr>
<td></td>
<td>Nuristan</td>
</tr>
<tr>
<td>----------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Mental health</td>
<td>Majority of patients they are seeing for mental health conditions are people with psychosis, then depression, followed by anxiety. It was mentioned that there are too many people with stress. Only 5 patients were seen in the last 2 weeks for epilepsy</td>
</tr>
<tr>
<td>Medication</td>
<td>Of the sites interviewed most of the medications were not available to treat depression, anxiety, psychotic and epilepsy or Parkinson.</td>
</tr>
</tbody>
</table>
### Barriers to identifying and managing mental disorders

| Not enough knowledge, cultural bias and there is a need for support from local and spiritual leaders to help increase the general understanding of society. There is not enough space for people with mental health disorders, not epilepsy or Parkinson. Only Mehtarlam Provincial Hospital and Kakas CHC said they never have access to antipsychotic or generic antiparkinsonian medication. and anti-anxiety drugs than anti-psychotic, anti-epileptic and Parkinson being less readily available. | Barriers to identifying and managing mental disorders | Not enough staff providing MH support in the centres, there are many people with mental health disorders, there aren’t enough specialists, lack of space, medicines and rooms. Not enough awareness of MHPSS. | There is not enough medication, not enough staff or space to provide these services. | There is a limited understanding of MHPSS, there is not enough specialist, medicine or staff to provide this support. In this community there is a lot of shame when |
| enough medication. |  | people talk about mental health problems |
Survey findings: stressors, mental health and coping from the four provinces

Survey demographics:

There were a total of 1522 respondents from across the four provinces of Kunar, Laghman, Nuristan and Nangarhar. Using the representative sample, each province was divided according to remote, semi-urban and urban status. Below are the demographics of the survey respondents.

From the survey, the top stressors, symptoms and wellbeing factor were identified across the four provinces. Participants were asked to report on the top three stress concerns as well the top three wellbeing factors.

Top stress factors

The five top stress factors, of the surveyed population not disaggregated by gender or province, are: first, poor living conditions (53%), followed by war, no job (25%) closely followed by violence, conflict and killings (24%), money problems (21%) and explosive devices/bombs at 17%. Women, following the same pattern as the general population, are similarly mostly stressed by poor living conditions (53%); money problems (24%); no job (21%) and war, violence, conflict and killings (20%) and their fifth concern with both health concerns and family problems at 19%. Men in turn, were most concerned about poor living conditions (53%),
followed by no job (30%) and war, violence, conflict, and killings (28%) then explosive
devices/bombs (20%) and with their fifth stressor as money problems (19%).

Across the districts, the results differ, with Kunar women reporting the same top two stresses
with poor living conditions (70%), money problems (41%), but with mental health problems
(27%) as a third main stress factor. To be noted that mental health issues as a stressor for Kunar
females were much more represented in urban areas (62%) than semi-urban (35%) and remote
areas (8%).

Laghman women also acknowledged poor living conditions (51%) as their most stressful
factor, but less than Kunar women. The second concern is no job (36%), followed by money
problems (31%) and family problems (29%).

In Nangarhar, women identified that their main stress factors are, firstly, poor living
conditions (56%), followed by family problems (32%), war violence, conflict and killing
(30%).

Women living in Nuristan, in turn, of top three stressful concerns mentioned poor living
conditions (34%), followed by health concerns at 28%, violence in their communities at 22%.
Poor living conditions are mostly a problem in urban (21%) and semi-urban (22%) areas, while
in remote areas the #1 concern is violence in their communities, at 11%.

Graph 1: Top stress factors for Kunar females according to remote, semi-urban and urban
Graph 2: Top stress factors for Laghman females according to remote, semi-urban and urban

Graph 3: Top stress factors for Nangarhar females according to remote, semi-urban and urban
Graph 4: Top stress factors for Nuristan females according to remote, semi-urban and urban

**Kunar men** cited poor living conditions at 72%, with no job at 35%, explosive devices/bombs at 30%, followed closely by war, violence, conflict and killing with 29%.

**Men in Laghman** found the most stressful thing for them is no job (51%), followed by poor living conditions (40%) and money problems (39%).

**Men living in Nangarhar** found poor living conditions as their greatest stress factor, at 21%, with explosive devices and bombs rated second, at 13%, and war violence, conflict killings rated third, at 12%. Men living in Jalabad’s third greatest stress factor, at 10%, is political authorities.

**Men living in Nuristan** rated their worst concern as poor living conditions (12%); in second is war, violence, conflict and killings (9%), followed closely by not enough healthcare services (7%).

The major stress factors between the four areas and for both women and men are mostly related to living conditions, economic worries, and violence in communities. While there are a few differences, most are based on gender and urban status. More women are concerned about violence and conflict in their communities. While men did mention war, violence, conflict and killings, as well as explosive devices, as their concerns, women mentioned this more than men as one of their main contributors to stress. Important to note is women mentioned mental health as a stressor while men did not. Women also listed family problems, which is a cultural euphemism for domestic violence, while men in the four provinces ranked family problems as
their 9th worry in Kunar (8%) and Laghman (12%), for Nangarhar it was number 7 (13%) and Nuristan number 16 (6%).

Graph 5: Top stress factors for Kunar males according to remote, semi-urban and urban

![Graph 5](image)

Graph 6: Top stress factors for Laghman males according to remote, semi-urban and urban

![Graph 6](image)
Participants, men and women, living in all four Eastern provinces of Kunar, Laghman, Nangarhar and Nuristan rated the top three factors which give them a sense of peace and wellbeing as: peace, security, justice (71%), economic security/ability to provide for family (32%), and physical health/economic security/access to resources (26%). When compared across genders, 26% of men chose peace, security and justice, 11% chose ability to provide for a family, 9% chose leisure activities or time to enjoy living, and 9% chose freedom. For women in these provinces, 21% said that peace, security and justice gave a sense of peace and wellbeing, followed by 11% who feel a sense of peace and wellbeing from love and support in
their families, 11% from strong family networks, and 10% from the ability to provide for their families.

Women living in remote areas have different ratings for peace, security and justice, at 56%, followed by strong family relations (31%), economic security to provide for family (30%). Those living in semi-urban areas rated their factors in a similar order, but with peace, security and justice largely represented with 82%, followed by love/support in the family (46%), economic security to provide for family (30%). In urban areas, women’s wellbeing factors included peace, security and justice (63%), strong family relations support (41%), and love/support in the family (38%).

For men living in remote areas, 78% said that peace, security and justice bring them feelings of wellbeing; freedom (32%); feel good from leisure activities or time to enjoy living (36%)

Among those living in semi-urban areas, 91% said peace, security and justice gave them a sense of peace and wellbeing, followed by economic security/ability to provide for family (45%), physical health/economic security/access to resources and freedom (27%). Men living in urban areas also rated peace, security and justice at 65%, followed by economic security ability to provide for family (47%) and love/support in the family (21%).

WHO and UNHCR WASSS

The WHO and UNHCR WASSS (2012) identified the occurrence of symptoms over the period of two weeks in the 1522 respondents. It is interesting to note that the results (table X) show more women reporting on these symptoms than men. However the same symptom for females (75%) and males (63%) were scored highest, namely being unable to carry out essential activities for daily living because of feelings of fear, anger, fatigue, disinterest, hopelessness and/or upset most or all of the time in the last two weeks before participating in the study.
51% of respondents felt so afraid that nothing could calm them down most or all of the time in the last 2 weeks.

64% of respondents felt so angry that they felt out of control most or all of the time in the last 2 weeks.

56% of respondents felt so uninterested in things that they used to like that they did not want to do anything at all most or all of the time in the last 2 weeks.

53% of respondents felt so hopeless that they did not want to carry on living most or all of the time in the last 2 weeks.

66% of respondents felt so severely upset about the emergency/disaster/war or another event in their life, that they tried to avoid places, people, conversations or activities that reminded them of such event most or all of the time in the last 2 weeks.
69% of respondents felt unable to carry out essential activities for daily living because of feelings of fear, anger, fatigue, disinterest, hopelessness or upset most or all of the time in the last 2 weeks.

Graph 10: Percentage of respondents according to the four provinces WHO and UNHCR WASS symptoms most or all of the time in the last 2 weeks
Afghan Symptoms Checklist

The Afghan Symptoms Checklist uses culturally appropriate symptoms of distress to identify the prevalence of mental health symptoms based on cultural idioms of distress. The listed symptoms include common expressions of distress in communities, they are grouped into three clusters, each one describing three factors of distress:

1. feelings of sadness with social withdrawal and somatic distress,
2. feelings of sadness without social withdrawal, and
3. somatic distress and stress reactions.

The checklist score was designed to identify the average score based on a lickert scale, ranging from 1 never experiencing the symptoms, to 5 experiencing the symptoms every day.
Graph 11: ASCL Factor 1 according to the four provinces of the study

![Graph 1: ASCL Factor 1 according to the four provinces of the study](image1.png)

Graph 12: ASCL Factor 2 according to the four provinces of the study

![Graph 2: ASCL Factor 2 according to the four provinces of the study](image2.png)
Graph 3: ASCL Factor 3 according to the four provinces of the study
Males, across the four provinces reported that on average, over three or four days a week in the last two weeks, they have shown symptoms of distress where they thought too much, felt sad and had headaches. For at least three days a week, most men have become jigar khun (sadness following interpersonal loss), lost their appetites, had insomnia, and/or experienced asabi (irritability). Two or three days per week, the average male respondent experienced trouble remembering things, intrusive unwanted memories, felt irritated, hopeless, felt socially withdrawn or isolated and had difficulty functioning at home or work, had a nightmare, quarreled with family, were easily startled, and/or beat their children. Other symptoms that were not experienced as often, with never to one day a week, were crying, fishar payin (lethargy), fishar bala (agitation), quarrelling with friends and neighbors, and beating oneself.

Females, in turn, experience slightly more symptoms of distress. On average, women show the following symptoms of distress between three and four days a week: feeling sad, headaches, thinking too much, becoming jigar khun, trouble remembering things, asabi, loss of appetite, insomnia, feeling hopeless, crying, and/or intrusive, unwanted memories. On average, women experienced difficulty concentrating, feeling irritable, feeling socially withdrawn or isolated, difficulty functioning at home or work, had nightmares, beat their children, quarreled with family, were easily startled, and/or fishar payin between two and three days a week. Women feel fishar bala, beating themselves or quarrelling with friends and neighbors.

On most of the ASCL Symptoms, females score higher than men; except for thinking too much, for which women score 3.57 and men 3.65, and fishar bala, for which both score an average of 1.88.
Graph 14: ASCL Average scores according to gender and district from all four provinces

Table 8: ASCL Symptom scores according to gender from all four provinces

<table>
<thead>
<tr>
<th>ASCL Items</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crying</td>
<td>1.99</td>
<td>3.09</td>
</tr>
<tr>
<td>Loss of appetite</td>
<td>3.02</td>
<td>3.26</td>
</tr>
<tr>
<td>Insomnia</td>
<td>3.02</td>
<td>3.26</td>
</tr>
<tr>
<td>Quarrelling with family</td>
<td>2.25</td>
<td>2.55</td>
</tr>
<tr>
<td>Quarrelling with friends or neighbours</td>
<td>1.64</td>
<td>1.70</td>
</tr>
<tr>
<td>Feeling hopeless</td>
<td>2.79</td>
<td>3.12</td>
</tr>
<tr>
<td>Beating one's children</td>
<td>2.12</td>
<td>2.61</td>
</tr>
<tr>
<td>Feeling socially withdrawn or isolated</td>
<td>2.59</td>
<td>2.90</td>
</tr>
<tr>
<td>Feeling sad</td>
<td>3.53</td>
<td>3.67</td>
</tr>
<tr>
<td>Becoming jigar khun</td>
<td>3.21</td>
<td>3.36</td>
</tr>
<tr>
<td>Headaches</td>
<td>3.22</td>
<td>3.65</td>
</tr>
<tr>
<td>Nightmares</td>
<td>2.35</td>
<td>2.68</td>
</tr>
<tr>
<td>Feeling irritable</td>
<td>2.81</td>
<td>2.92</td>
</tr>
<tr>
<td>Easily startled</td>
<td>2.23</td>
<td>2.55</td>
</tr>
<tr>
<td>Intrusive, unwanted memories</td>
<td>2.82</td>
<td>3.03</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>Thinking too much</td>
<td>3.65</td>
<td>3.57</td>
</tr>
<tr>
<td>Asabi</td>
<td>3.00</td>
<td>3.34</td>
</tr>
<tr>
<td>Trouble remembering things</td>
<td>2.83</td>
<td>3.36</td>
</tr>
<tr>
<td>Beating oneself</td>
<td>1.59</td>
<td>1.76</td>
</tr>
<tr>
<td>Fishar payin</td>
<td>1.91</td>
<td>2.52</td>
</tr>
<tr>
<td>Fishar bala</td>
<td>1.88</td>
<td>1.88</td>
</tr>
<tr>
<td>Difficulty concentrating</td>
<td>2.60</td>
<td>2.93</td>
</tr>
<tr>
<td>Difficulty functioning at home or work</td>
<td>2.48</td>
<td>2.79</td>
</tr>
</tbody>
</table>

Using the division of ASCL items into three factors by Miller et al (2006), across the four provinces, Factor 2 (ruminative sadness without social withdrawal and somatic distress) shows the highest average occurrence of symptoms across a two-week period in the four provinces. This is followed by Factor 1 (Sadness with social withdrawal and somatic distress) and lastly by Factor 3 (Stress Induced Reactivity).

For Factor 1, there is not much discrepancy across the average occurrence of the symptoms based on remote, semi-urban and urban districts. Those living in remote areas score marginally higher in eight out of the 13 symptoms. Semi-urban only have higher averages for crying and *Fishar Payin*, while for the remaining three symptoms (headaches, feeling sad and becoming *jigar khun*) those living in urban areas score a higher average. The most prevalent in the three districts is feeling sad, with urban residents having an average of 3.75 occurrences per week, followed by 3.61 days in remote areas and 3.42 days in semi-urban areas.

For Factor 2, those living in semi-urban areas score the lowest average prevalence on all the symptoms, compared to those living in remote and urban areas. Out of the seven symptoms, those living in remote areas have a greater prevalence of experiencing them each week; but those living in urban areas have a higher prevalence of feeling sad and becoming *jigar khun*. These two symptoms are closely related, as *jigar khun* refers to a form of sadness relating to
interpersonal loss and reaction to a very painful and disappointing experience. *Jigar khun* can also describe the emotional reaction of people who have lost family members during the war.

Of the symptoms in Factor 3, *asabi* has the highest occurrence across the four provinces, district and gender. *Asabi* is a cultural term referring to feeling nervous; and those with *asabi* are often those who are feeling overwhelmed by major life stressors. They are more likely to beat their children. There is a very small discrepancy between the four symptoms of stress-induced reactivity: even though those living in remote areas reported a higher prevalence of quarrelling with family and friends or neighbors, they reported beating their children slightly less than those living in semi-urban areas. It is important to note that the prevalence of quarrelling with friends or neighbors is very low across the provinces, districts, and genders.

**Focus group and key informant findings**

Key informant interviews took place with community leaders, while focus groups took place with conveniently recruited health staff of the health care facilities. The Key informant interviews asked questions to identify what the problems in the community are, symptoms of mental health conditions and distress in the community, how those who were distressed were treated and what are the natural ways of coping and receiving help in the community. Included in the interview were questions on family problems (domestic violence), rape, alcohol and drug use in the community. Focus group discussions took place with adolescent and adult mixed gender groups, children and male and female only groups. Focus group discussion questions were used to identify what the main concerns of the group are, how these impacted their lives and how these problems were resolved. Focus group with children asked children what made them feel sacred, angry and what they worried about and what made them happy as well as where they seek help from.

**Laghman**

A total of 6 community leaders were interviewed in Laghman, 2 from remote, 2 from semi-urban and 2 from urban districts. No female community leaders could be recruited; therefore, all the community leaders were males.
7 FGD with 56 male participants, 3 groups took place in remote Laghman, 2 groups were semiurban, and 2 in urban areas. There were a total of 5 focus groups with male adolescents, 3 in semiurban areas, one in remote and two in urban areas. In total there were 46 male adolescents participants in the focus group. There was one group of 7 urban males living with disabilities.

There were 91 children participating in the children’s 8 focus group, with 2 male only and 2 mixed gender groups from semiurban areas, 1 male only group and 3 mixed genders from remote areas and 1 male and 3 mixed gender groups from urban areas.

**Nangarhar**
The key informants from Nangarhar were 6 community leaders from remote, semi-urban and urban districts, each community leader was a male.

There were 104 participants in the 13 focus groups. 3 male adolescent groups from remote areas, 4 male adult groups in semiurban areas and 3 male adolescent groups and 1 male adult and 1 male living with disabilities group in urban areas.

12 focus groups with 93 children took place with 2 mixed gender and 2 male group from remote areas, in semi urban areas 4 mixed groups and 3 mixed groups and 1 male groups in urban areas.

**Nuristan**
7 key informants were interviewed from Nuristan, across three districts, 2 males and 1 female from remote areas. 1 female and 1 male from semi urban and 1 male and 1 female from urban. Of the 7, 3 were female and 4 were male. The three females were teachers, 3 of the 4 men were local leaders and the 4th man was a civil activist.

In Nuristan there were 10 focus groups with adults and adolescents with 62 participants. In remote areas there were 1 male adult group, 1 female group and 1 mixed gender adolescent group. Semiurban areas had 1 male adult group, 1 female group and 1 mixed gender adolescent
group. There were 1 male group, 1 female group, 1 mixed gender adolescent group and 1 male living with disabilities in urban areas.

3 children focus groups took place with 1 mixed gender in remote area, 1 mixed gender in semiurban and 1 mixed in urban areas, with a total of 16 children participants.

**Kunar**

KII with 11 community leaders from remote, semi-urban and urban areas which we had 8 men and 3 women. Of the men there were 5 local leaders, 1 spiritual leader and 2 teachers. From the women we had 1 teacher, a nurse and a university student. 3 males and 2 female key informants from urban areas, 3 males and 1 female were from remote and 2 males were from semi-urban areas.

In total there were 10 focus groups with adults and adolescents, with a total of 66 participants. In remote areas there were 2 mixed gender adolescent groups, 1 female group and 1 male group. In semiurban areas there were 1 mixed gender adolescent group, 1 female group and 1 male group. In urban areas there were 1 mixed gender group, 1 male group and 1 male living with disabilities.

There are 3 children focus groups of 15 participants. There was 1 mixed gender group from remote area, 1 mixed gender from semiurban and 1 mixed gender urban areas.

**Nangarhar**

**Problems in the community**

Questions about family problems, rape, and alcohol and drug problems in the community were asked other problems were also identified as the cause of people distress. For women, children and men it was acknowledged that the war and conflict in the community were the reasons they were distressed as well as the economic and social situation.

Family problems were perceived as either conflicts, disunity in the family and included family separation or disunity. These families did not have enough food or clothes or were unemployed.
A key informant from semi-urban Nangarhar said that the community perceive these people as having bad characters.

It was noted that in urban, semi urban and remote areas of Nangarhar those who had been raped were likely to isolate themselves from the community as they are not treated well by the community as noted by a semi-urban community leader, the many are killing themselves fur to shame. Another noted that those who have been raped develop mental disorder due to the tension and pressure. Interesting to note is that all community leaders requested to receive training on “brutal violence and rape”.

Drinking alcohol was described as a “great sin” and these people who drink are perceived as bad people in remote Nangarhar, while those in semi urban and urban Nangarhar mentioned that the community does not treat them well as they are called bad names and are not respected. These same community leaders mentioned that these people are isolated from the community and the people do not have relationships with these people.

Adolescents living in remote Nangarhar were mostly concerned with the lack of teachers in the community than those living in Urban Nangarhar. Urban youth were more concerned with the limited access to government departments and banking problems. Both youths mentioned unemployment, agricultural and no electricity as problems in the community.

Similarly, adults from remote and semi-urban mentioned that there the main road has been destroyed in the community while adults from all areas mentioned problems relating to schools, no teachers and education materials were lacking in the community. While urban adults mentioned that schools and universities for girls havening been closed, poverty and living conditions were problems. Those living in remote areas mentioned health problems, and unemployment. Semi urban adults also mentioned agriculture problems. According to key informants, men in remote and urban areas had similar reasons for distressed, the economic problems. Insecurity and the inability to meet their basic needs as well as emigration.

Key informants noted that stresses of children were the war, conflict, poverty and unemployment and in urban areas the death of their parents in the war.
Remote community leaders said the reason for women’s distress was because of forced marriage and violence towards girls and that they don’t have their rights. This was repeated by urban community leaders who also mentioned family violence, brutality in the community and forced marriage. While in semi urban it was mentioned by the community leaders that women are distressed cause of war, conflict, and unemployment.

Males living with disabilities in urban areas mentioned that they cannot meet their basic needs such as access to water, food and shelter. They were also concerned that there is no education for girls as well as the poverty and insecurity.

MH and psychosocial distress
The issue of violence, bombing and disunity in the community of Nangarhar and its impact on the mental health and psychosocial wellbeing of those living in Nangarhar. One key informant mentioned that there are a lot of people with disorders due to family conflicts, war in the country and insecurity in the community. The problems they face are, sleep disorders, conflicts of the community and families. Another said about 40% of people face mental health problems within the community.

Children who are described as distressed had the following symptoms: in remote areas and semi urban areas they look sad and upset. In semi-urban areas both key informants said that children don’t speak nicely to each other. In urban areas these children are uninterested and disappointed, have sleep problems, act confused, don’t behave well and are sacred and startled easily. Children were also noted in remote and urban areas to have trauma symptoms of being startled responses due to the bomb blasting and gun sounds, while in remote areas children’s “minds were altered, and they are confused due to the poverty, war, conflict, explosions and unemployment. One key informant from urban Nangarhar mentioned “a girl had sensibility with the sound of bomb blasting and loud voices. She reacts strongly to this and as well has had anorexia, headaches, body pain and sleeping problems”.

Distressed women were described by key informants as, sad, angry, silent, tense, they appear disappointed and depressed. In semi-urban and urban areas distressed women specifically mentioned as causing fights and arguments with others and in families. In remote areas it was
mentioned these women are jealous and pray for bad things to happen to the community. One community leader from remote Nangarhar said they are “they are not here, and their minds are weak as if they have lost their minds due to the pressure and the tensions”.

Men distress was identified through their behaviour and facial expressions by key informants. Men who are distressed are aggressive in their behaviour; they fight with others in the community and use abusive words and are in a bad mood and their behaviour is described as “not acceptable”.

Those who were described as having mental health problems are people with sleeping problems, have conflict in the community and family conflict. These people have social, political, economic and political problems and are often intoxicated and are not able to look after themselves.

Adolescents from remote Nangarhar mentioned that mental health disorders were the result of stress in the community while those in urban Nangarhar mentioned that there is a lack of awareness of mental health.

Adults from all areas identified mental health problems in the community as severe depression, or feeling depressed and tension. Remote and semi urban adults also included talking with himself and sometimes crying with oneself. While those in urban areas mentioned emotional outbursts, sleep and weight problems or appetite changes and being quiet and withdrawn. Both remote and urban adults mentioned epilepsy. Adults living in semi urban areas mentioned “people are flurried due to the conflict and no one can help them”. While adults living in urban areas mentioned there is a lack of mental health awareness. Male adults living in urban Nangarhar with disabilities from said that there are mental health problems in the community but did not mentioned what they were.

Most children in the mixed gender focus group from remote, semi urban and urban areas as well as the male children focus groups from remote, urban areas mentioned that they do not feel safe and are sad due to the current situation poverty, instability, and the insecurity. Some of the children from all the areas mentioned they do not feel safe at home. One male child
mentioned he is happy at home. Many of the children said they are not happy. The mixed gendered focus group children from semi-urban and urban areas as well as the male children from urban areas mentioned they become sad when they hear the bombs. Children from all areas said they feel sad when they see people fighting and the poor people. The male groups from remote and urban areas each had one boy mention they scared when they see Afghan flag.

**Impact**
Adolescents from both remote and semi urban areas were disappointed when they think about the future, as according to youth living in remote areas to the “current situation of Afghanistan is not appropriate for living”. Others from urban Nangahar said that barriers are insecurity, poverty and no changing of the regime. Adolescents from remote Nangahar mentioned that the stress of being unable to meet their needs have led to mental health problems. Adolescents from urban Nangahar mentioned there is conflict in the family.

Adults from remote and semi urban areas responded to the impact of these problems and mentioned that it has resulted in community conflict, and health problems as well as inability to access health facilities. When asked about the future adults from all the areas mentioned they feel disappointed or feel bad when they think about the future. One adult from urban Nangarhar mentioned “as there is no way to improve, you don’t know if you will live”. Male adults living with disabilities mentioned they felt bad when thinking about the future as they are “unable to work for their family”.

When asked the mixed gender focus group of children about the future, the children said they have wishes. The children from urban areas said they have many wishes but can’t achieve them. In turn the male children mentioned they have wishes to help the community when asked about what their future wishes are.

**Coping**
All the children mentioned they can go to their parents, friends and family member when they feel scared and sad. When asked about if they play games with their friends, all the different groups said they do play, the games listed cricket and playing with their classmates. The adults from remote areas mentioned they are borrowing money and have gone into debt to cope while
adults from semi urban Nangahar mentioned the use of homemade drugs. Going into debt was also mentioned by adolescents as to a way to cope from remote and urban areas.

One of the main ways of coping with the stress of problems, distress and mental health problems was to get advice either from the community leaders, family members or from religious leaders. “Advice” was given to people who are distressed, people who had family problems, had drinking and drug problem, had been raped or had mental health problems. It was specifically mentioned that people with mental health problems in semi-urban and urban areas in Nangahar go to shrines where they make amulets and pray and request help from god. It was noted by the key informants from all areas that one of the ways was to prepare themselves for bad times coming ahead. This was through educating people on how to be ready for tough and emergency situations.

Regardless of location the family and community were perceived as a key source of support for women, men and children experiencing distress by the key informants. Husbands were especially seen as a source of support for distressed women in semi urban while in urban and remote elderly women were also included as a source support.

Request for support
All locations made requests for trainings. These trainings include mental health awareness, PFA, brutal violence and rape. It was also mentioned that people need education, food, winter clothes and health facilities. Male adults with disabilities from urban Nangarhar said they need wheelchairs, education, trainings on how to live life.
Nuristan

Problems in the community
When asking the key informants from Nuristan about family problems (domestic violence) all described this as family violence, bad relationships in the family. Remote key informants noted that this was also when there are “bed problems”. Only semi-urban key informants said this is when there is violence against women.

One of the questions asked was about rape in the community, one remote female key informant said they did not want to answer, while two key informants from semi urban areas said that people do not get raped in their community. The remote key informant who did answer the question said that people who have been raped have mental and social problems and are viewed negatively in the community and will not value themselves and isolate from the rest of the community. This was echoed by semi urban key informants as well as the urban key informant who mentioned that these people will be sad and have anxiety and want to isolate themselves. Urban key informant said that the community will also think negatively about them and not trust them.

Alcohol and drug use, was noted by remote key informants as being prohibited in Islam and that those who do drink, their family will feel sinful and the family will be seen negatively in the community. All key informants from the different areas mentioned the person who is drinking and using drugs will be treated badly in the community and will not be trusted.

Problems identified by the male adolescent focus groups across remote, semiurban and urban areas included violence in the community, increase of instability and the specifically in urban areas, violence against women as well as health problems and the lack of health facilities. In semi urban areas the youth mentioned there is fear of the leasers and the religious leaders.

Key informants from remote semi urban and urban areas said the reason for children’s distress was due to the crises as they don’t have shelter, access to food and health facilities and have bad family relationship. In urban areas child work and family problems were distinctly mentioned as problems.
From the women focus group discussion violence was a problem across remote, semiurban and urban areas. In remote areas religious conflict, ethnic conflict, family problems and violence against women were mentioned. Semi urban and urban areas, explosions bombing, increase of deaths and “death everyday”, presence of armed persons. Other problems such as financial, no food, limited education, increase of hunger were mostly mentioned in semi urban and urban areas. Key informants from remote and urban areas identified violence against women as a reason for their distress while in all three areas financial problems, unemployment was included. The uncertainty of the future was included in urban areas.

For men violence was also included as a problem, in remote and urban areas violence against women was mentioned. Other forms of violence included, violence in the community and family problems (remote areas), death of the youth (semi urban) and political conflict, religious conflict (urban). Other problems were related to the meeting of basic needs such as no electricity, not good housing, health problems, no clothes and hunger increasing. Limited access to education was mentioned only in semi urban and urban areas as a problem.

Males living in urban areas with disabilities identified violence against women as a problem. Other problems included difficulty in getting married and the inability of meeting basic needs which included food shortage, no clean drinking water, no health centres or facilities for women to give birth and no good shelter. In all three areas, key informants said that the uncertain future is resulting in stress for men, while the inability to meet family needs was mentioned. Violence, conflict and insecurity was mentioned in remote areas.

Violence in urban areas of Nuristan was also emphasized as a problem as 5 of the 6 children felt sad due to some form of violence or conflict; when parents become angry, when teacher beats them, when friends fight, when they see blood, when they see someone die.

**MH and psychosocial distress**

Children who are distressed are identified according to how they behave and look. In all the areas, children who were distressed are described as sad, worried and their behaviour is bad, they get angry quickly and are agitated. One key informant from semi urban Nuristan said that
distressed children “colour will change and one can see poverty in their face”. While distressed children in urban areas isolate themselves and don’t participate in daily activities.

Women who were identified as distressed are described by key informants as thinking too much, are tired, they look sad, hopeless and upset. One key informant from remote Nuristan said they look as if “they had suffered a lot”. Key informants from semi urban and urban areas said these women behave violently and do not treat people well.

Distressed men according to key informants are characterized by showing signs of being sad and tired and hopeless. Distressed men from remote, semi urban and urban areas all were described as having a short tempers, using bad words and not being trustful of others.

There are people with mental health problems in remote, semi urban and urban areas of Nuristan. In remote, semi urban Nuristan these people have anxiety, become angry, can’t focus on what they say and cannot remember things. In semi urban areas people with mental health problems isolate themselves while in urban areas these people are not accepted in the community. All the key informants from remote, semiurban and urban areas said that people with mental health problems are not accepted in the community and are mocked by community members.

Male adolescents from remote areas said there is a problem of anxiety, depression, anger and negative thinking while in semi urban areas there is an increase of drugs and opium use. In urban areas distress and anxiety was mentioned.

All women mentioned anxiety, thinking too much or negatively as mental health problems. In remote areas mental health problems included increase of anger, feeling numb, being unable to sleep and isolating oneself. In urban areas, drugs and a bad social life and stress were included as mental health problems.

For men from remote and semiurban areas mental health problems included anger while suicide was only mentioned in remote areas, anxiety, thinking too much and stress and mental disorders were identified in semi urban areas. Urban areas included mental disorders and isolation.
Children from the mixed gender focus group across the three areas were mostly scared about the unstable infrastructure of their houses, some were worried that the windows would fall, another said the roof and another said the entire house. One child from remote areas said he is sad when the elders beat him. Some children from semi urban areas said they are sad when they are alone and think too much.

**Impact**

Adolescents from remote areas said that there is no longer employment opportunities and it difficult to get an education while in semiurban and urban areas the social life of the community was seen as negatively impacted. House and family life are negatively impacted (semiurban) and the unity of the family and the community have been negatively impacted as people are alone and don’t see their relatives (urban). Similarly in semiurban and urban areas security had decreased and in semi urban areas there is a limited ability to move freely.

Violence had been one of the impacts in the community according to women in remote, semiurban and urban areas. There are bad relationships, death and hate between people in the community (remote), increase of violence in the community and lack of safety and security in the community (semi urban) and children become disabled (urban). Women in semi urban areas said that mental health problems and stresses increase. Love was also mentioned in semi urban and urban areas as “love doesn’t exist” (semiurban) and “Love is not permitted” (urban).

In both remote and urban areas men feel that they are not able to meet the basic needs of their family. Education in all areas was also limited in the community due to the situation. Men in remote areas mentioned they feel shame as they can’t find work. There is also reduced unity in the remote areas according to men and people can’t move safely in the community this was also mentioned by urban men as conflict and wars have increased. In semi urban areas men said the future does not look good.

Men living in urban areas with disabilities said that children are hungry, and the economy is weak with negative effects on the health and behaviour of people. People are not able to move freely, and the literacy level is decreasing.
When asked about the future, adolescents from the different areas all said they feel sad when they think about the future. Women in turn mentioned from remote and urban areas said they are happy when thinking about the future but the women from semi urban areas said they feel hopeless. Men from the different areas did not view the future positively as they all feel sad when they think about the future and men in urban areas said they wish life becomes better. Men in remote areas said “till now we couldn’t bring any changes but hope to bring positive changes. We have too many problems - don't have access to the city, no good transport.”. Urban males living with disabilities said they feel sad when they think about the future. In comparison, children all said they had positive goals for the future and to become a positive person in the community.

**Coping**
The community is one of the main sources of support when people are distressed or needing to resolve their problems. For children the community tries to help them to know how to respond to emergency situations and how to think positively while for women it was noted that the community should treat women better and for men they should not be left alone by the community, and they should help motivate them. Elders of the community were also identified as key sources of support for men. While for people with mental health problems the community could support them. In remote areas psychologists were mentioned and in semi urban areas spiritual leaders were mentioned as a source of support. In urban areas the directorate of martyrs and disabilities should be asked for support. Spiritual leaders were also mentioned as people who have been raped can seek help from in remote and urban areas.

For family problems in remote areas people should have a better understanding of religious teachings while this was identified as one of the ways to help people with drinking and drug problems in urban areas.

Helping people think positively and to prepare peoples responses to emergency situations were also mentioned as one of the ways to cope with the current situation. Adolescents mentioned this as one of the ways to cope. Women from remote, semi urban, and urban areas all identified faith as a form of coping, with remote women saying the use of amulets, praying and having faith in Allah. In semi urban areas and in urban areas recitation and praying. Women living in
remote areas mentioned the beating of children as a way of coping. Women in semi urban areas said having to defend themselves. While women in urban areas said that they come together to solve the problem.

For men in semi urban areas praying and the use of amulets was an important way of coping. Other forms of coping for men were coming together as a community to help each other (remote), give positive advice and try to motivate people for peace (semi urban) and work on daily wages, give positive advice and use psychotropic drugs (urban). Men living with disabilities also mentioned giving good and positive advice and the continuation of educational courses as well as giving birth in homes.

All the children said they were able to go to their parents, family member and the community when they felt scared and sad. It was also noted that the children were all able to play games with their friends. Except for one child from remote areas who said they do not play games but rather goes to the relative house.

Request for support

Improving health facilities, services and access was a main request from adolescents, women, men and men living with disabilities. Adolescents from remote areas mentioned the need to increase MHPSS services. There was also a request to provide services and amenities to meet basic needs of people living in Nuristan. Job opportunities was also requested. From the different areas, adolescent, women and men all requested for efforts to be made to improve the unity and safety in the community.
Kunar

Problems in the community

When asked about family problems (domestic violence), one male key informant from rural and semiurban Kunar did not want to answer this question. From the other key informants, family problems were described as bad family problems, violence in the family, bad relationships between family members and when the father has bad relationships with the children.

Two male and one female key informants, one male from remote, one male from semiurban and one female from urban Kunar did not want to answer questions about rape in their communities. While it was noted across the three areas by other key informants that the person who had been raped would not be respected in the community as they would not be trusted, and the community would isolate them. The urban key informant mentioned that the person who had been raped would have shame and not have much value in the community.

One male key informant from a remote area in Kunar did not want to answer the questions about drinking and drug abuse. It mentioned by all key informants that those using drugs and alcohol are viewed negatively in the community and are not accepted by the community. Key informants from semiurban and urban areas declared the use of drugs or alcohol as strictly prohibited and forbidden in Islam. Key informants from remote and semi urban areas said these people would not be healthy while key informants from urban areas said these people have mental health and physical problems.

Across remote, semi urban and urban areas according to key informants’ children are commonly distressed by financial problems. While in semi urban and remote areas education opportunities were one of the reasons for children being distressed. In remote semiurban and urban areas children were distressed because of violence. Remote areas due to family problems (domestic violence) and in semi urban areas this was due to the war and conflict, the bad actions of the government to community leaders and someone having died in the family while in urban areas, it was because of family violence, having lost a family member being orphaned. In both semiurban and urban areas child work was one of the reasons as to why children feel distressed.
In addition, mixed adolescent groups said that their distressed caused by the following problems, limited of education opportunities, hard life, being unemployed, bad behaviour, no support and drought (remote), financial problems, unemployment, limited access to health care, the coming winter, no support for the spiritual leaders, corruption, no clean water (semi urban), unemployment, increase of poverty, health problems, child work and unable to afford daily needs (urban).

According to key informants from remote areas, women are distressed due to not being able to meet their basic needs and the government not being recognized internationally. In semiurban areas due to the changes in the government, loss of jobs, economic and health problems as well as poverty. In urban areas women are distressed because of family violence, economic problems, forced marriages or have been given to another family in compensation of conflict or violence and unemployment. Women from the focus groups said they are distressed due to the increased unemployment, limited education for girls and there being no care taker for the family, death, conflict and illegal activities happening in the community (remote) and the poverty, health problems, bad living conditions, no employment, family health issues and no shelter and health centres (semiurban).

For men key informants said that men are distressed in all the areas are due to them not being able to meet the family needs. Other reasons included the conflict and family violence (remote), political problems (urban) and limited education for children (semi urban). One key informant said the problems men face are the reason as to why someone uses drugs.

It was mentioned by the male adult focus groups that in remote, semiurban and urban areas that limited access to education, poor economy, unemployment and while in remote areas family violence, political inability was mentioned. In semi urban areas, disabilities, increase of violence and no facilities for a good life, with no clean water to drink. In urban areas men said they were distressed due to the illegal work, child work and family problems, that houses are destroyed and poor living conditions. These were echoed by the mixed adult group from urban Kunar, who said that limited education opportunities, poverty, no aid from organisation, economy, family problems, no salary of teachers, immigration, scarcity of food, no land for planting, debt (borrowing from others).
Urban men living with disabilities mentioned poor living conditions, insecurity and not feeling safe, family violence, violence against women and children and bad relationships in the families as well as the that health clinics are faraway.

Mental health problems and psychosocial distress
According to remote, semi urban and urban key informants children who are distressed look sad, worried and hopeful. Both semiurban and urban key informants described children who are distressed as having different behavior, “they don’t have patience and don’t behave with good manners” (semiurban) and “they behave as if something is stolen from them” (urban). Children in remote and urban areas who distressed were scared or become frightened easily.

Distressed women in remote, semiurban and urban areas were all described as being sad, depressed, hopeless and their behavior as negative. In remote areas this behavior was not interacting with others, not trusting others, thinking too much and not paying attention to their children. In semi urban areas distressed women were described as ill-mannered while in urban areas these women become angry quickly.

Men who are described by key informants as distressed in remote, semiurban and urban areas are sad and hopeless, have anger problems and do not treat people well. In remote areas these men are “ready to commit suicide” and isolate themselves. In urban areas these men also isolate themselves. In all three areas men who are distressed become angry quickly.

All the key informants agreed that there are people with mental health problems in their communities. One urban key informant said that 80% of the people in the community have mental health disorders. These disorders are described as not having controllable movement, not caring for themselves and living in dirty places. Those in remote areas were described as not being able to differentiate between good and bad and can’t be independent. In semiurban areas these people are isolated and have health problems.

Mixed gender remote adolescent youth said they had the following mental health problems, drug use, distressed due to family life, isolation, feel bad as they are unable to achieve what
they want to. Semi urban mixed adolescents focus group said insomnia, daily stress and urban mixed adolescents said anxiety, uncertain future and depression.

Remote female adults mentioned depression and worrying about life, can’t memorize, think too much and isolate themselves (remote). While semi urban female said there is not enough knowledge about mental health problems, anxiety, hopelessness, depression, worrying about children’s future and thinking too much.

In all three locations the male focus group participants said that anxiety, is a mental health problem, remote males described not having respect in the community as a stressor and not being able to focus and thinking too much. Semi urban men said that there is not enough medicine and doctors on mental health while mental health problems are that they cannot focus on tasks and become angry quickly. In urban areas men said drugs were a problem, they are unable to sleep and forget things very quickly and feel sad. A mixed adult group said that drugs, depression, anxiety, distress and thinking too much and not being able to remember things as well as bad behaviour were mental health problems in the community.

Urban Men living with disabilities when asked about mental health problems said that most people think negatively and are under stress.

Children in remote areas said they feared the roof, feeling alone while in semi urban areas, 2 of the 5 children said they were scared of car accidents and the one of the urban children said that one part of their house is destroyed. When asked about what makes them scared most of the children from all the areas were scared from something relating to violence and conflict. 2 of the 5 children from remote areas drew a mines or guns, 2 children from semi urban areas drew a gun while a third drew a car accident and 3 of the 5 urban children drew a gun.

Impact
Female adults from remote areas said that their daily lives are impacted as they cannot focus on their tasks and they think about suicide. For semiurban women they have become sick mentally and have poor health and can’t achieve their daily tasks as well as limited social lives and education. Men from remote, semiurban and urban areas also said that their daily lives
have been disrupted and can’t achieve what they need. Family life in remote and urban areas were also impacted while semiurban men said their social life had been impacted. Remote makes said that the relationships in the community are no longer trustful. The mixed adult group also said that relationships with others and the community had been negatively impacted. In addition, there is little improvement and the development of society has been limited. While urban men living with disabilities said that children health is now poor and that daily life and family life have been negatively impacted.

When asked about the future children most of the children from the different areas said they had hoped for the future and have positive goals. Only one child from remote Kunar, said that he has hopes for the future, but doesn’t think he can achieve it. Mixed adolescent focus groups from remote and semi urban Kunar said that they feel bad (remote) and “hopeless because the situation of our country is not good” (semi urban) while urban youth said that they have a positive feeling about the future.

Adult females from remote Kunar said the future is indefinite and to use their energy positively and work hard to have a bright future while semiurban females said they feel sad and hopeless about the future. Men in turn also had mixed responses, when men from remote Kunar saying they feel bad when they think about the future while those from semi urban Kunar said they feel happy. One man from urban Kunar said “I will try to improve my life”. The mixed adult group respondents said they feel sacred when they think about the future, “They have fear”. While urban men living with disabilities say they feel sad as they can bring any changes to their lives and the economy is weak and literacy will increase.

**Coping**

It was noted by the remote Kunar key informants that children need to have a safe and secure environment and they can seek help from their parents, uncles, and teachers (remote) as well as relatives, friends and the community members (semiurban) and village and spiritual leaders (urban). When asked to who do children go to help, the children responded by saying that they go to their friends or families as well as their neighbours, religious leaders teachers and elders. One child from remote Kunar said he goes to a safe space.
Key informants described relatives and community leaders and elderly women as a key source of support for women in all areas, while in urban areas it was mentioned that spiritual leaders are also key supporters. While women from the focus groups from remote areas said they do exercise, sports and stay with friends and try to control their mental health symptoms, while women from semiurban areas said they recite or study the Quran.

According to key informants, the community would come together to assist men with their problems, and they could seek help with job opportunities, and provide them with food and aid. One key informant from urban area said men should depend upon Allah and then seek help from villagers and relatives. In addition, men from the focus groups in remote and semi urban areas try to use the local resources that are available to bring solutions to their problems. Men from remote areas said to have patience and to motivate themselves. Semiurban and urban men said that they help each other. Mixed adult groups from urban areas said that they borrow from others, try to change their mind, motivate themselves, focus on studying and try to find a job.

Urban men living with disabilities said they stay alone and try to find the resources on the mountain to meet their basic needs and try providing healthy food and try to go hospitals and look for mental health services

For people with mental health disorders, they seek help from psychologists, relatives, humanitarian organizations and health centers. In urban areas it was mentioned that the community would support them with food and clothes. People with mental health disorders seek help from family members.

In remote areas, according to key informants those with family problems are often helped by the community to identify the problems and provide the best solution and others try to get help from international NGOs. In semiurban areas the community help them identify the problems and give them the solution as well as give them positive advices. In urban areas the spiritual and local leaders as well as the humanitarian organization try to help them.

Those who have been raped according to key informants; must be away from where the incident happened (remote areas) and the rapists are taught according to Islam that this is not permitted
and that there will be punishment in the hereafter (remote and semiurban). In urban areas the community members come together to find out the reasons as to what happened and to decide what to do next.

In remote areas those who are using drugs or drinking alcohol are arrested by the community and government, while in semiurban and urban areas the spiritual leaders try to stop it from happening.

**Request Support**

Health care was requested as to have talented doctors, improve access to health services and medication. It was also asked to improve access for children to education and to provide emergency aid as well as to create job opportunities. MHPSS sessions were also requested as well as providing mental health doctors and increasing the general understanding of mental health disorders. It was also requested to help people with disabilities and poor people.
Laghman

Problems in the community

Family problems when asked were described by all key informants as family conflict and disunity in the community. One semiurban key informant mentioned the problems that women have in the community, these were; poverty, taking their dowry, and the forcing of women into marriages.

According to key informants, people who had been raped are perceived in remote, semiurban, and urban communities as being untrustworthy and are not treated well by the community. One semiurban key informant said that these people will be bothered their whole lives by the community, and they isolate themselves from the community. The key informant from remote Laghman said that those who have been raped “sometimes commit suicide as people are making problems for them and/or because of the shame”

In remote areas the key informants said those with drinking problems are not allowed in the community as they are fighting and scaring the children. While in semiurban and urban areas it was noted by key informants that these people do not have relationships with others in the community. According to one urban key informants these people have mental health problems which was described as “heart beating”. Another key informant said in some cases of these people commit suicide and others run away from the community due to shame.

According to key informants across the three areas, the reasons for children’s distress was due to the conflict in the community, the explosions, poverty and unemployment in the community as well as not having access to education.

Women according to key informants were distressed due to the poverty, unemployment and the insecurity and war (remote), poverty, hunger and unemployment (semiurban and urban) in the community. Based on key informants’ perception, the reasons for men’s distress were similar across the three areas: economic problems, insecurity, emigration, aren’t able to meet their basic needs.
The boy children said they felt sad because of their houses infrastructures not being safe, they don’t have winter clothes, poverty and poor living conditions. While the mixed gender children said they feel sad when there is fighting in the community and in the family.

Male adolescents from urban, semiurban and urban areas said that there are economic problems in the community, there is no access to education and no hospitals. While male adolescents from remote and semiurban areas both mentioned insecurity and it not being safe, with male adolescents from semi urban Laghman saying the community elders are violent. In urban areas the male adolescents said there are no wheelchairs. Both the semiurban and urban male adolescents also said the road infrastructure is not good.

Across the three areas, the men said that war, conflict and violence were problems. Other problems that were found across the three areas were economic issues, unemployment, lack of social cohesion in the community. The men in remote Laghman said that the livestock are being killed in the war and the children do not feel safe at the school, the houses have been destroyed and they also mentioned that there is a lack of social cohesion in the community. Semiurban men also said that there is “discrimination between the community leaders”. In remote and urban areas, it was mentioned that there are orphaned families due to their parents dying in the war. In remote areas one of the problems in the community was the escaping of girls from the community with someone they are in love with and get married without the permission of the family.

Urban males living with disabilities mentioned economic problems, can’t meet their basic needs, and have limited access to health facilities and disability is a big problem as well as poverty and unemployment. They also mentioned that there is no education for girls.

Mental health problems and psychosocial distress
Across remote, semiurban and urban areas, distressed could be identified according to how they look and behaved. These children were “yellow and are flurried”. Semi urban and urban key informants said that these children appear very serious and solemn when talking to others.
Women who were distressed are perceived by all key informants as being silent, calm and depressed and they have bad character and behavior. The male key informant from urban Laghman said that these women behavior are immoral.

Distressed men from the three areas were described by key informants as sad and disappointed and behave badly and isolate themselves.

While key informants from Laghman did not directly mention the symptoms of those with mental health disorders in their community they did identify that people do have mental health disorders. These people with mental health disorders are people who have become disabled by the war and conflict. Male adolescents from remote areas in Laghman did not mention any mental health problems or psychosocial distress, only those from semiurban and urban areas. Male adolescents from semiurban said drugs while urban male adolescents said depression and tensions as well as there is an increase of mental health problems.

Male adults from remote Laghman when asked about mental health mentioned tension, anxiety, depression, bipolar, anxiety from the bomb explosion, anger and impatience. Similarly, men from semiurban and urban Laghman said, anxiety from poverty and bomb explosions, depression, anger, impatience and added sleeplessness, isolating themselves, dissociation. Unique to semiurban Laghman was intoxication, and intoxication of young people. Urban men mentioned crying as well.

When asked people living with disabilities they mentioned there are mental health problems but did not give the details of the mental health problems.

The majority of the male focus group participants from remote, semiurban, and urban areas said they do not feel safe. The reasons were due to the insecurity, pollution, (remote) bombs planted by the insurgents, (semi urban) and conflict (urban). When asked about what makes them feel sacred, the children from remote and urban areas mentioned different childlike things, while most the boys from semiurban areas said they were scared of something relating to conflict and violence.
Similarly, to the boy groups the mixed gender groups said they do not feel safe in their communities due to the war and conflict while one child from remote Laghman said that their friends have disabilities. The mixed children’s group from semiurban Laghman said he feels scared when he sees his home destroyed.

Impact

When asked the male adolescent about the impact both remote and semi urban respondents said they are not able to meet their own and family needs. While remote male adolescents said there are no rights for women and semi urban male adolescents said they are unable to earn money and there are severe economic problems. The adolescents from all the areas said they feel bad when they think about the future. One male adolescent from urban Laghman said “Feel bad about the future and don’t have wishes for the future”.

Similarly, as to the male adolescents in semi urban areas, the men from semi urban focus groups said that they have enormous problems and they are unable to meet their families’ basic needs and cannot work properly. When asked about the future the men from remote, semi urban, and urban areas all said they feel disappointed when they think about the future. Remote men said it was because the government is not yet well organized, semi urban men said it was because of the poverty and insecurity.

Urban men living with disabilities said they struggle more than before to earn money and are unable to work for themselves due to their disabilities and struggle to go to different places. When asked about the future they also said they feel bad about the future.

When we asked the boy children what their wishes were the male children from remote and semi urban areas said they have wishes for the future but they don’t think they will be able to achieve these. This was similar to the response of the mixed gender focus groups from remote and semiurban areas. While the male children from urban Laghman said they have wishes and these are to help the community. One of the mixed gender children’s groups said they don’t have any wishes for the future due to the political situation but the other two declared they have wishes but they don’t know if they will be able to achieve them.
Coping

Key informants said to help children the try to care for the children’s need (remote) and help prepare them for future situations while giving them advice and teaching them how to relax (semiurban). In urban areas the key informants said they can’t help the children because of the poverty and bad economy. The children in all three areas do get support from their families, in semiurban Laghman the families follow Islamic shariah and recite the holy Qaran and seek help from Allah.

According to key informants from remote and urban areas the community help distressed women meet their needs while in semiurban areas they are unable to help them with their needs due to the poverty. Distressed women seek help from their families and the community, (remote) and families and husbands (semiurban and urban).

Key informants from remote, semiurban and urban areas said that when men are distressed, they come together with the community to meet their needs and find a solution. In all three areas it was mentioned that the community counsel these men and give them advice or encourage them. Men seek help from family and relatives, in semiurban and urban areas men also seek help from international organizations.

In remote, semiurban and urban areas the key informants said the community do not know how to support those with mental health problems as they do not have the education to know how to help them with their problems. However, it was mentioned in remote and urban areas by the key informants, people with mental health problems go to the shrines and make amulets for the future and pray for themselves. The key informants mentioned that those with mental health problems do not know where to get help from but the community counsel them and send them to the nearest health centre.

Those with family problems are helped by the community, in semiurban areas according to the key informants previously the community would come together and work through the problem to find a solution while in urban areas they would help them prepare for difficult upcoming situations. Currently remote, semiurban, and urban communities refer them to welfare organizations. In addition to this in urban areas they are also working on their relationships.
Those who do have family problems in remote and urban areas seek help from the community, relatives, friends and people with the financial ability to help them.

According to key informant from the different areas those who had been raped are referred to doctors, religious leaders and community elders. Those who have been raped seek help from their relatives, friends and international organizations.

According to key informants from remote areas the community ask the parents of those with drinking problems to look after them better. Community members also refer them to health facilities for help and try to give them other things to be occupied with. Semiurban areas said these people need to be counselled and be occupied with other things but they do not know how to deal with these problems. The key informants from urban areas said that the community encourage them to stop drinking and some do not know how to deal with this problem. Those from remote areas said people who have drinking problems do not look for help as they are unable to separate themselves from the drinking.

The ways that male adolescents from remote and semi urban Laghman cope is to look for work and to work harder. The adolescents from both areas said they lock up the children who are using drugs in the rooms and do not let them go out the house.

Men only from semi urban Laghman said how they were coping, they said they lock the children in the rooms to stop them using drugs, try to work hard in the community and self-finance teachers.

Urban men living with disabilities did not mention how they cope with the stresses.

Children are playing games in the different locations but these are mostly outdoor games such as cricket, football and volley ball, that acceptable for boys to play. The semiurban mixed gender children group from Laghman said they enjoy studying. All the children said they go to their parents and family when they are scared and can get help from the community.

Request for support
Adolescent boys across the locations requested for education, medication and jobs. Men asked for MHPSS awareness and public health awareness as well as disaster training and also asked for medication and food to be given to the community. They also requested for religious schools. Urban men living with disabilities requested wheelchairs, education, training and guidelines for life.
Key informant interviews with key stakeholders

Key informant interviews have been conducted with key International Non-Governmental Organizations and Non-Governmental Organizations staff. These have included International Medical Corps, Mental Health and Psychosocial Support Working Group Chair, International Organization of Migration, Citizens Organization for Advocacy and Resilience, HealthNet TPO, Save the Children, Conflict Mitigation Assistance for Civilians, and PU-AMI MHPSS Specialist and the previous PU-AMI MHPSS Adviser

Findings

Key themes from the key informant interviews included domestic violence, restrictions on the freedom of movement and expression, poor relationships between men and women - and amongst family members, the witness of violence and conflict, daily stresses such as debt, job insecurity and inability to meet needs. Anger and aggression are common problems amongst men, while women show mostly symptoms of depression and hurt themselves. Children are also showing signs of stress, isolating themselves with some not leaving the house and others arguing and fighting with their friends and families.

Some key stressors mentioned are; lack of job security, poverty, not able to meet basic needs, witnessing of killings and bombs, the decades of war, collapse of the government, concern of the future, social media with fake news and rumours adding to a sense of insecurity, change of political authorities. Men and women have very different experiences of life and what is stressful. Many men directly witnessed, encountered, or participated in violence and conflict while women are mostly experiencing interpersonal violence and conflict. In turn it was mentioned that children experience child abuse and child neglect within families.

Symptoms of distress and mental health conditions included sleeplessness, loneliness, not contributing to the community, low mood, low energy and no interest in daily activities, anxiety and depression symptoms, trauma symptoms and fear of what is coming and thinking too much. In some cases, people are coming for physical ailments to the doctors which don’t have clear physical causes and are often found to be linked to mental health and psychosocial distress.
Many believe that mental health disorders and psychosocial distress are medical or spiritual problems. It was mentioned that some treatment of distress and symptoms of mental health conditions included the reciting of the verses from the Quran, and the heating of a knife which was placed over the eyes of children to frighten the Jinns away by the Mullah. This was mostly found in the remote areas of Nangarhar and needs to be researched more to establish its prevalence. It was also noted that many go to the doctor to receive medication for mental health conditions and distress as many think that is a medical problem with a medical solution with little focus on the psychosocial.

It was also mentioned that recently on social media, videos were being shared of children who were showing symptoms of psychosis and were harming family members and themselves and were chained up. Drugs and alcohol were also used as negative coping mechanisms, while in many cases when those who were showing signs of mental health conditions and psychosocial distress were sent to the doctor to receive medication.

One of the key points from the key informants was how the family space has been shaped by the social, political, and economic conditions and how these interact and shape mental health and psychosocial wellbeing within families.
Section 6: Data analysis

Afghan people understand mental health illness using three concepts (1) biological mental disorders; (2) distress caused by djinns, spirits who take over a person’s mind and body for either good or ill; and (3) distress from adverse life experiences, including war, poverty, and violence (Miller et al., 2006). From the data, little reference was made to the explanation of mental health symptoms by spiritual forces (djinns) or biological disorders. Most of the causes and reference to mental health symptoms and psychosocial problems was due to the current stresses of war, poverty and violence. The spiritual was mostly referred to when seeking help either by asking spiritual elders for advice, going to a shrine, praying, making amulets and Tawiz. In an interview with the Save the Children Child Protection Manager, there are cases where children are taken to spiritual leaders and where rituals are practiced on the children to scare the “jinns” away, however, this was not mentioned by any of the participants.

Adverse life experiences

Afghanistan has been at war for over 4 decades, which has accumulated to the current crises of the current humanitarian crises, economic crash, poverty, poor living conditions and high levels of violence in the community. When participants were asked about their three top stresses, they overwhelmingly chose poor living conditions, war conflict related killings, violence and unemployment. Although there were some differences on province, district status and gender, the main three themes that emerged were violence, living conditions and access to resources. This was reiterated in the focus group discussions and the key informant’s interviews indicating that the biggest problems that Afghans experience are related to living conditions, meeting of basic needs, infrastructure, poverty, war and conflict and lack of educational opportunities and facilities. This supports the findings in the literature where the daily stresses and everyday forms of suffering and adversity is prevalent in Afghanistan (Panterbrick 2009).

While these were identified as the key stresses in the four provinces, interesting to note is the link made between these problems and distress, mental health symptoms and psychosocial problems. When speaking about their lives and the reasons for women, children and men’s distress, key informants mentioned war, conflict, community violence, violence in families, gender-based violence, interpersonal violence, poverty, no food, no warm clothes for winter,
grief and death of loved ones, not having a bright future for their children and immigrations, no job opportunities and not being able to meet their basic needs.

This was not only mentioned by key informants but was also discussed in the interviews with children. Children said that they felt unsafe, unhappy or scared because of poverty, being poor, the houses being in bad condition, not having food or warm clothes for winter. Reiterating the finding by Ken Miller and colleagues that Afghans acknowledge that mental health is a result of adverse life experiences.

**Conflict and Violence in Society**

Violence in the home and the community is one of the key problems identified in the findings. Women were more likely to report on this as a problem than men when asked what their top three stressors were. This could be due to the high prevalence of violence against women where according to the Third Quarterly Protection Analysis (2021), 90% of women have experienced intimate partner violence. Additionally, in the key informant interviews, the majority stated that women were distressed due to the violence in the home. This was also one of the symptoms in the ASCL that showed on average women beating their children over 2 days a week. This was also found in a recent study by IMC (2021).

Violence against women is a major problem in the four provinces, whether this is in the form of forced marriage, rape, emotional abuse or interpersonal violence in the home by either husbands, fathers or in-laws. Key informants with the MHPSS WG chair spoke about the brutality of the violence against women and mentioning this is not out of the norm but a part of the day-to-day experience of women in Afghanistan.

While men are often the perpetrators of interpersonal violence - especially in post conflict and patriarchal societies - women can be too. This could be the result of displaced aggression as women do not have many opportunities to express their frustrations in a highly patriarchal society such as Afghanistan (Slotter et al, 2020).
People Living with Disabilities

Focus group discussions were set up with people living with disabilities. People in the community spoke about the problems of people with disabilities, including children as well as adolescents, who mentioned that there are a number of people with disabilities in the community. It was mentioned that most of these people were disabled from the war, conflict and violence and that these people have mental health problems. Focus group discussions with people living with disabilities noted they had limitations in accessing services in the community and needed support. These needs were reiterated in the findings by IMC (2021). Attention needs to be given to people living with disabilities mental health and psychosocial wellbeing, especially in the context of Afghanistan where majority of their injuries are in relation to a violent event.

Mental health symptoms

Symptoms reported on using the WHO and UNHCR WASS and the ASCL showed high rates of trauma symptoms, symptoms of depression, anxiety and distress. These findings are consistent with the IMC assessment and the HNO (OCHA 2022). The findings showed that these symptoms were disrupting respondents' lives and making it difficult to focus on their daily task and the meeting their basic needs thus resulting in more stress – a vicious cycle. Women self-reported more symptoms of distress across the survey, this reiterates the findings from previous studies where women were more likely to report symptoms of depression and anxiety than men. Symptoms of mental health problems and distress were described as “sleeping, thinking too much, shying away from the community, bad behavior, not normal mentally, being flurried, look yellow, being tired, think negatively, weakness of the mind, tension and heart beating, anger and impatience”.

Depression, anxiety and traumatic symptoms

Studies have found that living in a war-torn area is associated with significant and lasting anxiety, depression, PTSD and other adverse culture specific outcomes for both children and noncombatant adults (Briere and Scott 2015).
Depression Symptoms

Over 50% of respondents reported symptoms of depression in the last two weeks. While in the ASCL these symptoms were on average experienced between 2 and 3.5 days a week, thus within the last two weeks about 50% of the time respondents experienced some form of a depression symptom. Important to note is the link between the mental health symptoms and adverse experiences. Participants reported emotional distress related with Jigar Khun (having lost someone) on average 3 days a week.

Findings from the focus group discussions indicated that participants experienced feelings and states of disappointment, hopelessness and could not envision a future for themselves and their community. These findings were found across all genders and ages – including adolescents and children. Reasons cited by the participants were due to the lack of certainty and the systematic barriers to achieving goals and dreams such as poverty, community violence and lack of social cohesion. As noted by Macloed (2001) negative thinking and hopeless about the future is also symptom of depressive thinking. Depressive symptoms were a common occurrence with over 50% of the survey respondents reporting on depression symptoms over the last two weeks and key informants and focus group participants describing mental health problems and distress with depression symptoms.

Anxiety Symptoms

Anxiety symptoms as reported on in the WHO and UNHCR WASS showed high rates of anxiety with over half of respondents reporting on symptoms where they could not calm down and felt out of control over the last 2 weeks. In addition, ASCL anxiety symptoms were reported by participants to be experienced on average between 2 and 3 days a week. Anxiety symptoms were also described by the participants in the focus group as not being able to concentrate on what they were saying, loss of appetite and having racing hearts. Thinking too much was reported on average of 3.5 days a week. While in the focus groups and key informant interviews “thinking too much” was used to describe the distress of women, men, children and people with mental health disorders. This can be interpreted as one of the core general anxiety symptoms of intense, excessive and persistent worry and fear about everyday situations.
Traumatic Symptoms

In the findings, somatic symptoms of traumatic stress were reported on not only using the tools but also in the focus group discussion and the key informants. Symptoms of trauma as described in the DSM-5 do not include psychosomatic symptoms as an indicator for a post-traumatic stress diagnosis. However, ground breaking work has been done that shows the prevalence of psychosomatic symptoms in response to traumatic stress (van der Kolk 2014). Summerfield (2000) also recognizes that somatic presentations are central to the subjective experience and communication of distress wrought by war and reflect traditional modes of help seeking and how to talk about distress more generally with health professionals. Understanding and acknowledging that stress affects all systems of the body (including musculoskeletal, respiratory, cardiovascular, endocrine, gastrointestinal and nervous systems), that the body stores and contains highly stressful events and how this impacts a person’s response to the surrounding environment is key to the success of MHPSS interventions. This is especially relevant due to the prevalence of adverse events in the four provinces of the study and the reporting of psychosomatic symptoms of the participants. These findings highlight the multilayers and continual stress which characterizes the daily lives of the study participants.

Further findings of trauma symptoms were intrusive thoughts, avoidance, negative changes on cognition and mood, nightmares, unwanted memories, hyper-arousal. More than half of the men and the women survey participants said their daily lives were disrupted by these symptoms. While the study was implemented during a highly stressful time - which included a military takeover, ongoing drought and a harsh winter as well as an economic crush and a global pandemic - and even though there is potential that these events could skew the results, these types of events appear to be cyclic and the norm in Afghanistan. These findings point to a prevalence of trauma symptoms for men and women in the four provinces of the study along with possible historic trauma. Distressed children were described by key informants as being scared and easily startled while most of the children in the focus groups were scared or sad due to the conflict and the violence happening in their communities.

This is reiterated in the literature as a study in 2004 found that the majority of participants in Eastern Afghanistan had experienced between 8 to 10 traumatic events in their lives, and 14% experienced 11 or more (Scholte et al, 2004). In 2018, the National Mental Health Survey and
Assessment of Mental Health Services found over half of participants had either experienced or witnessed a traumatic event; this was the case in the later study in 2021 (Kovess-Masfety et al; 2021). This study does not aim to diagnose PTSD as the data collection tools were not designed to diagnose. However, the prevalence of adverse events in the history and current situation of Afghanistan needs to be taken into consideration along with the daily struggle of Afghans to meet their basic needs. This context of Afghanistan places the importance of exploring the current symptoms described in the study with a trauma informed lens.

The research identified most of the children do not feel safe due to the current crises and poor living conditions, the current and past violence in the community as well as the violence in the homes. While this was a general trend across the four provinces, a high majority of children in Nangarhar and Laghman province reported that the cause of these feelings of being unsafe is due to the presence and threat of violence. In Nangarhar, the feelings of being unsafe was due to insurgents, the sound of bombs and poverty. In Laghman, the feeling of being unsafe was attributed to poverty, the presence of bombs planted by insurgents and houses close to the army checkpoints. In Nuristan, children reported the house’s infrastructures were not secure and in Kunar, the children drew in detail either guns, mines or bombs as reasons for being afraid - but the majority of children attributed the dark, cemetery and the yard for feeling unsafe.

Suicide

Suicide in Afghanistan is taboo and those who have attempted suicide are often isolated from their community (Ahmad, 2017). Suicide was not spoken about often but was most often addressed when when key informants of communities spoke about people who had been raped and when referring to the distress of men. For men in Nangarhar and Laghman, suicide ideation was attributed to feelings of shame and the way suicidal people they were treated in the community. It was also noted in Kunar that the feeling of hopelessness and sadness were also the reasons for suicidal ideation in men. Suicide in Nuristan was not cited as a common problem. Suicide ideation in Nuristan was perceived to be related to financial and health problems, and the community was perceived as not treating the person with respect. The person who was known to have committed suicide in the community was perceived as mentally ill.
In addition, a recent study noted that women were more likely to commit suicide than men (Kovess – Masfety 2021) whereas from the findings more men reported suicide ideation. Depression and domestic violence were the causes of attempted suicide by Afghan women and “only agency is her decisions around death” (Ahmad, 2017). These findings point to the fact that even though suicide is not reported on and spoken about freely, the prevalence of depression symptoms and domestics violence as found in the study reiterates the importance of health care professionals and mental health workers being aware of suicide ideation in the population. We observe that from the four provinces two of them, Laghman and Nanagahr provinces mentioned that those who have been raped are committing suicide due to the shame. This reason was also cited by a recent study (Maniam, et al, 2021) when rape is another very strong taboo in Afghan society.

Drug and Alcohol abuse

When key informants were asked about drug and alcohol use, there was a strong reaction of labelling this as a bad behavior and those who are involved in this activity are perceived as bad people in the community with many problems. The use of drugs and alcohol has been acknowledged as a coping mechanism to Adverse Childhood Experiences (ACE) and other mental health disorders and traumatic events (Mate, 2008). This is reiterated in interviews done with Kabul youth who used drugs to help them forget their worries, pain and fears (Samuel Hall, 2016). While there was no direct reference made to this in the data, there was reference made to those who use drugs and alcohol as having mental health problems. Further both adolescents and male focus group discussions in Laghman said that there is a drug problem amongst the youth. To deal with this problem, some of these children are locked in a room and are not let out for fear of them using drugs. The majority of youth in the focus group discussions said they felt hopeless about the future and had many problems relating to their circumstances. Key informants stated that many of the youth experience hyperarousal due to the experiencing and witnessing of explosions and bombs. When working in the communities, there needs to be a sensitivity to the use of drugs and alcohol in adolescents and adults, a strategy some use to cope with the overwhelming stresses and pervasive violence experienced.
Anger

Anger and aggressiveness are the expression of often deeper suffering and part of the survival response (Kaminer and Eagle, 2010). Anger was also a common symptom used to describe mental health symptoms (Fernandez, E & Johnson, S., L., 2016). Anger is a complex emotion as it is often used to protect oneself from the underlying emotion which could be more overwhelming and threatening to the self. Within the context of Afghanistan and the patriarchal society for men, anger is an acceptable way to express emotions and maintain a façade of control. The findings showed that “bad behavior” was also used to describe men’s symptoms of distress. These “bad behaviors” included bad words, starting fights in the community and being irritable. Shame was mentioned as a common experience of men, both in the findings and in the literature. Both attributed anger to the inability to fulfill their masculine roles that had been imposed on them from the culture. Echavest et al (2016) found this experience to be a great dishonour “be-ghhairat-I’ and shame, this was confirmed by key informants as well as men in focus group discussions. Shame is an important emotion to consider as it can be one of the contributing factors to men becoming perpetrators of violence (Gilligan, 2003).

Coping mechanisms

Social support is a key form of coping in the four provinces, whether this is due to the limited access to health care facilities, not knowing where to access mental health services, stigma or due to the traditional norms and values within Afghan society. This finding reiterates the importance of rebuilding the social fabric of the four provinces to ensure the natural forms of support and resilience which exist in the society can be utilized. However, key informants and focus group participants did mention that these natural support systems have been challenged as disunity, lack of trust between people and feelings of shame and disrespect are problems in their community.

When asked about how people cope with distress in the community and help seeking behavior, the community and family were cited as central. For women, most of the support was from the family and elder women in the community while for men, it was from the community, specifically community elders, leaders and spiritual leaders. This was confirmed by the literature, which points to the importance of supportive family and community to help seeking.
behavior (Alemi et al. 2018, Eggerman & Panter-Brick, 2010, and Afghanistan protection analysis update, October 2021). In addition, for children and adolescents, family and parents were their main source of support when they were feeling sad and scared.

Religion was a very common response to coping in the eastern provinces and is used to guide and shape people’s lives and behavior including help seeking behavior. This included praying to Allah for help, going to shrines, making amulets. Religion and spirituality are a phenomenon which creates meaning, a sense of structure and offers an opportunity to connect with others with similar beliefs (Greenstein, 2016). In the four eastern provinces, the Quran is the basis of life for advice and mental health treatment. Recitation is also used to help people be “quiet and calm”.

Barriers

Many of the respondents of the study asked for more awareness of mental health and psychosocial wellbeing in the community. There appears to be a lack of knowledge and acceptance of mental health conditions. Stigma was one of the barriers mentioned as to why many don’t access support. This was confirmed by one of the Health Centre staff in Kunar, mentioning that there is shame when people talk about mental health problems. However, despite apparent shame and stigma, mental health issues have been discussed quite openly and the respondents did express the need for better access to psychological consultations and psychotropics. While the healthcare data showed that there are a high number of staff who have been trained to identify and treat mental health conditions and psychosocial problems, there appears to not be enough staff available and competent to provide this support. Part of this was the acknowledgement of health staff that there needs to be more specialists and medication for the treatment of those with mental health conditions. Included in this was the lack of adequate space for patients to be able to receive these services while respecting cultural norms of respecting the privacy of families and the women needing muharams. In addition, key informants and focus group participants mentioned that health centers are difficult to access because the roads have been destroyed due to the war and the Health Centre was far from their communities. Further some mentioned that they did not know what MHPSS services were available that they could access.
Not being able to meet basic needs, malnutrition of children and health problems was a common cause of mental health symptoms and distress mentioned by key informants and focus group participants. Following the WHO assertion “there is not health without mental health”, one also needs to take into consideration the wider socioeconomic, biological, and environmental factors which contribute to the wellbeing of people. Attention needs to be paid to the stress and survival mode which many find themselves in due to the current social, political, and economic environment. To achieve this, one cannot only take a perspective of providing mental health programs but rather include the IASC principles and approach in the meeting of basic needs and services in such a way that promotes human dignity and agency.

Section 7: Recommendations

Following the IASC (2007) Guidelines on Mental Health and Psychosocial Support in Emergency Setting, the recommendations will follow the intervention pyramid for mental health and psychosocial support in emergencies. The layers of the IASC intervention pyramid emphasises a need for a multifaceted and multi-layered approach that acknowledges the individual within the wider social, political and economic environment. The intervention pyramid ensures that activities are built upon one another and emphasising the majority of mental health and psychosocial problems can be addressed if one follows the order of the pyramid. First by providing social consideration in basic services and security and then followed by strengthening community and family supports. However, a large majority of people require non specialised support to recover and promote mental health and psychosocial wellbeing. A small percentage only require specialised services, that may be provided as a complement to focused and non-specialised mental health and psychosocial care. These layers need to be used as a ladder where each rung is a step up onto the next layer of services to effectively address mental health and psychosocial needs.
Layer one: Social consideration in basic services and security.

Meeting basic needs

Acknowledging the impact of the inability to meet basic needs and the continual reduction of life to a survival status is vital to ensure wellbeing in Afghanistan. Part of this is to provide the basic needs in such a way that promotes a sense of agency and empowerment. The majority of respondents in the study noted the continual stress of being unable to meet their basic needs, such as food, health, electricity, shelter and water.

More consideration needs to be done in how humanitarian programs and activities are designed and implemented in Afghanistan to include community led and sensitivity to the lived experience of the beneficiaries. This could be done by doing rapid needs assessments and stakeholder mapping to identify existing systems of coping and support as well as continual Knowledge, Attitude and Practice (KAP) assessments. Findings should guide the implementation and the monitoring of the humanitarian activities while following the 4
SPHERE Protection Principles. Integrating these principles into any sector of humanitarian interventions and MHPSS activities will promote a feeling of safety and security, a sense of agency and dignity to the person while also strengthening the social support already available in the community, therefore promoting the innate resilience within a community.

Effort should be made to strengthen social support and community networks in facilitating the distribution of aid as this is one of the positive coping mechanisms in Afghanistan. This will mean that humanitarian actors need to reduce the gap between programs and the community and to ensure that programs are informed by the community needs and the leaders of the community are included as key stakeholders. Community elders and spiritual leaders should be made aware of the services being offered by different humanitarian organisations within their areas and how to access this support. These individuals can be included in trainings on how to support and refer people who need humanitarian support.

In addition, there are already community structures which can be utilized to spread accurate and up to date information for people to be empowered and treated with dignity such as the community councils (health Shura), teachers and spiritual leaders. Part of this is to also ensure cultural and social norms are taken into considerations when disseminating information and aid as these structure the day to day living of Afghans. This can be done by ensuring that information is shared with beneficiaries in such a way that builds trust and fair expectations between humanitarian organisations and the affected community.

Afghanistan is a patriarchal society where women and men lead different lives and have different ways to address their needs which needs to be respected both for the organisation to have acceptance and to ensure the safety of beneficiaries and staff. Research should be done either informally or formally to better understand how cultural norms and beliefs impact how particular services such as mental health and health are accepted and accessed in different communities.

The findings recognized GBV, SGBV and domestic violence as taboo in the community. Due to the sensitive nature rather than implementing GBV and SGBV programming which could cause harm to the beneficiaries focus should be on identification and emotional support of
families and survivors. Health and MHPSS staff should be trained in reflective listening and non-judgmental support and how to assess risk of harm rather than case management. A general support response should be given to prevent the shaming or identification of the survivor by the community. Only after the permission is granted by the survivor and assessment of risk should the survivor be referred. Forms of cultural and social bias such as moral judgement and should also be considered in when addressing these needs in the community.

MHPSS mainstreaming

As outlined in the IASC MHPSS Guidelines for Emergency Settings these 6 core principles should be integrated into MHPSS activities and all humanitarian interventions. These 6 principles are:

1. Human rights and equity
2. Participation
3. Do no harm
4. Building on available resources and capacities
5. Integrated support systems
6. Multi-layered supports

One such way to identify how to integrate these principles into humanitarian interventions is to include MHPSS into service mapping and multisectoral needs assessment. Frontline staff should be trained on ensuring dignity, display respectful behaviours towards beneficiaries and show empathy, listening, identification of distress, communication and basic helping skills.

It is recommend that all staff providing aid and having contact with beneficiaries should have training in PFA. PFA is an approach to providing aid that is humane, supportive and practical. It allows for the affected person to share their concerns and needs while helping the person to address their basic needs. It also helps the affected person to connect to information, services and social support and establishing a sense of agency.
Trauma informed approach

Violence in Afghanistan and the four provinces of study were set on a spectrum of interpersonal violence to war and conflict. Each person in the study had been indirectly or directly impacted by violence while other studies have found that over half have either witnessed, experienced or indirectly experienced a traumatic event. Due to this it is imperative that in the provision of services, a trauma-informed approach is adopted. A trauma informed approach recognises the impact of traumatic experiences on the wellbeing of the individual such as losing the sense of control over one’s life, feeling of helplessness, heightened awareness and the violation of trust of others.

Health staff and mental health and psychosocial staff should be trained on what trauma and stress is, how it impacts the body, behavior and relationships. Included in this should be an understanding of the psychosomatic impact of stress and trauma, cultural and social understanding of distress and how to approach and engage with stressed people should be included in health and MHPSS staff training package.

The six principles of trauma informed care should be integrated into the services provided by humanitarian workers. These principles are;

1. Safety
2. Trustworthiness and transparency
3. Peer support and mutual self-help
4. Collaboration and mutuality
5. Empowerment voice and choice
6. Cultural, historical and gender issues

Together, these principles aim to establish a sense of safety, regain a sense of agency and control and rebuild trust in society and others.
Layer two: Strengthening community and family supports

Community and family support were the main ways in which different genders and ages coped with the distress and mental health symptoms. While this could promote the resiliency and long term coping, it can also perpetuate harmful practices. Also it was important to acknowledge how the community and family responded to people’s distress such as rape, disabilities and mental health symptoms had a direct impact on either promoting recovery or increasing distress. Identification of positive and negative coping mechanisms could be included in needs assessments and through the development of relationships with community leaders such as elders, spiritual leaders and health shuras. Positive coping mechanisms should be encouraged while negative coping mechanisms can be addressed through psychoeducation and psychoawareness campaigns.

Sensitising Community Leaders

Community leaders, elders and spiritual leaders should be supported in their role in the community as a form of social support and to reduce stigma of mental health. People already go to them for advice and guidance when they experience distress. By strengthening this response, more can be done to reduce social and cultural norms that cause harm. This will be a precarious balance as it has been mentioned that certain human rights and humanitarian principles and values are associated with imperialist culture. Effort must be made to use the already existing positive social and cultural understandings to counter harmful practices which exist.

Community leaders, elders and spiritual leaders should be included in mental health and psychosocial workshops and more effort should be made to include them as implementers of mental health and psychosocial support activities in the communities. MHPSS awareness campaigns should target these actors and should cover topics such as mental health awareness sessions, the normalisation of stress responses for women, children and men, stress management through relaxation and grounding techniques, anger management and mood regulation through a cultural lens; and information of what MHPSS services are available in the community and how to access these.
Empowering communities

Throughout the four provinces help seeking behavior was to approach community leaders and elders, family members and spiritual leaders. Very rarely was outside help such as humanitarian organisations or health centres mentioned. This emphasizes the need to equip communities with positive coping mechanisms by strengthening community leaders’ ability to support people who are distressed and to refer when necessary. Through psychoeducation of stressors, basic communication skills and human rights knowledge community leaders will be able to rebuild social networks and provide a sense of stability and normalcy. Two recommended ways is through the mhGAP Community Toolkit and facilitating community support structures.

One tool that could be used to guide this intervention is the mhGAP Community Toolkit. The modules can be integrated into different community roles such as teachers, healthcare workers and other community activities. Included in the toolkit is selfcare which is important to include as those who are providing support are also likely to have experienced the same types of stressors as those they are providing support in. This toolkit also promotes self-help and a sense of control which highly stressful events often challenge. It also builds resilience and resources that can be utilised even after humanitarian actors leave or when another emergency happens. Social capital can also be rebuilt through these actions and leave long-lasting impacts that promote social cohesion and resiliency.

REPSSI and Transcultural Psychosocial Organisation (TPO) have introduced steps on how to identify and equip community leaders through community support structures. Combining with the IASC guidelines as well as their lessons learnt they suggest the following steps in their Community Structure Support (CSS) Model (REPSSI, 2010: 13 – 14);

Step 1: Identification of a community and/or target populations in need of psychosocial and mental health support
Step 2: Identification of a CSS group
Step 3: Needs assessment of the capacities of a CSS group
Step 4: Development of a capacity building plan for a CSS group
Step 5: Facilitate interactive learning sessions with a CSS group

Social Support Groups

Social support groups can be formed to disseminate information into the community and supporting referral processes to humanitarian services. Gender and age specific groups can be formed to build coping mechanisms and reduce the stigma of mental health and psychosocial distress in the communities. From the findings, it is recommended to implement peer to peer group support with parents, women, people living with disabilities, men, adolescents, elderly, and children. Topics should include awareness of mental health and psychosocial support, the normalisation of stress responses and the inclusion of relaxation techniques to assist in the day to day stresses.

Parental groups

Parental groups to assist parents in positively supporting children when they are distressed as well as providing support for parents. An entry point could be through health sexual and reproductive health and nutrition services to reduce the harm of singling out families. In some cases it could be optional to work alongside community and spiritual leaders to refer families that are in need of additional psychosocial support. The groups would be an opportunity for parents to share concerns and techniques while learning about the impact of stress on children and how to support children who showing signs of distress as well as self-care for parents. Children who are suffering from malnutrition and their families should be targeted as a separate group which includes activities that promote healthy interaction between family members, children psychomotor activities and the stress reduction activities for both parents and the child.

Safe Spaces for children and adolescents

Peer to peer groups for children and adolescents will assist in providing opportunities for youth to learn positive coping mechanism, share their worries and provide an opportunity for social development. These groups are to be centered around recreational activities and structured curriculums which support mental health and psychosocial wellbeing as well as creating an
opportunity for children and adolescents to play and practice healthy social engagements and releasing stress. This might be easier for boys than for girls due to the current social and political environment. Effort should be made to include girls either through culturally appropriate advocacy or activities.

It is recommended to follow the assessment as designed by Save the Children (2008:48) Children Assessment Tool Example Afghanistan Child Protection Quick Assessment to identify the needs and resources available in the community. From the research, schools and/or mosques (or religious centres) were identified as safe spaces and should be utilized as place of safety where children where child friendly and safe spaces can be implemented. Following the recommended tools and resources as prescribed in the Child Friendly Spaces in Emergencies: A Handbook for Save the Children Staff, one is able equip staff, design and facilitate child friendly spaces. Resources that are included are;

1. Being Aware of Sources of Stress and Common Reactions after an Emergency
2. Resilience Factors
3. Psychological First Aid
4. Talking with Children: A Quick Introduction to Principles and Techniques
5. Decision Making about Child Friendly Spaces in Emergency Response
6. Logistics Checklist

Family support

Family in the four provinces is central to the wellbeing either as a support or as a site of distress with high rates of interpersonal violence in the home, inability to meet needs and poor living conditions. How to strengthen family wellbeing and building safety within the family should be included in MHPSS programming. Topics should include, building relationships in families, positive parenting, dealing with stress and being positive role models for children.

Layer Three: Focused (Person to Person) Non specialised Support

Individual and group sessions should be follow cultural norms and practices to promote the psychosocial wellbeing as well as the safety of the beneficiary and the reputation of the
organization. A few considerations; as women are required to have a chaperone it is recommended that the staff to take this into consideration when speaking to the women with the chaperone about their problems and introducing the services. Designated areas where services are provided should not be labelled in such a way as to promote stigmatization and identification. Designated areas should be private to protect the reputation and the privacy of beneficiaries but staff should know to not be alone with the beneficiaries.

**Male Focused Interventions**

Domestic violence and violence against women were listed as one of the common reasons for distress of women and children. Currently it is difficult to implement GBV focused activities in Afghanistan due to the political situation and cultural norms, however effort does need to be made in how to address this problem in a culturally sensitive manner that doesn’t place beneficiaries or staff at risk.

One such way is to do men focused interventions to address the prevalence of GBV in these four communities. A program could be set up where key male role models are trained in culturally appropriate messaging and concepts which support the male centric culture while countering norms that support GBV. Topics to include;

- Being a role model in the community
- Leading your family
- Principles and values to live by
- Stress and anger management
- Resolving conflict
- Counting blessings
- Relaxation and grounding techniques.

**Women focused interventions**

Women focused groups need to address the symptoms of distress while building their internal and external resources. WHO programs, such as Thinking Healthy in the frame of perinatal mental health, Doing What Matters in Times of Stress or Problem Management Plus (PM+).
can be used in this context as it assists in identifying problems, adapted strategies and solutions while addressing symptoms of depression, stress and anxiety. Activities to be included should be culturally specific activities which promote current positive coping mechanisms. Relaxation and grounding techniques should also be included to assist the body’s transition from “survival mode” to a more calm and relaxed state.

Children focused interventions

Child friendly spaces can follow the program developed by War Child I Deal and Big Deal; which follow a curriculum designed to assist children and adolescents deal with life in post conflict settings. IFRC and Save the Children resilience programs are also adapted to the needs and context in Afghanistan. The aim of these curriculums is to develop healthy life skills to promote healthy development in children and adolescents, in and out of school. Due to the social and cultural norms the one topic, boy and girl relationships might need to be adapted or not included to ensure the support of the community. Gathering groups might be difficult, therefore it might be easier to include these either in schools or at health centres while the parents are receiving healthcare.

Building Capacity through Supervision

Even though it was mentioned by health facility staff the need for more training to provide MHPSS services, the data showed that a majority of staff have received different training on a variety of MHPSS topics. Rather than providing additional training, it might be better to set-up a knowledge-retention approach through on-the-job capacity building and regular supervision on specific topics, where staff have an opportunity to share their challenges as well as an opportunity to practice and grow their skills. More effort needs to be made to equip healthcare providers with the ability to adequately respond to common mental health symptoms such as stress, depression, anxiety, dissociation, sleep disorders, alcohol and drug abuse, and suicide that counter cultural and social norms. From the assessment, a high number of health care workers were trained in different mental health disorders but not in the topic of bereavement. Considering that there were a number of people quoting the loss of loved ones
due to the war, bereavement support for adults and children needs to be included in MHPSS trainings.

Layer four: Specialized services.

Equipping specialised services

From the data in 2018 and with the current mass emigration in late 2021, it can be expected that there are even less people with specialised mental health training and experience in Afghanistan. Even so, the specialised services that are available should be mapped and should be interrogated to know the quality of these services and their risk potential. Identified specialized services to be referred to should meet the following prerequisites;

1. Extensive experience and maturity in MHPSS programming
2. Strong technical competencies and sustainability
3. Availability of medical staff and experts in MH
4. Alignment with the national health strategic plan and policy of the country

Appropriate referral mechanisms should be put in place, that respect the agency and dignity of the beneficiary as well as ensuring the confidentiality and safety of the beneficiary and staff at all times. To address potential cultural bias of severe symptoms, those referring beneficiaries for specialised support should rely on referral SOPs including clear criteria of those who need this support and those who can be referred to other forms of support. The criteria should include common and severe signs of distress, severe mental health disorder symptoms, suicide ideation and a pathway of referral steps. Specialised mental health care to be dedicated only to severe and/or complex cases that cannot benefit from focused MHPSS interventions.

Further reporting of those being referred and followed up should be integrated into the referral process. Regular clinical supervision and training should also be offered to those who are offering referrals. A minimum presence and availability of experts in mental health should be ensured at all stages in order to ensure sustainable and quality services and limit the risk of
harmful practices. They also should be involved in the design of adapted MHPSS programming.

**Culturally relevant approaches**

Any mental health and psychosocial services should include culturally appropriate idioms of distress and culturally relevant mental health and psychosocial support - including appropriate support in the process of bereavement - that ensure the uptake and acceptance of the services in the community. Awareness of the availability of these services and the provision of psychoeducation about mental health related topics should be given in the communities and in health centres to reduce stigma and promote acceptance. One such way is through value-based counselling.

Value based counselling, as introduced by Missmahl (2018) in her reflections of fourteen years in Psychosocial support in Afghanistan, shows the importance of providing counselling that takes in consideration the lived experience as well as culturally relevant symptoms. The approach explores the meaning of the symptom in the sociocultural context and the worldview of the client. The focus of this approach is not on diagnosing but rather on exploring what is limiting the persons day to day functioning and together with the client, reaching a solution and influencing the situation. This approach is one that should be included in the focused and in the specialised mental health services for those with moderate to severe mental health conditions. The following principles of value based counselling should be followed:

(1) Every person, regardless of their symptoms, is at any time able to act
(2) Counsellor and client meet in a symmetrical relationship as equals
(3) Each person has to be understood within his or her own frame of values
(4) The meaning of symptoms needs to be understood within their given social and cultural context
(5) The counsellor meets the client with authentic interest, unconditional regard and with an empathetic, non-judgemental attitude
(6) Restoring self-efficacy, meaning and access to one’s own resources are prioritised within the counselling process
Conclusion

The research concluded that the lived experience of people in these communities are highly stressful due to the long-term impact of years of conflict war. There has been an erosion of basic infrastructure which have effected people’s ability to meet their basic needs. As well as the insecurity and violence in community make it difficult for people to be able to access to services.

Based on the survey results over 50% of respondents have symptoms of depression, anxiety and distress. The results also pointed to high levels of traumatic stress as many live in a state of survival as they are unable to meet their basic needs, the uncertainty of the political, social and economic situation and violence and conflict which characterise family and community life. Symptoms of distress included sleeplessness, isolation, thinking too much, becoming angry, being flurried and bad behaviour. Children also reported feeling sad, scared and unhappy due to the insecurity, violence and poverty in their communities. Most of the participants reported feeling disappointment and hopelessness when thinking about the future.

Central to the wellbeing of people living in these four provinces is the community networks and the traditional meaning of life as described through cultural and social norms. It is therefore imperative that MHPSS and other humanitarian interventions take this into consideration. Further research should be done to identify how cultural and social norms dictate how services are accessed and how they can be worked with to support the wellbeing of communities.

One cannot focus solely on the macro level of the past 4 decade of war, conflict and violence and its impact on the political structures. Rather one needs to take a step further and recognize how the pervasive threat, violence and multi-layered threats to survival have altered the social fabric, normalisation of attitudes and behaviour that promote violence and living in “survival mode”. This approach shifts the focus from diagnosing and labelling people as traumatised but rather as taking a socio-ecological approach that acknowledges the characteristics of continuous trauma in the four provinces of the study.
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Annex 1: Top three stressors

Kunar Province
Top Stress Factors for Kunar Males

- Remote (n=87):
  - Health concerns: 5%
  - Poor living conditions: 30%
  - Money problems: 35%
  - No job: 34%
  - War/violence/conflict/killings: 21%
  - Explosive devices/bombs: 24%

- Semi-urban (n=80):
  - Health concerns: 21%
  - Poor living conditions: 38%
  - Money problems: 21%
  - No job: 24%
  - War/violence/conflict/killings: 38%
  - Explosive devices/bombs: 30%

- Urban (n=29):
  - Health concerns: 14%
  - Poor living conditions: 34%
  - Money problems: 34%
  - No job: 34%
  - War/violence/conflict/killings: 34%
  - Explosive devices/bombs: 34%
Top Stress Factors for Laghman Females

Top Stress Factors for Laghman Males
Nangarhar Province

Top Stress Factors for Nangarhar Females

- Remote: 40% Family problems, 57% Poor living conditions
- Semi-urban: 38% Family problems, 58% Poor living conditions
- Urban: 50% Family problems, 42% Poor living conditions

Legend:
- Family problems
- Poor living conditions
- Health concerns
- War/violence-conflict/kilings
- Explosive devices/bombs

n=131, n=26, n=36
Nuristan Province
Top Stress Factors for Nuristan Females

- Remote: n=107
  - Health concerns: 24%
  - Poor living conditions: 27%
  - Economic concerns: 34%
  - No job: 22%
  - Violence in your community: 3%
  - Violence against women and children: 7%
  - Discrimination against women and children: 34%

- Semi-urban: n=26
  - Health concerns: 31%
  - Poor living conditions: 27%
  - Economic concerns: 27%
  - No job: 4%
  - Violence in your community: 4%
  - Violence against women and children: 8%

- Urban: n=41
  - Health concerns: 34%
  - Poor living conditions: 20%
  - Economic concerns: 39%
  - No job: 5%
  - Violence in your community: 5%
  - Violence against women and children: 5%
Top Stress Factors for Nuristan Males

- Remote (n=115)
  - Health concerns: 17%
  - Poor living conditions: 17%
  - Economic concerns: 27%
  - Not enough healthcare services: 10%
  - War/violence/conflict/killings: 12%
  - Feeling unsafe: 8%

- Semi-urban (n=26)
  - Health concerns: 42%
  - Poor living conditions: 42%
  - Economic concerns: 8%
  - Not enough healthcare services: 15%
  - War/violence/conflict/killings: 23%
  - Feeling unsafe: 25%

- Urban (n=55)
  - Health concerns: 15%
  - Poor living conditions: 20%
  - Economic concerns: 7%
  - Not enough healthcare services: 9%
Annex 2: WHO and UNHCR WASS Graphs

Kunar Province

Kunar residents who frequently felt so afraid that nothing could calm them down in the last 2 weeks

- Remote: Males 41%, Females 34%
- Semi-urban: Males 34%, Females 59%
- Urban: Males 41%, Females 59%

Kunar residents who frequently felt so angry that they felt out of control in the last 2 weeks

- Remote: Males 46%, Females 33%
- Semi-urban: Males 56%, Females 77%
- Urban: Males 56%, Females 86%

Kunar residents who frequently felt so uninterested in things that they used to like that they did not want to do anything at all in the last 2 weeks

- Remote: Males 60%, Females 56%
- Semi-urban: Males 48%, Females 49%
- Urban: Males 48%, Females 90%
Kunar residents who frequently felt so hopeless that they did not want to carry on living in the last 2 weeks

![Graph showing percentages for Remote, Semi-urban, and Urban areas for males and females.]

Kunar residents who frequently...tried to avoid places, people, conversations or activities that reminded them of [events] in the last 2 weeks

![Graph showing percentages for Remote, Semi-urban, and Urban areas for males and females.]

Kunar residents who frequently felt unable to carry out essential activities for daily living because of feelings...in the last 2 weeks

![Graph showing percentages for Remote, Semi-urban, and Urban areas for males and females.]

132
Laghman Province

**Laghman residents who frequently felt so afraid that nothing could calm them down in the last 2 weeks**

![Bar chart showing the percentage of residents in different areas who felt afraid.](image)

**Laghman residents who frequently felt so angry that they felt out of control in the last 2 weeks**

![Bar chart showing the percentage of residents in different areas who felt angry.](image)

**Laghman residents who frequently felt so uninterested in things they used to like that they did not want to do anything at all in the last 2 weeks**

![Bar chart showing the percentage of residents in different areas who felt uninterested.](image)

**Laghman residents who frequently felt so hopeless that they did not want to carry on living in the last 2 weeks**

![Bar chart showing the percentage of residents in different areas who felt hopeless.](image)
Nangarhar Province

Nangarhar residents who frequently felt so afraid that nothing could calm them down in the last 2 weeks

Nangarhar residents who frequently felt so angry that they felt out of control in the last 2 weeks

Nangarhar residents who frequently felt so uninterested in things that they used to like that they did not want to do anything at all in the last 2 weeks
Nangarhar residents who frequently felt so hopeless that they did not want to carry on living in the last 2 weeks

- Remote: Males 73%, Females 79%
- Semi-urban: Males 82%, Females 73%
- Urban: Males 56%, Females 50%

Nangarhar residents who frequently...tried to avoid places, people, conversations or activities that reminded them of [events] in the last 2 weeks

- Remote: Males 66%, Females 87%
- Semi-urban: Males 71%, Females 85%
- Urban: Males 85%, Females 58%

Nangarhar residents who frequently felt unable to carry out essential activities for daily living because of feelings...in the last 2 weeks

- Remote: Males 80%, Females 67%
- Semi-urban: Males 80%, Females 71%
- Urban: Males 71%, Females 54%
Nuristan residents who frequently...tried to avoid places, people, conversations or activities that reminded them of [events] in the last 2 weeks

Nuristan residents who frequently felt unable to carry out essential activities for daily living because of feelings...in the last 2 weeks
Annex 2 ASCL

Factor 1: Sadness with Social Withdrawal and Somatic Distress

ASCL Factor 1 (Sadness with Social Withdrawal and Somatic Distress) by Gender

ASCL Factor 1 (Sadness with Social Withdrawal and Somatic Distress) by District Status
Factor 2: Ruminative Sadness Without Social Withdrawal and Somatic Distress

ASCL Factor 2 (Ruminative Sadness Without Social Withdrawal and Somatic Distress) by Gender

ASCL Factor 2 (Ruminative Sadness Without Social Withdrawal and Somatic Distress) by District Status

Distress
Factor 3: Stress Induced Reactivity

![Bar chart showing ASCL Factor 3 (Stress-Induced Reactivity) by Gender. The chart compares the levels of quarreling with family, quarreling with friends or neighbors, beating one's children, and Asabi for males and females. The bars indicate higher levels for females in most categories.](image-url)
Annex 3: Top Wellbeing Factors Per Province

Kunar
Nangahar Province

Top Wellbeing Factors for Nangarhar Females

- Remote | n=131
  - Peace, security, justice: 56%
  - Economic security/ability to provide for family: 31%
  - Strong family relations support: 44%
  - Freedom: 38%
  - Leisure activities: 8%
- Semi-urban | n=26
  - Peace, security, justice: 85%
  - Economic security/ability to provide for family: 15%
  - Strong family relations support: 19%
  - Freedom: 35%
  - Leisure activities: 3%
- Urban | n=36
  - Peace, security, justice: 81%
  - Economic security/ability to provide for family: 47%
  - Strong family relations support: 47%
  - Freedom: 3%
  - Leisure activities: 6%

Top Wellbeing Factors for Nangarhar Males

- Remote | n=131
  - Peace, security, justice: 49%
  - Freedom: 50%
  - Leisure activities, or time to enjoy living*: 16%
  - Economic security/ability to provide for family: 17%
  - Freedom: 17%
- Semi-urban | n=28
  - Peace, security, justice: 82%
  - Freedom: 32%
  - Leisure activities, or time to enjoy living*: 32%
  - Economic security/ability to provide for family: 25%
  - Freedom: 46%
- Urban | n=36
  - Peace, security, justice: 67%
  - Freedom: 25%
  - Leisure activities, or time to enjoy living*: 31%
  - Economic security/ability to provide for family: 47%
  - Freedom: 14%
Annex 4: Key informant interviews and focus group discussions across the four provinces

Laghman

A total of 6 community leaders were interviewed in Laghman, 2 from remote, 2 from semi-urban and 2 from urban districts. No female community leaders could be recruited; therefore, all the community leaders were males.

Key informants

Problems in the community from Key Informants

Key informants express issues of trust and unity in the community, according to them, people in the community do not support each other enough and do not trust each other. They explain that the current situation is due to the security issues, poverty, and the political situation. It is believed that “things will improve only when they government of Afghanistan doesn’t work for other countries but rather for the Afghan people”. They share the feeling that the condition will get worse if things do not change.

One Male KII from remote Laghman noted that due to the current regime, many cannot fulfil their basic needs with many in the community wanting to change the regime. Another remote male key informant said that if we respect elders, then we will be able to have a better country. Another male key informant from urban Laghman said “We should respect the country rules and regulation of the government, if we do not follow the rules, then we could not recover ourselves from the crisis”. Semiurban male key informant mentioned that if the situation continues as is the future will be very bad. The other semiurban male key informant said people are fighting each other and “they have bad deeds with each other”.

This community recognizes that those who are the most vulnerable are the orphans, women and children as well as those who do not have jobs. The KII’s also mentioned that all people
suffer from the crises. The table X below reports specific statements on how the community typically identifies vulnerable individuals and the main reasons for their distress.

<table>
<thead>
<tr>
<th>Distressed children</th>
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<tbody>
<tr>
<td>Remote</td>
</tr>
<tr>
<td>Semi urban</td>
</tr>
<tr>
<td>Urban</td>
</tr>
</tbody>
</table>
Currently the children are very sensitive to the bomb blasting as they scared from the bad conditions and have anxiety. The community are trying to prepare them for bad situations and to reduce the stresses of the children by preparing them. Also, they are trying to change their minds and advise them and give them relaxations.

All the community children seek help from their families.

<table>
<thead>
<tr>
<th>Distressed women</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Remote</strong></td>
</tr>
<tr>
<td><strong>Semiurban</strong></td>
</tr>
<tr>
<td><strong>Urban</strong></td>
</tr>
</tbody>
</table>
and one mentioned that *their behavior is immoral*. Reasons for their distress are that there is poverty, hunger and unemployment in the community.

*Before the current situation, they were trying to prepare for life, daily activities and business and to be prepared for bad and good situations, due to war and conflicts. Currently the community supports them with their needs.*

Women’s husbands and families are helping them in the time of depression. *Can provide them their needs and according to Islamic shariah prepare them appropriate path for them for their jobs and business.*

*They want to be involved with jobs or something to support their families.*

<table>
<thead>
<tr>
<th><strong>Men</strong></th>
<th>Their facial expressions and their behavior show they are distressed. The men behave very badly and isolate themselves in the community. There are reasons for this depression: there are economic problems, insecurity and emigration. The community meets together to come up with a solution on how to support them. Before the emergency, the community encourages them and counsels them. Men look for help from their family and relatives and request that they have help to meet their basic needs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>remote</td>
<td>Distressed men are depressed and they look very sad and disappointed. They behave badly and isolate themselves. The reasons for the distress are, economical problems, insecurity, aren’t able to meet their daily expenses, emigration. In normal circumstance, the men host a meeting and come together to help each other. Currently the men encourage each other and give them counselling. Men also seek help from their family, relatives and international humanitarian organisations. Men are requesting for jobs and business in the community.</td>
</tr>
</tbody>
</table>
Urban

Recognize them on how they look – sad and disappointed. *They behave badly and want to be alone.* Reasons for the depression is due to the economic problems, insecurity, *men can’t afford their daily expenses and want to emigrate.*

*Before the current situation, men tried to prepare themselves for the future bad conditions and emergencies and tried to help each other.* Now, *provide counselling and encourage them.*

*Men seek help from their family and relatives.* One mentioned getting help from international humanitarian rights.

*The men have asked for jobs and have business in the community.*

<table>
<thead>
<tr>
<th>People with mental health disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>remote</td>
</tr>
<tr>
<td>The conflict and war has caused many disabilities in the community, and they try to treat them well and base counselling on their cultural norms and values. Many feel they do not know how to help them as they <em>don’t have education to know how to help them with their problems.</em> They also don’t know where they can get help. But they do refer them to the nearest health center. They did mention that those with mental health problems go to the shrines and make amulets for the future and pray for themselves to Allah.</td>
</tr>
</tbody>
</table>

| Semiurban                        |
| These people are disabled due to the war and conflict and community leaders want to treat them well. These people have economic problems due to disabilities and mental health problems. These people are treated well in the community and they are counselled by the community.

*The community do not know how to help these people as they do not have the education to help them. The community only helps them with their needs and guide them based on their knowledge. Those with mental health disorders do not know where to get help from. Currently the community give them counselling and refer them to the nearest health facility.* |
**Urban**

There are lots of people who are disabled and have mental health problems. They face economic, social, community conflict problems and poverty. The community tries to treat them well and counsel them using their culture. Sometimes, the people go to the shrine, make amulets for the future and pray to Allah.

Some mentioned that the community doesn't do anything as they don’t know how to help them. Others mentioned they do help them but that they do not know where to go for help. Others say they get help from their family and relatives. Others mentioned they provide counselling and refer them to the nearest health centers.

**Family problems**

**Remote**

Families have economic, social and political problems. The community has problems with these people. Family problems are due to conflict in the family, poverty, community conflict, security problems and cultural problems.

The community tries to help them and treat them well, but some people think these people have bad behaviors. Currently they try to refer them to a welfare organization, and seek help from relatives, friends and those how have money. The community should help them and provide for them financially.

**Semiurban**

One key informant mentioned the problems of women in the community and said these women have poverty, the taking of their dowry and the forcing of marriage. Both Key informants also mentioned conflict and disunity in the family. The community do treat these people well but some in the community think they have bad behaviour.

Previously the community comes together and they work through the problem to find a solution. Tin the current situation the community refer them to the welfare organisations and from the government relevant offices.
Urban

The community has many problems with these people, which includes poverty, conflicts and disunity in the family. They need support in social relationships within the community. The community does treat them well, but some are thinking that these people have bad behavior. In normal circumstances, preparing for difficult situation in the future. Currently they are working on their relationships.

Those with family problems seek help from the community, relatives, friends, and people who have the financial ability to help them. They also go to the welfare organization and the government offices.

<table>
<thead>
<tr>
<th>Region</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>- The community has many problems with these people, which includes poverty, conflicts and disunity in the family. They need support in social relationships within the community. The community does treat them well, but some are thinking that these people have bad behavior. In normal circumstances, preparing for difficult situation in the future. Currently they are working on their relationships. - Those with family problems seek help from the community, relatives, friends, and people who have the financial ability to help them. They also go to the welfare organization and the government offices.</td>
</tr>
<tr>
<td>Remote</td>
<td>- Those who have been raped are not treated well in the community, many abuse them and call them bad names. They are not trusted in the community. Because of this, they isolate themselves. Some have mental health problems. Some commit suicide as people are making problems for them and/or because of the shame. - The community gives them advice and refers them to doctors, religious leaders and community elders and tell them they will solve the problem soon. Those who have been raped seek help from relatives, friends, and international organization. - To be noted that the KIIIs requested for training on MHPSS and other topics to the community people.</td>
</tr>
<tr>
<td>Semiurban</td>
<td>- Those who have been raped are not treated well in the community as the community no longer trusts them and they are abused in the community. One KII also noted that their whole life will be “bothered” by the community, and they will be “shy from them”. - In normal circumstances these people are provide then with good advices and help them continue with their lives. Currently they are referring them to</td>
</tr>
</tbody>
</table>
doctors, religious and community elders. Those who have been raped seek help from their family members and from their relatives.

All KIIIs requested for trainings on “brutality, violence and forceful raping”.

<table>
<thead>
<tr>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>It was noted by the KII’s that the community will not trust those who have been raped and will not treat them well. Others in the community use bad terms about them.</td>
</tr>
<tr>
<td>Some of those who have been raped kill themselves due to shame. One KII said that the community does not interfere in others’ problems as they have their own problems.</td>
</tr>
<tr>
<td>The community give them good advice and during community meeting, they talk about the problem of those who have been raped, isolating themselves from the community and family. Some seek help from their family members and relatives as well as organizations that deal with human rights. The community refer them to the doctors and religious elders.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>People with drinking problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remote</td>
</tr>
<tr>
<td>Those who are drinking do not care about seeking help as they are unable to separate themselves from the drinking. When they do seek help, it is from family members, doctors, relatives, and community people. The current government should implement the strict rules.</td>
</tr>
</tbody>
</table>
Semi urban: These people cause problems with the family and the community. The community try to treat them well and help them stop drinking. One Key informant said that the no one in the community has a relationship with these people.

Previously the community try to give them treatment. But now they need to be counselled and try to get them busy with other things. It was noted that the community do not know how to deal with this problem. Those with drinking problems seek help from their family, doctors and the community.

Urban: Those who are drinking in the community show mental health problems, “heart beating”, economic problems, relationship problems. They are not having respect in the community. One KII mentioned that some of them commit suicide and run away from the community due to shame. These people make problems for the community and their families. The community members try to treat them well and encourage them to stop drinking.

Another KII mentioned that the community has no relationship with those who drink. It was also mentioned that those who drink are not allowed to be in the community and that they refer them to the nearest health facility where they can get counselling. The KII's say the community do not know how to deal with this problem.

This problem was seen as one of the most dangerous. It was suggested that they need to be treated strictly.

Adolescents Focus Group Findings

<table>
<thead>
<tr>
<th>Male adolescents</th>
<th>Remote</th>
<th>Semi urban</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems</td>
<td>Economic problems, no education, insecurity and unsafe</td>
<td>No clean water, unemployment, poor economy</td>
<td>Economic, no wheelchairs, can’t meet basic needs</td>
</tr>
<tr>
<td>MH problems</td>
<td>Drugs</td>
<td>Increase of people with mental health problems, depression and tension</td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>-------</td>
<td>---------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Impact</td>
<td>Don’t meet the needs of the family, no rights for women.</td>
<td>Struggle to meet their needs and to earn money, severe economic problems.</td>
<td></td>
</tr>
<tr>
<td>Coping</td>
<td>Look for work, locking them in the rooms and not letting the addicted children out.</td>
<td>Working hard, younger generation are being treated for addiction: drug users are being locked in rooms and not allowed to go outside</td>
<td></td>
</tr>
<tr>
<td>Future</td>
<td>Feel bad about the future</td>
<td>Feel very bad for the future because the condition is not appropriate for finding a job</td>
<td>Feel bad about the future and don’t have wishes for the future.</td>
</tr>
</tbody>
</table>

in the community, don’t look after the woman in the community, unemployment, no health facility.
disabilities, road infrastructure poor, community elders are violent, no hospitals and clinics, no schools, poverty, no warm clothes, not enough food, no madrassa.
(clothes, food and health, no clean water), roads and streets are bad in the community, no electricity, no schools, no health facility
## Request for support

<table>
<thead>
<tr>
<th></th>
<th>Remote</th>
<th>Semi urban</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education, aid to meet their needs (clothes, food)</td>
<td>Get education, medication, jobs, keep busy</td>
<td>Basic needs to be met, jobs, medication</td>
<td></td>
</tr>
</tbody>
</table>

## Adults Focus Group Findings

<table>
<thead>
<tr>
<th>Males Problems</th>
<th>Remote Problems</th>
<th>Semi urban Problems</th>
<th>Urban Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>No business, economy, no clean water, no winter clothes, main road in bad condition, don’t have electricity, homes are badly destroyed due to the war and instability, lack of social cohesion, orphaned families from the war, girls escaping from the community (marriage of those in love with), previous military people not having jobs, civil employees not paid, livestock being killed from the war and conflict, lots of war between the</td>
<td>Economic problems, lack of education facilities, poverty, disabilities, war, conflict, distance from school to home, “discrimination” between the community leaders, girls are uneducated, road in poor condition.</td>
<td>Economic problems, no wheelchairs, no winter clothes, no electricity, no clean water, main road is destroyed, livestock killed, orphaned families from the war, lots of disabilities, food prices increase, conflict between the government and insurgents, not enough food, unemployment,</td>
<td></td>
</tr>
<tr>
<td>MH problems</td>
<td>government and the insurgents, children don’t feel safe at school</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tension, anxiety, depression, bipolar disorder, anxiety from the bomb explosions, people become angry and impatient.</td>
<td>Sleepless, anxiety, depression, weakness of the mind, like to be alone. Fear/Anxiety from the poverty. Anxiety from the bomb explosions, become angry, impatient, intoxication, intoxication of young people,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dissociation and dissociative disorders, anxiety, Fear and anxiety from the war, sleeplessness at night. Mental health problems, such as insanity, anxiety from the poverty, crying. The community people like to sit alone in the community. Fear and anxiety from the war.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Impact | Face enormous problems, can’t meet their basic needs of their families, can’t work properly. |

| Coping | Ask PU-AMI for help, lock the children in rooms to stop using drugs, |
| Future          | “Very disappointed in my future because our government is not yet well organized, therefore I am very upset”. | Disappointment due to poverty and insecurity. Can’t think about wishes for the future. Feel bad about the future. “To be honest, we do not have any wishes for the future, as you better know that the condition of Afghanistan getting worse day by day” | Disappointment when thinking about the future. |

**Request for support**

| Remote          | Need clean water, electricity, winter clothes, MHPSS awareness, public health awareness and disaster trainings, provide jobs, education |  |
| Semi urban      | Teachers, education, jobs, gain knowledge about MHPSS, PFA, disasters, medication, religious schools. Provide food, business support |  |
| Urban           | Give cash, education, trainings, provide jobs, medication, food |  |

People with disabilities focus group findings
<table>
<thead>
<tr>
<th>Urban Males</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem</strong></td>
<td>Economic problems, can’t meet basic needs (water not clean, no electricity, unable to keep warm in winter, don’t have food), health facility is far, disability is a big problem, don’t have girl education, poverty and vulnerability, unemployment.</td>
<td></td>
</tr>
<tr>
<td><strong>MH problem</strong></td>
<td>Mental health problems</td>
<td></td>
</tr>
<tr>
<td><strong>Impact</strong></td>
<td>Struggle more to earn money, unable to work for selves due to disability, cannot run or walk (can’t get to places)</td>
<td></td>
</tr>
<tr>
<td><strong>Coping</strong></td>
<td>Didn’t mention</td>
<td></td>
</tr>
<tr>
<td><strong>Future</strong></td>
<td>Feel bad about the future</td>
<td></td>
</tr>
<tr>
<td><strong>Support needs</strong></td>
<td>Wheelchairs, education, training and guidelines for life,</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children Focus Group Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Feeling safe and happy</strong></td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Remote</td>
</tr>
<tr>
<td>Feeling safe: Home was not seen as a safe space for 4 out of the 8 boys, due to pollution, the insecurity in the neighbourhood with boys saying the house is next to an army checkpoint. The others mentioned infrastructure related issues, no electricity, not enough rooms,</td>
</tr>
<tr>
<td>Feeling sad:</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>They were sad as they can’t meet their needs and the house is old, don’t have winter clothes. One said he was sad at home. One said he is sad because there are bombings near to the house.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feeling happy:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only two said what made them happy, which was when the country had peace and security. All the others - 6 out of 8 - said they were not happy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don’t feel good at school as it is not meeting their needs. Many of the children can’t go to school as it is not safe for them and the school is far away.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feeling sad:</th>
</tr>
</thead>
<tbody>
<tr>
<td>They were sad because they don’t have warm clothes for winter. One other said he is not feeling well. Feeling happy was to have peace in the country.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some boys said they feel better at school but the way to school makes them feel unsafe. There have been some attacks on the school and during some attacks the school was burned. Some of the children don’t go to school and some go to the city to sell things.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feel good at school.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some of the children feel good at school. Some of the children don’t go to school and some go to the city to sell things.</td>
</tr>
</tbody>
</table>
away. Most are working. the attack “they don’t feel good”. Some of the children go to school other children work in the city to support their families,

<table>
<thead>
<tr>
<th>Games</th>
<th>They all enjoy football and playing games with friends and classmates.</th>
<th>Play cricket with their friends.</th>
<th>Play cricket and with their friends</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sad and angry</td>
<td>The instability and the insecurity of the country makes them sad. They are sad when they see poor people.</td>
<td>Participants said they don’t like it when people talk badly, and when they use sarcasm and mock others.</td>
<td>They are sad cause of the instability of the country and when they see poor people.</td>
</tr>
<tr>
<td>Makes them scared</td>
<td>Most said they feared different childlike things (dark in the room), others said not scared of anything.</td>
<td>6 of the boys were scared of something relating to conflict and violence. One child drew a dangerous man and said he is scared of “them”. Another said of the instability and insecurity. One mentioned he is scared of the guns, bullets and rockets. Others said they</td>
<td>Most of the boys said they weren’t scared of anything, one said electricity the other the main road and the other the Zarafa (giraffe).</td>
</tr>
</tbody>
</table>
aren’t scared of anything, another said they were scared of the main road and the yard

<table>
<thead>
<tr>
<th>Social Support</th>
<th>Parents are who they get support from. They give them money or say they will buy something. Their close friends help them and others in the community can help them</th>
<th>Parents help them resolve their problems and have their families and friends help them. They can request help from the community.</th>
<th>They said they can go to their parents, and they try to make them happy. Play with their relatives and can get help from their families and the community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Future</td>
<td>Have wishes but can’t achieve these</td>
<td>Have wishes but can’t achieve these.</td>
<td>They have many wishes, and these are to help the community as well as themselves</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mixed</th>
<th>Remote</th>
<th>Semi urban</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling safe and happy</td>
<td>Don’t feel safe in the community due to the war and conflicts in the community, one mentioned that their friends have disabilities. Others drew their school as don’t have what they need to learn, others</td>
<td>Most mentioned school was not a happy place as they don’t have to learn. One mentioned that on the way to school he doesn’t feel safe as there are bombs planted by insurgents against the</td>
<td>Most of the children mentioned they do not feel safe at school either as the school doesn’t have what it takes to learn, others said because of the poverty at school. Others mentioned the community and</td>
</tr>
</tbody>
</table>

164
said they are sad as they don’t have things to keep them warm in winter. Some drew cricket as for when they feel happy, but still responded they are not happy. Two mentioned they want to feel peace. government, one said don’t feel safe due to the checkpoint. Others said they feel sad at home as they are poor and can’t meet their needs. Others said they are not safe at home or school, others said they are not feeling well or happy when asked about what makes them happy. conflict and the insecurity in the community. One mentioned due to not being able to meet their needs while another said don’t feel safe at home. Most said they are sad as they don’t have clothes to keep them warm, others cause of poverty don’t have food. Most of the children spoke about having peace in the country will make them happy, another said to have security.

<p>| School | School is not feeling well, as the school is far away and it not safe at school. Some go to school, some work in the city, to support their families. | Feel better at school. But don’t have the things they need and then we don’t have the right clothes and they laugh at us. Some said they don’t feel safe at school as they heard a bomb blast. Some children go to school, others | One FGD said that the school was good as it is better than the other schools. Others said they don’t have enough books or facilities, some of the children do work to sell things to earn money for their family. |</p>
<table>
<thead>
<tr>
<th>Games</th>
<th>Sell things at the bazaar and carry things. Others don’t feel happy at school as it is far from home.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sad and angry</td>
<td>Some children mentioned they play cricket, others said there is nothing to enjoy. Some play with friends and classmates from the village, some said they enjoy their study.</td>
</tr>
<tr>
<td>Makes them scared</td>
<td>Gets sad with the instability and insecurity, and when they see the poor people.</td>
</tr>
<tr>
<td></td>
<td>Played games with their friends and classmates.</td>
</tr>
</tbody>
</table>

Games: Play with friends and classmates, sports such as cricket, football and volleyball.

Sad and angry: One FGD mentioned they get upset due to the fighting in the community and in the family, sad for the insecurity and instability in the country and community.

Sad and angry: One FGD said they become sad with the fighting, another FGD said they are sad when people are mean and when people lie.

Sad and angry: Gets sad with the instability and insecurity, and when they see the poor people.

Sad and angry: One child said he is scared when he sees his home destroyed, a few said they were not scared of anything, others said

Sad and angry: All the children said they aren’t scared of anything.
<table>
<thead>
<tr>
<th>Social Support</th>
<th>scared of dogs, the roof.</th>
<th>the road, or the jinns (spirits).</th>
<th>Go to their parents and they help them. Their friends and sister and brothers also help them and can get help from the community.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Go to their parents and their sisters and brother, friends also play with them, and others in the community can help them.</td>
<td>They go to their parents who buy them something and talk to them about their problems, play with their brothers and sisters as well as their friends, and can go to the people in the community.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Future</td>
<td>One FGD said they had wishes for the future but can’t achieve their wishes. Their wishes are to make the community good and have a good life.</td>
<td>One FGD said they don’t have wishes due to the bad and poor conditions of Afghanistan. The other FGD said they have many wishes but can’t achieve them.</td>
<td>One FGD said they don’t have any wishes due to the political situation. The two other groups said they have many wishes but don’t know if they will be able to accomplish them.</td>
</tr>
</tbody>
</table>
KII Community Leaders

The key informants from Nangarhar were 6 community leaders from remote, semi-urban and urban districts, each community leader was a male.

Problems in the community

The community leaders described the current situation as negative with problems of conflict, violence, poverty, economic problems, unemployment. They all noted that things will get worse if things do not change. Two themes came up from the key informants: there are bombs that disrupt the daily functioning of people and there is a need for unity in the community. Political issues also came up with the key informants noting the need for unity amongst the government, an inclusive government and the inclusion of politicians who worked for the previous government. In Nangarhar, key informants acknowledged that there are mental health problems in the community. One key informant mentioned there are lots of people with these problem: “we have a lot of people with disorders, due to family conflicts, war in the country and insecurity in the community. So they will face various problems such as: sleep disorder, loss of jobs, conflicts of the community and families”. Another said there are about 40% of people facing mental health problems.

When asked who were suffering the most in the community, community leaders said that most of the people are suffering in the community. This was attributed to the poor living conditions and the social, political and economic problems which characterized daily living.

The below table gathers KI community leaders responses about distress faced by different groups of people in their community.

<table>
<thead>
<tr>
<th>Distressed children</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi urban</td>
<td>Children are sad and say they feel bad. Both key informants said they don’t speak nicely to each other. The reasons for the distress are due to poverty, war, unemployment, explosions, and community conflict. In the community, the children are very sensitive to the bomb blasting sounds and the shooting</td>
</tr>
</tbody>
</table>
of guns. They try to change their minds from feeling scared by advising them. Those who work with children provide trainings.

Children seek help from their families and friends and the humanitarian organizations. Parents should provide more opportunities for them to be educated and more activities to be involved in.

| Remote          | Children look sad in their daily life and look upset. Their minds are “altered and they are confused”. This is due to poverty, war, conflict, explosions, and unemployment. Previously they were preparing them for the emergency and they give them education, food and try to meet their needs. The community tries to care for them and to reduce their distress. The children seek help from the community elders and those who look after them and their friends. If there is no war and conflict, they can take the children to the parks. |
| Urban           | Their behavior and appearance change due to the mental health problems, they look very sad, depressed, uninterested and disappointed. Their behavior is not acceptable and they have sleeping problems. Reasons for their distress are: schools are closed, schools are being burnt by insurgents, death of parents due to the war, unemployment. One key informant mentioned “a girl had sensibility with the sound of bomb blasting and loud voices. She reacts strongly to this and as well has had anorexia, headaches, body pain and sleeping problems”. They are currently trying to change their minds and prepare for them for insecurity. Those who work directly with children are providing training such as about preparedness to disasters, explosions, and conflict. The children seek help from organizations, families, and friends. The community tries to play with them and motivate them to change their behavior and mood. |
### Distressed women

<table>
<thead>
<tr>
<th>Location</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi urban</td>
<td>Women who are distressed show they are depressed and are silent and look angry. They cause fights and arguments in the family. Their problems are the results of war, conflict and unemployment. Prior to the current situation, they would support and help each other and prepare themselves for a tough situation. Now they are providing them freedom under Islamic law and give them their rights based on need. The family members come together and try to help them with “their mind” and keep them busy with something that makes them happy. The husbands are helping them. They can have help from the community women and those who have authority of human rights. In the future, they need to be involved with jobs.</td>
</tr>
<tr>
<td>Remote</td>
<td>Some women become silent with tension while others are talking a lot. They look like “they are not here, and their minds are weak as if they have lost their minds due to the pressure and the tensions”. These women have jealousy for others and pray for bad things to happen to the community. The reasons why they are distressed is because of forced marriage and violence towards girls and women and they don’t have their rights in the community. They need to have their rights and they have counselling but currently the community needs to provide them their rights based on the Islamic law and regulations. Currently the community is also fighting for their rights and assist them in the time of the emergency. They seek help from their family, elder women. In the future, we should care for women based on the Islamic sharia and should let them work and not have violence towards women.</td>
</tr>
<tr>
<td>Urban</td>
<td>They are depressed, solemn and in a tense mood. They are irregular in how they talk and move. They show they are disappointed and upset in their faces. Their behavior changes as they fight with each other and have arguments in</td>
</tr>
</tbody>
</table>
their families. The reason for their distress is there is poverty, unemployment, family conflicts, forced marriage, not having male children, family violence and brutality in the community.

In normal circumstances they prepare themselves for the war, conflict and other problems and support each other to find assistance in the families. The community is now trying to help them by guiding them and providing what they need. Another key informant mentioned they are giving them freedom as supported by the Islamic law and giving them humanitarian rights based on their need.

When the women are upset the family and elder women in the community come to her and try to keep her busy with something that makes her happy. It was mentioned that the head of the family should work and earn money for the children as the women are upset about the future of the children and that they should have a calm and safe place for the children.

| Distressed men | Semi urban | Based on their behavior and their facial expressions, they can see they are upset and sad. These men don’t act normal and they are making conflict with people. People try to avoid them because of this.

In normal circumstances, they prepare for bad situations. Through the unity of the community, they come together to give them support and give them education.

These men seek help from the family and relatives. According to the type of problem, they go to the international NGOs,

|       | Remote    | These men have confusing and abusive words, and they have many things they are responsible for in the community and are depressed. These people behave badly and cause conflict. |
The reasons for their depression are economic problems, insecurity and the fact that they can’t meet their daily needs and are immigrating.

In normal situations they prepare themselves for tough and emergency situations. They gather their support from the community to help each other and to encourage and give counselling. They seek help from the family members and relatives and from the different organizations.

### Urban

Men in the community who are distressed look angry, depressed and as if they were in a bad mood. Many of them don’t have good behavior and don’t have the appropriate clothes. Their behavior is not acceptable, they generate fights in the community so the people avoid them.

The reasons for the distress are economic problems, they can’t provide for their families, can’t cover daily needs and are immigrating. Previously they had tried to guide and control each other to have a safe environment and have jobs.

The community tries to help them with their problems, but they request for government and humanitarian help with jobs and meeting their problems.

### People with mental health problems

<table>
<thead>
<tr>
<th>Semi urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>These people have sleep disorder, loss of jobs, conflict in the community and with their families. They also have economic, social, and political problems. They try to treat them well and give them counselling, they also go to the shrines where they make amulets and pray and request help from god. They refer them to specialists but the community requests help from god. They treat them well and give them support. They seek help from the relatives,</td>
</tr>
</tbody>
</table>

...
family and those who work in health sections such as clinical doctors, nurses, psychologists.

<table>
<thead>
<tr>
<th>Location</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remote</td>
<td>Those with mental health disorders fight with others in the community, become intoxicated and their physical wellbeing is not good. In the community some people treat them well and others don’t, some think these people are not normal. They treat them with counselling and give them advices and refer them to the nearest hospital or clinic. They seek help from relatives, family members and those who work in the community health facility.</td>
</tr>
<tr>
<td>Urban</td>
<td>One key informant mentioned there are lots of people with these problem: “we have lots of people with disorders, due to family conflicts, war in the country, insecurity in the community, so they will face various problems such as: sleep disorders, loss of jobs, conflicts of the community and families”. Another said there are about 40% of people with mental health problems. They treat them by counselling them and giving them advices and referring them to the hospitals. They also send them to the shrines and make amulets and request help from god. Refer them to specialists and provide them with economical support. These people request help from relatives, family members and from the hospitals (nurses, doctors, psychologist- available in the community health facility). Ultimately it was said that the family members are responsible to care for these people.</td>
</tr>
<tr>
<td>Semi urban</td>
<td>These people have conflicts, disunity and need the full support of the community. Many people think these people are immoral, have bad characters and their family problems are due to the lack of food, poverty.</td>
</tr>
</tbody>
</table>
Previously they tried to prepare for bad situations. In the current situation they fight poverty and provide them with shelters. They try to help them with their needs. They seek help from the community people and relatives. Also, from those who have money and from the welfare organizations. Should give them jobs and business.

Remote

They have conflict with the children in the community, family conflict.

Urban

These were classified as family conflict and disunity, people who are divorced or separated due to the poverty. These people have problems related to not having enough food, lack of clothes, unemployment.

They do treat them well in the community, but some think these people have bad behavior. Give them public awareness and help them solve their problems.

These people seek help from the community elders, relatives’ friends and welfare organizations. The community elders mentioned that the community should give them jobs and education opportunities to get rid of the problems.

People who have been raped

Remote

These people are not well treated in the community, they isolate themselves. One KII said “Face to face have very good behavior but in the absence of the raped people, all people in the community talk badly about them”. Provide them with counselling and help them based on their needs. They try to tell them to be normal and not stress. They refer them to doctors and religious elders, community elders and give them advice to be calm. They seek help from the close friends and from WHO, WFP.

Those who work in GBV should give trainings about violence and forced raping.

Semi urban

The community won’t treat these people well as they call them bad names, and that they don’t have good character and attitude. These people isolate
themselves from the community and their family. People in the community cause problems for these people and many are killing themselves due to shame. Refer these people to the doctors, religious elders and community elders and try to give them advice. Request for training about GBV.

**Urban**

Those who have been raped will isolate themselves from the community and would not communicate with anyone as the community insults them. They would also avoid their family members. Shame is recognised as a huge problem in the community. Because of such event, they would develop a mental disorder due to the “tension and pressure”

There is a common perception that those who have been raped do not have a good character and they get treated very badly and get called bad words. The community does try to give good advice and guide for them in living a good life as many kill themselves due to shame. They refer them to the doctors, religious leaders and community elders.

Those who have been raped go to close friends and some cases go to the human rights organizations. The key informants requested training on GBV, in relation with brutal violence and rape.

**People with drinking problems**

**Remote**

Drinking is a big sin in Islam and the community think they are bad and call them bad names. They don’t have relationships with those who are using drugs and drinking as this is not seen as good. They see them as abnormal. The community refers them to the nearest health facility and try to ban alcohol and drugs and also stop the trade. They also give religious counselling to these people based on the Islamic sharia.

They seek help from the government.

They should ban the smuggling of drugs.
Semi urban | They have mental health problems as well as economic, relational and economic problems. The community doesn’t treat them well as they are drinking a lot. They do not have relationships with people in the community. They refer them to the nearest health facility and give them good advice. People also try to give them advice on how to stop drinking and doing drugs. The people seek help from family members, doctors, and community people.

Urban | These people have mental health disorders which were described as heart beating by the KIIIs. These people are not treated well in the community, they are called bad names and are not respected in the community. Many do not have relationship with them and isolate them from the community. The community try to refer them to nearest health facility.

These people try to get help from family members, doctors, relatives, and community people. The people should avoid drinking alcohol and the people who are trading the drugs and the government should implement the rules to prevent the selling of drugs and alcohol.

Adolescents Focus Group Findings

<table>
<thead>
<tr>
<th>Males</th>
<th>Remote</th>
<th>Semi urban</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems</td>
<td>Unemployment, no medication and drugs, seasonal diseases, no learning material in the community schools, don’t have good teachers in the community, the community road is not in good condition</td>
<td>Poverty, unemployment, don’t have enough access to the government departments, conflict, banking problems, drought, family conflict and health problems, no</td>
<td></td>
</tr>
</tbody>
</table>
due to the war and conflict. No water for agriculture, no school for the girls, no electricity.

<table>
<thead>
<tr>
<th>MH problems</th>
<th>Stresses caused the mental health diseases</th>
<th>MHPSS disorders and lack of awareness about MH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact</td>
<td>Don’t have enough money for fulfilling the needs and the stress is causing MH problems, health problems. Don’t have family support to buy the books for school, can’t take the severe patients to the health facilities.</td>
<td>Go into debt, don’t have enough money for their needs, conflict amongst the family, unemployment</td>
</tr>
<tr>
<td>Coping</td>
<td>Debt: borrowing money.</td>
<td>Borrow money from the banks</td>
</tr>
<tr>
<td>Future</td>
<td>Become disappointed when thinking about the future as there is poverty and all the problems they face. The current situation of Afghanistan is not appropriate for living smoothly. Another</td>
<td>Doesn’t matter how much they think about the future as there is no facility. Become disappointed when think about the future as the current condition. Barriers include insecurity,</td>
</tr>
</tbody>
</table>
said that he doesn’t think they will have a good life. Another said that if the situation continues their future will not be bright. poverty, and no changing of the regime. Another said, “right now I can’t guess about my future”.

### Request Support

<table>
<thead>
<tr>
<th>Location</th>
<th>Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remote</td>
<td>School, health facilities, trainings</td>
</tr>
<tr>
<td>Semi urban</td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>Need more trainings on PFA, MHPSS, nutrition, need food, winter clothes and cash, health and education facility</td>
</tr>
</tbody>
</table>

### Adults Focus Group Findings

<table>
<thead>
<tr>
<th>Adults</th>
<th>Remote</th>
<th>Semi urban</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems</td>
<td>Health problems, unemployment, limited learning material for the school, no teachers, main road is destroyed,</td>
<td>Roads are damaged in the community, need agricultural items, economic problems, no medications in the health facility, insecurity in the community, no good teachers, poverty, no electricity, drought.</td>
<td>Don’t have jobs nor a library. Schools and universities for the girls have been closed, other problems include the poverty and the vulnerabilities in the community, no clean water, family conflict, no waste management, no recreational facilities, drought and diseases,</td>
</tr>
<tr>
<td>MH problems</td>
<td>Mental diseases, such as severe depression, epilepsy. Talking with himself, use body languages on the way with himself, sometimes they are laughing with himself, and sometimes crying with himself.</td>
<td>People are “flurried” due to the conflict and no one can help them. Depression, and tension. They are talking with themselves, using abusive words, repeating the nonsense words</td>
<td>MHPSS disorders and lack of awareness of the MH. Feeling depressed or unhappy, Emotional outbursts, sleep problems, weight, or appetite changes, quiet or withdrawn. They have convulsion and epilepsy</td>
</tr>
<tr>
<td>Impact</td>
<td>Health problems, can’t take the patient to the health facility, conflict in the community</td>
<td>Can’t access the hospital due to the road, community conflict, health problems,</td>
<td></td>
</tr>
<tr>
<td>Coping</td>
<td>Debt – borrowing of money</td>
<td>Homemade drugs</td>
<td></td>
</tr>
<tr>
<td>Future</td>
<td>Feel bad when think about the future, don’t know about future life.</td>
<td>Disappointed when think about the future, no one can improve their lives in Afghanistan due to the instability of the country. “I don’t</td>
<td>Disappointed as there is no way to improve, don’t know if you will live</td>
</tr>
</tbody>
</table>
know if the condition will let me bring changes in my life or not, it is based on nature”.

<table>
<thead>
<tr>
<th>Request for support</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Remote</td>
<td>All types of support, cash, food, winter clothes, training about PFA, MHPSS nutrition, jobs,</td>
</tr>
<tr>
<td>Semi urban</td>
<td>Training, on MHPSS, food, medication, winter clothes, jobs, cash, provide counselling, medical doctors,</td>
</tr>
<tr>
<td>Urban</td>
<td>Trainings PFA, MHPSS, nutrition, health and education facility, doctors and teachers,</td>
</tr>
</tbody>
</table>

People with disabilities focus group findings

<table>
<thead>
<tr>
<th>Males Urban</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem</td>
<td>Can’t meet basic needs due to disability, don’t have access to clean water at the house, unemployment, don’t have electricity, don’t have winter clothes, health facilities are far, no school, no food, no wheelchairs, no education for girls, poverty and insecurity.</td>
</tr>
<tr>
<td>MH</td>
<td>MH problems in the community</td>
</tr>
<tr>
<td>Impact</td>
<td>Unable to meet the needs of the family, can’t walk,</td>
</tr>
<tr>
<td>Coping</td>
<td>Not mentioned</td>
</tr>
<tr>
<td>Future</td>
<td>Feel bad when thinking about the future as unable to work for family, desires were to be able to meet their needs and receive a pension.</td>
</tr>
<tr>
<td>Support</td>
<td>Wheelchairs, education, trainings, guidelines for life,</td>
</tr>
</tbody>
</table>
Children focus group findings

<table>
<thead>
<tr>
<th>Mixed</th>
<th>Remote</th>
<th>Semi urban</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling safe, sad and happy</td>
<td>8 of the children in the FGD said they don’t feel well, 6 said they don’t feel safe at home, the other two said poverty doesn’t make them feel safe. Feeling sad was because of the current situation, not being happy at home, the reasons were due to poverty, security issues and insecurity of the country.</td>
<td>The most dominant theme is that the children do not feel safe at home or in the community due to the instability, the poverty and the current situation. One child mentioned, “we want peace in Afghanistan, and we are not feeling well”.</td>
<td>Most of the children said they do not feel safe and were not happy due to the insecurity in the country, another said due to poverty and their house is not safe. Another child mentioned there is no safety in the country. When asked to draw something happy, many said they were not happy now, one said due to the instability, the other due to poverty. One child did say he was happy at home.</td>
</tr>
<tr>
<td>School</td>
<td>One FGD said they do not feel happy at school due to the insecurity of the county. Majority go to school, but many go to work for</td>
<td>There are limitations of learning materials and books. They are mostly unhappy as the school is on the main road, and they are disturbed by the</td>
<td>Aren’t happy at school as there aren’t many books and learning equipment. It is also easy for the children to get to the school. Some</td>
</tr>
</tbody>
</table>

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supporting their family needs. noises from the road. Another FGD said they were not happy at the school due to the instability in the country. Most of the children go to school but some go to work to be able to provide for their families. children don’t go to school as they work in the city to help their parents for meeting the family needs.

<table>
<thead>
<tr>
<th>Games</th>
<th>They play games and play with their friends.</th>
<th>All the children said they play with their friends.</th>
<th>They play cricket and enjoy watching it on TV and they play with their friends,</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sad and angry</td>
<td>The one FGD said they become sad when they see the poor people and the students fighting each other.</td>
<td>Become sad and disappointed when they hear the bombs and the children are fighting. When they see poor people and when they see the poor students.</td>
<td>Become sad when they hear the bombs and when there is fighting with each other.</td>
</tr>
<tr>
<td>Makes them scared</td>
<td>Nothing makes them scared; others said the electricity or the stairs.</td>
<td>Most of the children said they aren’t afraid of anything some said the rain, mice, stairs, the dark and the main road.</td>
<td>Most said they were not afraid of anything; others mentioned the road and one mentioned when he sees the flag with the colour red</td>
</tr>
<tr>
<td>Social Support</td>
<td>Both FGD said they can go to their mothers and their</td>
<td>They go to their mothers and their</td>
<td>All the children said they go to their</td>
</tr>
</tbody>
</table>
parents, and their family and friends as well as ask for help from the community. Their friends and the community also help them. parents, and they try to motivate them for a good life. Family, friends and the community help them.

<table>
<thead>
<tr>
<th>Future</th>
<th>They mentioned their wishes for the future</th>
<th>They have wishes for the future to help their community.</th>
<th>They have many wishes but can’t achieve them. Another FGD said they wish to respect elders, have a good future, and serve the nation.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Males</th>
<th>Remote</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling safe, sad and happy</td>
<td>The children said they don’t feel safe due to the security and the present conditions. 5 directly said they don’t feel safe at home because of this. Others said the poverty made them not feel safe at home. One boy said we are “feeling very sad at this time” another child said, “we are not happy at time because our community is faced with a big problem”.</td>
<td>They boys used red for the general insecurity in the country, community, villages, and schools. Another said because of his family and him are not safe, another said due to the poverty and can’t provide for the needs of the family. One child mentioned he is happy at home, One mentioned “we are not happy at home, so we want to be busy with our educations, courses and other relevant activities”.</td>
</tr>
<tr>
<td>School</td>
<td>School is good except for there is not enough learning materials.</td>
<td>The boys said they are happy at school, but they don’t have enough</td>
</tr>
<tr>
<td>Most of the children go to school but some go to work to help provide for their families.</td>
<td>learning materials. It is also east to get school. They mentioned some of them go to school, but others work in the city for their family</td>
<td></td>
</tr>
<tr>
<td>Games</td>
<td>All the children said they play games with their friends.</td>
<td>They enjoy playing cricket and playing with their friends and classmates</td>
</tr>
<tr>
<td>Sad and angry</td>
<td>Become sad when they see the students fighting, when they see the poor students and poor people. The other FGD said they are disappointed due to the poverty and people with disabilities</td>
<td>They become disappointed when they hear the bomb blast and when they fight with each other.</td>
</tr>
<tr>
<td>Makes them scared</td>
<td>One of the boys mentioned being scared from the red color of the flag, another said the main road and the street at night, the others said they were not scared of anything.</td>
<td>Most of the boys said they are not afraid of anything, another said the teapot, the other the ball, the main road, and the flag.</td>
</tr>
<tr>
<td>Social Support</td>
<td>Can get support from their parents, with their family and friends as well as the community.</td>
<td>They go to their parents when they feel scared, family and friends. The community also helps them</td>
</tr>
<tr>
<td>Future</td>
<td>They have wishes to help the community.</td>
<td>Their wishes are to be able to be useful to the community.</td>
</tr>
</tbody>
</table>
Nuristan findings

KII community leaders

Interviewed 7 key informants from Nuristan, across three districts, remote, semi urban and urban. Of the 7, 3 were female and 4 were male. The three females were teachers, 3 of the 4 men were local leaders and the 4th man was a civil activist.

Problems in the community

The current situation was acknowledged as being the result of an accumulation of factors, from ethnic division and conflict and not accepting the other, to the intervention of foreign countries and an internal enemy as well as low level of literacy. Two of the key informants, one from remote and the other from semi-urban districts, said the corruption in the previous government caused the current situation. All of the KIIIs said that the situation will get worse, one key informant from remote Nuristan said that mental health problems will increase and another from remote Nuristan said “We will drown in crisis”. Many noted the future will be bad and they will keep on facing many crises, as their daily life is impacted and unemployment will increase. One female KII from semi-urban said: “we are Muslim and for the future we don’t lose hope and Allah will make everything good”, while a male KII from urban said “the future seems dark”.

Two of the key informants, both from semi-urban areas, said that those most at risk include people who worked for the previous government. Key informants answered about women, children, orphans, those who don’t have money, one key informant from urban, mentioned people with disabilities.

<table>
<thead>
<tr>
<th>Children distressed</th>
<th>Remote</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Children are sad and stressed, mentally disordered and worried. Behaviour is abnormal and they have bad manners, they are not normal – sometimes good, sometimes bad, become angry</td>
</tr>
<tr>
<td></td>
<td>After the crises children seemed very sad and hopeless. Don’t have good shelter, limited access to food and health facilities, bad family relationships.</td>
</tr>
</tbody>
</table>
| Semi-urban | Previously, in normal circumstance, community helped them on how to respond to emergency situations, how to think positively. Help the children not think about the crises. Currently they are trying to help them see a bright future and to think positively. Children can get help from humanitarian organisations. People should be more aware of children’s health.  

A distressed child is sad and worried, doesn’t have self-confidence and their “colour will change and one can see poverty in their face”. Their behavior is bad, they get angry quickly and are unfair.  

Social problems, family problems, financial problems, the community is unable to help them, don’t have access to first aid.  

Normal circumstances: keep them busy, motivate them, forbid child work and help them have a bright future and give them sports facilities. Currently prevent child work, keep them from daily stresses, open schools and social cooperation to reduce their stress.  

Can seek help from families, elders and local leaders. Good family nurturing will be helpful to decrease the children’s distress. |
| Urban | Distressed children isolate themselves and don’t participate in daily activities. They look sad and agitated and seem worried. They will be disquiet and uncontrollable.  

Problems are child work, poverty, family problems, no schools and areas to play. Previously, they would support children in all areas and try to help them know what an emergency situation is and how to respond to it.  

The family and mosque should love the children and treat them well. They should support their children and try to educate them and provide them with a safe and secure environment. |
Can get help from clinics, religious leaders and their parents. We should tell them good stories and advice to help them reduce their stress.

<table>
<thead>
<tr>
<th>Distressed women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remote</td>
</tr>
<tr>
<td>Semi-urban</td>
</tr>
</tbody>
</table>
jobs and give them their rights. Provide professional courses for them. Give women their freedom, women can have jobs.

Seek help from village leaders and other organisations.

**Urban**

When a woman is unable to go through her daily life, she is not able to support or be aware of her children. She looks tired, disorganised, emotional and upset, she doesn’t speak much and her actions aren’t kind and full of violence.

Problems are family, financial and unemployment, uncertain future. Reasons for the problems should be resolved and teach their rights, decrease the violence against women. They can seek help from their family, elders, psychologists and doctors. Give education to women, give job opportunities.

Women can go to women affairs, justice, government and community leaders for help.

**Men distressed**

**Remote**

Men who are distressed will show signs of being sad and tired, being emotional, and their mental situation is not good. Their behaviour show they are angry, they are “harsh” towards others. They will not be able to do their daily work.

The reasons for their distress is the uncertain future, poverty and unemployment. Violence in society, conflict and security and political situations as well as the humanitarian crises were included.

Two KIIs mentioned men can give information about the emergency situation and help with positive thinking. The third mentioned giving them positive advice. Currently two of the KII’s said that there is a need for a psychologist to help people with their distress, as well as giving them a job.
Community members should not leave them alone and should motivate them.

Men should also seek help from their relatives, neighbours and community elders as well as the psychologist.

| Semi-urban | Each person is different – sad and stressed, emotional and don’t have self-confidence. Not trustful and becomes angry.  

The current uncertain situation is distressful: poverty, non-availability of food, clothes, winter is coming (weather is cold). They cannot support their family or children, poverty, unfair government. Community comes together to support and employment should be given to them to keep them busy.  

Motivate them to not isolate and keep company with the community. Try to make a fair government and improve Afghanistan. Help them provide for their families.  

Seek help from government authorities and humanitarian organisations. Provide courses for them. |
|---|---|
| Urban | Men cannot perform their daily tasks as they did previously, they have bad feelings: “one can understand if a man is complaining too much from the current situation and using nonsense or poor words about the current government”. They appear to be sad and hopeless, look like they have a disorder and don't pay attention to themselves. They behave aggressively and are ill-mannered or wicked and angry.  

The reasons are: unemployment, anxiety, financial problems, health problems and other social issues, the current uncertain situation. In normal situations, men should learn how to respond in an emergency and to be ready for anything to happen. Community helps them find a job and to provide for |
their family. Currently, they should be motivated by influenced individuals, local leaders and family elders. They should think positively. First get help from the community to meet their needs.

Can seek help from spiritual leaders and from a religious perspective, help from psychologists, community elders and own villages.

<table>
<thead>
<tr>
<th>People with mental health disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Remote</strong></td>
</tr>
<tr>
<td>All acknowledge that there are people with mental health disorders living in the community. They have anxiety, they become angry, aren’t able to focus on what they say and can’t remember things. The community members see them as crazy and insane and treat them well. Some of them make fun of them. Previously they had tried to pay attention to them and treat them well and give them the support they need. This they still try to do. All said they should have assistance from a psychologist. One added they should seek help from the spiritual leaders and the other said family members. It was noted that the general understanding of mental health should improve in the community and that there should be more support by the community for these people as well as providing them with medication.</td>
</tr>
<tr>
<td><strong>Semi-urban</strong></td>
</tr>
<tr>
<td>Both KIIS said they have people in the community with mental health disorders. These people cannot speak properly, laugh unnecessarily or scare children and isolate themselves. Some people mock them and don’t want to have relationships with them, don’t value them and don’t believe in them. People should try to have kindness towards them and speak to them.</td>
</tr>
</tbody>
</table>
Community members should “guide them, cure them and do spiritual remedy (Tawiz) for them”. People should try to send them to health centres and to keep them busy.

They can seek help from community, spiritual leaders, health centres and organisations. Attention should be paid to the causes of their mental disorders to help them.

**Urban**

Yes, there are people with mental health disorders, people don’t accept them in the community, don’t pay attention to them and mock them.

Normally they try to behave well to them and increase their understanding and help them to do their treatment. Those who are children with mental health disorders should go to a special school, help them get a job.

They can go to the directorate of martyrs and disabled and public health, seek help from the community leaders, humanitarian community and health centres.

The understanding of MH should increase, provide facilities to help them.

<table>
<thead>
<tr>
<th>Family problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remote</td>
</tr>
</tbody>
</table>

All noted there were people with family problems. Listed as these types of problems: family violence, not having trusting relationships between family members, bad relationships and “bed problems”. Those in the community who have family problems are not treated well and are not given good value in the community.

Some of the community try to help them respect each other and to come to solutions about the family problems and inform them of the rights each have. Humanitarian organisations should provide assistance. Those with family problems should go to those who have experience in family problems and know how to solve it.
Increasing the literacy and the religious knowledge of people will be helpful to solving family problems.

**Semi-urban**  
Family violence is when there is violence against women, bad relationship amongst other family members, can’t meet their basic needs in the family.  

Community don’t see those who have family problems positively and don’t treat them well. Local leaders try to help them and to tell the community to treat them well. Before they would try to give positive advice and not to put pressure on each other and help them come to solutions to their problems. Currently give them information about organisation which are helping and collect help from the community.  

They can get help from the local community, leaders, government and organisations. Should give them support and make them busy.

**Urban**  
Could be family violence, bad relationship, violence from in-laws, health and financial problems. People in the community don’t treat them well and don’t respect them. Some of them make fun of them, others help them.  

Normal situation, try to support them and help them get help with what they need. Help people know how to create a good family.  

Help those with family problems, and if they have mental health problems, link them to the centres or provide their address.  

They can get help from religious leaders, organisation in humanitarian rights, help from government, NGOs, elders.

**People who have been raped**

**Remote**  
One female KII did not want to respond to this question.
These people have both mental and social problems and are thought of negatively in the community, with people talking badly about them, not having relationships with them. The person who has been raped does not value themselves and will isolate themselves.

Few people show their support to them. In normal circumstances people should listen to them and come together to support them, they should punish the rapist.

Help them with positive thinking and they can seek help from community and spiritual leaders, the court and the international organisations. Public awareness should increase and the laws should be implemented strictly.

<p>| Semi-urban | One of the two KIIS said that in their community people are not raped. The other KII said the person will be sad and have anxiety and want to isolate themselves. People normally treat them well and try to help them, try to not leave them alone and help them to not think too much as “they will be numb, think too much and will have anxiety”. People empower them by punishing the rapist. They can seek help from the government and local leaders should help them and to keep them safe. |
| Urban      | These people will have mental, spiritual problems and there will be enmity between the two families or tribes. Most of the community think negatively of them and don’t trust them. Normally they will treat the person as a victim and help them, and try to punish the rapist. The community tries to help them achieve justice and not leave them alone. Get help from the community leaders, justice and spiritual leaders. Punish those who are rapists. |</p>
<table>
<thead>
<tr>
<th>People with drinking and drug problems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Remote</strong></td>
</tr>
<tr>
<td>One KII said that no one uses alcohol as it is prohibited in Islam. The other two KIIs said that those who drink will have their family feeling sinful and the family will be seen negatively in the community. They will have financial problems and have bad social relationships.</td>
</tr>
<tr>
<td>The person will become unhealthy and his behavior will change, people will not trust them and their relationships will end.</td>
</tr>
<tr>
<td>There should be awareness of drugs and people should get the advice of the leaders on how to reduce these problems. The government should implement their rules seriously. People should pay attention to people and not let them use it. Seek help from the government and organisations, they should get treatment and make them busy with jobs.</td>
</tr>
<tr>
<td>More should be done to prevent the planting of the drugs and strict implementation of the rules and regulations from the Islamic government.</td>
</tr>
<tr>
<td><strong>Semi-urban</strong></td>
</tr>
<tr>
<td>This person will be perceived and treated badly in the community. The person will have a mental disorder. This person will have financial problems and have poor health.</td>
</tr>
<tr>
<td>Drugs and alcohol should be banned in the community and the disadvantages of it should be made public. The community does help these people.</td>
</tr>
<tr>
<td>The people should seek help from health centres and organisations as well as the government and community leaders.</td>
</tr>
<tr>
<td>Employment should increase, opium and alcohol should be banned and the government rules and regulations be implemented.</td>
</tr>
</tbody>
</table>
These people will be disrespected in the community, no one will trust them and they will have health problems. The family will be isolated from the community.

They will think he is a bad person and treat them badly. The youth should have sport or education and know the disadvantages of alcohol and opium. Positive advice and preaching against drugs and alcohol from a religious point of view.

Take them to places where they can be treated for addiction. Remove its causes and reasons. Not to make relationships with people who are involved with drugs and alcohol.

Try to help them financially and ban the use of drugs or alcohol. Can seek help from health centres, hospitals and community elders.

Prevention centres increase, know the risks and provide other financial aids.

Focus Group Discussions

Adolescents focus group finding

<table>
<thead>
<tr>
<th>Males</th>
<th>Remote</th>
<th>Semi urban</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems</td>
<td>Limited health services, headaches, country in a bad situation, unclean water, air pollution, limited transport, poverty, no jobs, roads aren’t concreted, no shelter, child work, security issues, immigration, bad</td>
<td>No facilities for children to play on, no cricket academy, no drinking water, girls education limited, security issues, don’t accept parents advice, terror of leaders/religious leaders, poor</td>
<td>Violence against women, poverty, health problems, scarcity of food, no clean drinking water, limitation on education, no safety, displacement, no shelter, we have no</td>
</tr>
<tr>
<td>MH problems</td>
<td>Impact on lives</td>
<td>Coping</td>
<td></td>
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</tr>
<tr>
<td>Anxiety, depression, bad behaviour – anger increased, think negatively.</td>
<td>Can’t get a job or get an education, unemployment increase, can’t learn, children can’t get an education, illiterate people increase.</td>
<td>Try to help each other, think positive and give positive energy to people. Try to be patient, cooperate with the government, increase community members understanding, use natural medicine, help</td>
<td></td>
</tr>
<tr>
<td>Drugs and opium use increase, increase headache.</td>
<td>House and family life and tasks are negatively impacted, affect breathing and health, decrease women’s literacy, can’t afford food and physically become weak, become sick, decrease of religious leaders and people can’t receive religious education, can’t move freely.</td>
<td>Carry children to health centres, give people advice and learn about the disadvantages of drugs, use medicine, motivate people to help each other, use</td>
<td></td>
</tr>
<tr>
<td>Distress, anxiety.</td>
<td>Affect unity, behaviour of family and community, impact on all aspects of life, security decrease, negative social life, bad health, become alone and don’t see relatives, negative impact on collective living.</td>
<td>Deliver positive advice, work on local sources, agriculture, work with animals, support and help each other, establish local councils, request organisation aid, try to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Each other and use local resources.</td>
<td>Natural medicine, use pipeline for water, pray, use security and guard system.</td>
<td>Build our own country, work for other countries.</td>
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</tr>
<tr>
<td>Future</td>
<td>Feel sad when think about the future.</td>
<td>Feel very sad</td>
<td>Feel sad</td>
</tr>
</tbody>
</table>

**Request for Support**

<table>
<thead>
<tr>
<th></th>
<th>Remote</th>
<th>Semi urban</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems</td>
<td>Medicine, procure MHPSS and increase health services, give jobs, good life facilities, build facilities for entertainment, religious schools, increase literacy, have communities come together to resolve their problems.</td>
<td>Medicine and health services, build hospitals, parks and amusement place, act to improve the mental health, provide jobs, behave kindly and with love, coordinate with the community, work as a group.</td>
<td>Medicine, job opportunities, hospitals, shelter, use healthy food, stay away from dirty places and use clean drinking water, should work together in the community.</td>
</tr>
</tbody>
</table>

**Women Focus Group Discussions Findings**

<table>
<thead>
<tr>
<th></th>
<th>Remote</th>
<th>Semi urban</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems</td>
<td>Banning of education and schools for girls, financial problems, natural disasters, natural disasters, financial problems, natural disasters,</td>
<td>Explosions, bombs, mines, bad relations among community</td>
<td>Bad social life, conflict between people in the community</td>
</tr>
<tr>
<td>MH problems</td>
<td>Anxiety, think too much.</td>
<td>Drugs, anxiety, think negatively, bad social life, stress.</td>
<td></td>
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</tr>
<tr>
<td>Impact on lives</td>
<td>Increase violence in the community, bad impact on economic and social life, affect all life negatively, safety and security, love does not exist, behaviour is harsh, mental health</td>
<td>Health, people can’t do their jobs, children’s behaviour decrease, children become disabled and can’t work in the future, love is not permitted and people</td>
<td></td>
</tr>
<tr>
<td>family problems, no respect for elders, not having children, increase bad relationship in the community, religious conflict, bad neighbours, ethnic conflict, violence against women, health problems.</td>
<td>members, no safety, violence against women, political instability, death every day, financial problems, scarcity of food, limited access to education, increase of hunger, weak leadership, poverty, presence of unknown armed persons, cheap prices of livestock’s, debts.</td>
<td>community, children health problems, financial problems, security problems, limited education, less knowledge about religion, no education for girls, love, get married for second time, conflict and deaths increase, can’t afford daily needs, unconcentrated roads, immigration, children become disabled in some families.</td>
<td></td>
</tr>
</tbody>
</table>

Thinking too much, cannot focus on one thing, anxiety, increase of anger, think and feel numb, isolation, can’t sleep.

Can’t perform religious worship and educational gathering, cause bad relationships and death, can’t sleep, impact on health, can’t perform job or family tasks, family relationships are poor,
<table>
<thead>
<tr>
<th>Coping</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment, elders come together to resolve the issues, make oneself busy, use local products, use spiritual treatment (tawiz, Dam) give good advice, beating the children, patience, teach the girls in the houses.</td>
<td>Feel happy</td>
</tr>
<tr>
<td>Try to find solution to explosions, rise the problems in the media, immigration, work on local sources such as rug knitting, defend themselves, plant on own land, motivate others for peace, preach religious, have faith in Allah.</td>
<td>Feel hopeless</td>
</tr>
<tr>
<td>Provide good advice, marry a second time, motivate them to recitation and pray, come together and solve the problem, try to prevent immigration, keep them busy.</td>
<td>Feel happy</td>
</tr>
</tbody>
</table>

**Request for Support**

<p>| Remote          | Medicine, cure those with mental health disorders and sickness and give them jobs. Help them to be beneficial to the people and the community, increase health services and specialists, provide several health training or seminars in the health sector |
| Semi urban      | Assist poor people, increase health centres, deliver teaching about health, provide job opportunities, healthy food and increase health, work together in the community |
| Urban           | Increase hospitals and clinics, keep environment clean and have good food, respect elders and keep cooperation |</p>
<table>
<thead>
<tr>
<th>Problems</th>
<th>Remote</th>
<th>Semi urban</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic problems, security issues, political, cold winter, bad behaviour, no good housing, can’t meet needs in the winter, no electricity, health problems, eye sickness, increase of violence in the community, family problems, women work increase, snow slide, natural disasters, corruption.</td>
<td>No facilities for sport, no universities, no qualified teachers in school, no good transport, low level of education, can’t find beautiful wife, social problems, limited education for girls, children health, women work increase, no money, scarcity of food, death of youth (most of young generation died defending the country).</td>
<td>Financial problems, can’t afford daily need, no clothes for winter, political parties have conflict, natural disasters, corruption in government, no education for children, violence against women, no harvest, high dowry for wedding, religious conflict, discrimination, unemployment, no religious knowledge, no income, no concrete road, child work, hunger increase.</td>
<td></td>
</tr>
<tr>
<td>MH problems</td>
<td>Anger increase, mental health problems, suicide.</td>
<td>Anxiety, bad behaviour (become angry and sad), thinking too much, mental disorders, stress increased.</td>
<td>Mental disorder, isolation.</td>
</tr>
<tr>
<td>Impact</td>
<td>Don’t have food or houses and no access to education. Not feel they are unable to meet the needs of the family, bad relations in community and reduced unity, can’t</td>
<td>Level of education is reduced, mental health disorders, women's health decrease, health decrease, can’t do job properly, physically weak, bad future.</td>
<td>Can’t provide for the needs of the family, next generation will be illiterate, economy will weaken, social life bad, and people isolating themselves they are not aware of the issues</td>
</tr>
<tr>
<td><strong>Coping</strong></td>
<td>Advocate for ourselves, take rest, come together and help each other, find the causes of the MH problems and solve them. Work with government and provide solutions, live in tents, motivate people to provide electricity, increase health facilities and pharmacies.</td>
<td>Continue education in someone’s house, give positive advice, focus on education, use natural food, try and motivate people for peace, give instruction about health services, use spiritual way of treatment (dam or tawiz - amulet) praying, provide sport equipment in home, try and wait and be patient.</td>
<td>Work on daily wages, motivate children for education, send children by force to school, use local resources, give positive advice, negotiate and provide solution, use mental medicine, motivate people to treat people equally, agriculture work</td>
</tr>
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</tr>
<tr>
<td><strong>Future</strong></td>
<td>Feel sad when think about the future, till now we couldn’t bring any changes, but hope to bring positive changes. We have too many problems - don't have access to the city, no good transport.</td>
<td>Feel sad</td>
<td>Wish life become better</td>
</tr>
</tbody>
</table>
Request for Support

<table>
<thead>
<tr>
<th>Remote</th>
<th>Medicine, come together and exchange idea, hire more staff, increase their services and build hospitals, prepare good food, provide education.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi urban</td>
<td>Medicine and services, build clinics, provide transports, medicines, provide notebooks and pens, and prepare courses. Good food, build schools and grounds for playing, coordinate amongst each other and no discrimination against each other religion or ethnicity.</td>
</tr>
<tr>
<td>Urban</td>
<td>Hospitals and increase health services, stay away from dirty places and use fruitful food which have vitamins. Respect each other, respect religious leaders, teachers, stay united and working together.</td>
</tr>
</tbody>
</table>

People with disabilities focus group discussions

| Male and Urban                | Violence against women, young people behave badly. Difficult to get married. No forests, no parks and playgrounds, no sports. Obesity, no access to technology. Food shortage, poverty, financial problems, scarce clean drinking water, unemployment, limited access to the internet, low level of education, low level of religious knowledge, immigration. No health centres or facilities for women to give birth. No good shelter. |
| MH problems                  | Not mentioned |
| Impact                       | Children stay hungry and can't provide them alimony to the family. The economy will become weak, they will face health problems, bad effects on health and behaviour, can't keep their livestock. People will stay physically weak, stay alone, do heavy work and they may not give birth. Can't move and health problems rise, literacy level will decrease and people will stay uneducated. |
Coping
Find job, work on local sources, give birth in home, cover tents, benefit from livestock. Play in houses, roofs, work on daily wages and find jobs, give good and positive advice, establish several educational courses.

Future
Feel sad

Support
Provide children with stationary, receive medicine and health services, hire professional teachers, maintain stable security and have peace, have more health centres, access to education and work together in the community

Children Focus Group Discussion Findings

<table>
<thead>
<tr>
<th>Mixed</th>
<th>Remote</th>
<th>Semi urban</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling safe, sad and happy</td>
<td>4 out of the 5 children said they were scared about the instability of their houses, one was scared the wall would fall, the other the stairs would fall and the third to get burnt from the stove. Another was scared of the windows falling. Some mentioned they were sad when their elders beat them and won’t let them play. One said his brother made him sad while a third was sad as they didn’t have someone to support or care for them.</td>
<td>All the children said they were scared from something breaking or falling in the house or the entire house (stove, window, roof). Some felt sad when they were alone and thought too much. Playing, seeing outside and being near the stove to be warm were what made the children happy.</td>
<td>One child said that when he looks outside, others throw stones at the window. One mentioned the roof falling, the room not having electricity, the ladder falling, the tent as it is cold, and a dark room as no one lives there. Most were scared due to the forest, and were upset as there was nowhere to play. One is not allowed to play and the other had no</td>
</tr>
<tr>
<td>Section</td>
<td>Details</td>
<td>Details</td>
<td>Details</td>
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<td>-----------------</td>
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</tr>
<tr>
<td>Being outside and playing were what made the children happy.</td>
<td></td>
<td>Being outside and playing were what made the children happy.</td>
<td>Being outside and playing were what made the children happy.</td>
</tr>
<tr>
<td>School</td>
<td>Four said they were happy at school as they can learn, play with friends and feel safe there. One said they work at home and help their mother – but they said this is not something they want to do.</td>
<td>Four of the children felt happy at school as they see their friends and play and learn new things. One child said they feel sad at school as the teacher beats them.</td>
<td>All 6 of the children feel safe at school, one does feel sad as they are unable to play but are busy at school.</td>
</tr>
<tr>
<td>Games</td>
<td>Four of the five said they play games with their friends, one participant (the one who does not go to school) does not play games rather go to relative house.</td>
<td>All the children had games to play and played with their friends or by themselves.</td>
<td>All children played games with their friends and enjoyed it.</td>
</tr>
<tr>
<td>Sad and angry</td>
<td>The children said when someone fights with them or beats them, or someone becomes angry. One mentioned they feel sad</td>
<td>Two children mentioned they feel sad when they can’t play, one said when they get more work, one said they feel sad when they think about their parents</td>
<td>5 of the 6 children felt sad due to some form of violence or conflict; when parents become angry, when teacher</td>
</tr>
<tr>
<td>Makes them scared</td>
<td>One child of the five children said they fear different animals, one said they fear the Afghan flag.</td>
<td>Most of the children were scared of an animal</td>
<td>Most of the children were scared of an animal, the bathroom, a jinn or devil, injection or carrot.</td>
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</tr>
<tr>
<td>Social Support</td>
<td>They all go to a close relative. Other support mentioned were neighbours and all people.</td>
<td>All the children said they go to a relative. One child said that when it is said it becomes angry and runs to mother. Friends were also cited as help and all people.</td>
<td>All children said they go to a close relative, other support were friends and all people.</td>
</tr>
<tr>
<td>Future</td>
<td>All the children had positive views of the future and of becoming a positive person in the community.</td>
<td>All children had a positive view of the future with positive goals</td>
<td>All the children had a positive goal for the future.</td>
</tr>
</tbody>
</table>
KUNAR

KII with 11 community leaders from remote, semi-urban and urban areas which we had 8 men and 3 women. Of the men there were 5 local leaders, 1 spiritual leader and 2 teachers. From the women we had 1 teacher, a nurse and a university student. 5 were from urban areas, 4 were from remote and 2 were from semi-urban areas.

Problems in the community

Problems in the community were listed as political, economic and social as well as safety and insecurity with limited government administration available and lack of education. Many see the situation getting worse as poverty, unemployment will increase, civil war and people leaving the community to find work and poverty increasing.

Economic included lack of salaries and jobs with unemployment increasing, political there are corrupt people and limited governmental services available. Health problems were increasing especially children’s health were deteriorating with an increase in children’s death. Others also noted that mental health distress is increasing and people’s daily lives are negatively impacted. One of the major issues raised was that those living in Kunar regardless of district status were struggling to accomplish their daily activities.

“It affected the economic and financial position very badly and people's mental health is impacted negatively” -Kunar, urban local leader.

Many noted the lack of resources and the ability to provide for their families saying that poverty and hunger were issues in the community. Many see the situation getting worse with some acknowledging that civil war could happen in the future.

A spiritual leader from remote parts of Kunar noted the impact on the social fabric of society with many no longer trusting each other, another local leader noted this in urban Kunar as he said social relationships have been impacted negatively.
When the local leaders were asked who were suffering the most due to the crises and could be considered at risk, 8 out of the 11 specifically mentioned those who had been employed in the previous government. Others mentioned were women, widows, orphans, those are depending on daily wages, people with disabilities, poor people.

<table>
<thead>
<tr>
<th>Children distressed</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Remote</strong></td>
<td>Children who are distressed look worried, sad and cry. They often have uncontrollable movements and are scared. The reason for this is because of family problems, financial problems, no education and schools. Normally they give them hobbies and play with them, they also try to motivate them and treat them kindly. Now the community reduces the fighting amongst the children and tries to motivate them and help the families with their financial problems. They also try to create a safe and secure environment for them. They seek help from their parents and uncles as well as teachers.</td>
</tr>
<tr>
<td><strong>Semi urban</strong></td>
<td>These children look as if they have problems, they seem tired, hopeless, sad, withdrawn and silent. They don’t have patience and don’t behave with good manners. The reasons are because of the war and conflict, financial problems, limited education, bad actions by the government with community members, someone died in the family, or something else bad happened to them, no caretaker in the family and having to do child work. In normal situations, the community provides them with entertainment and gives them sport and games and education opportunities. Now the community members try to help solve the family problems and support them financially and with food while motivating them to be educated. Children should have a better understanding about the current situation and problems. Children can seek help from relatives, teachers and parents as well as friends.</td>
</tr>
</tbody>
</table>
### Urban

A child who is distressed behaves and looks different from other children. They are sad, worried or crying and they behave as if “something is stolen from them”. One female key informant mentioned that these children become frightened quickly and make lots of noise. Children are distressed due to family violence, financial problems, having lost a family member, child work, being orphaned, not having a healthy and safe environment and “their future seems dark”.

Normally the community lets them play, have motivation and help them see a hopeful future. Now community members try to meet their basic needs. Children mostly go to the village and spiritual leaders as well as their parents and family.

### Women distressed

| Remote | These women are deeply sad and disquiet, their behaviour is negative as they do not interact with others, don't trust others, think too much and don't pay attention to their children. They feel powerless and are worried. One key informant said this person would be normal if her “faith is strong and believes in Allah”. The reasons for their distress are: hunger, unemployment, economic problems, the government is not recognised internationally. In normal situations, community members try to increase the knowledge of Islamic rules and regulations and give women their rights. Treat women kindly, help them with their house work and decrease their distress. Now community and spiritual leaders help them to overcome their problems, give them clothes and food, try to bring justice to society. Women can seek help from their parents, close relatives, husband, and their families. |
| Semi urban | These women seem sad and weak and their behaviour is bad and ill-mannered. These women seem depressed and isolate themselves. They are |
distressed as to the changes in the government, loss of jobs, economic and health problems and poverty.

In normal situations, these people are treated well and people try to give them courses to help them get jobs. Now the community tries to reopen schools, providing them with a good and safe job environment. Help them overcome poverty and support them financially. Listen to them. They can seek help from their elders, husbands, and parents and relatives as well government authorities.

| Urban | Both key informants mentioned that their behaviour is bad and sadness is seen on her face, they are hopeless and become angry quickly. Women are upset due to the family violence, unable to meet their daily needs, economic problems, forced marriages or they have been given to another family in compensation of conflict or violence, unemployment. Community leaders and spiritual leaders would help them to reduce their stress and give women their rights according to Islamic rules and regulations. Currently they are trying to get support from the community and assist women with what they need. They seek help from their parents and other relatives. Education opportunities and rights should be given to women and people should treat women kindly. |

| Men distressed | Distressed men look sad, hopeless and weak and are ready to commit suicide. Their behaviour is negatively impacted as they think too much, are depressed, become angry quickly, isolate themselves. The reason for the distress is due to financial problems, they can't meet with their family needs, unemployment, conflict and family violence, poverty and there not being a safe environment for their children. |
In normal situations the community helps each other, as wealthier people give them jobs and financial support and the community gathers together and shares advice with the person. Now they share aid with men, create jobs and give food assistance. Men should have belief in Allah and then seek help from civil society and community councils, justice organisations and community leaders and other relatives.

| Semi urban            | These men seem sad and hopeless, have anger problems and treat people badly. These men are often unemployed. Their reasons for feeling distressed are because of the destruction of the country, the overall situation, poor financial position, unemployment, limited education for children and difficulty to meet the needs of their family.  
                           
                           The community tries to help them by providing job opportunities. Now they give them addresses of health centres, and provide them with food and aid. They seek help from relatives and organisations as well as the government and community leaders. |
|-----------------------|-------------------------------------------------------------------------------------------------------------|
| Urban                 | Men who are distressed show they are hopeless, upset, sad and tired. These men are irritable, “quick tempered” and they do not treat their family and relatives well. They isolate themselves and think too much. The reason for their distress is because of the economic situation, health issues, political problems and inability to meet daily needs. One key informant mentioned that these reason are why someone uses drugs.  
                           
                           In normal situations, these men are supported by the community by helping them feel happy, motivated and giving advice. Now the community tries to give them resources to meet their needs. There should be jobs given to these people and they should be referred to psychologists and specialists.  
                           
                           The establishment of a powerful and good government and good economic situation will reduce their stress. Men should first depend upon Allah and then seek help from villagers and relatives. |
<table>
<thead>
<tr>
<th>People with mental health disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Remote</strong></td>
</tr>
<tr>
<td>It was noted that due to the current situation people, with mental health issues have increased. These people aren’t able to differentiate between good and bad, they can’t be independent in their daily lives. They have social, economic problems and create stress for their parents. The community thinks these people are insane and don’t treat them well, some people cheat them, while others try to help them become healthy. One key informant said “in general most of the people have problems and they cannot help or support each other.”</td>
</tr>
<tr>
<td>In normal situations these people are supported in their needs and daily work, they try to help them financially and motivate them. Now people have problems and find it difficult to cooperate and help each other. Others try to help them go to humanitarian organisations. They can seek help from psychologists, relatives and humanitarian organisations and health centres.</td>
</tr>
<tr>
<td><strong>Semi urban</strong></td>
</tr>
<tr>
<td>These people have family problems, financial problems. They often stay alone and have health problems. The people in the community view these people as sick and don’t treat them well. Normally these people are treated well in the community and are supported with their problems. Currently they try to give them positive advice and introduce them to health centres where doctors can help them. They seek help from their relatives, community leaders and the government as well as international organisations.</td>
</tr>
<tr>
<td><strong>Urban</strong></td>
</tr>
<tr>
<td>One key informant said that 80% of people in the community have mental disorders. Those with mental health disorders are described as not having controllable movement, don’t care for themselves and live in dirty places. Some people in the community treat them kindly, others think they are crazy and treat them like children. In normal situations, they try to increase the understanding of mental disorders. Currently they try to introduce them to health centres and</td>
</tr>
</tbody>
</table>
specialists and support them with food and clothes. Those with mental health disorders seek help from their family members.

<table>
<thead>
<tr>
<th>Family problems</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Remote</td>
<td>One male key informant from rural Kunar did not want to answer this question. Family problems include bad family problems, health problems, violence in the family or the community, poverty. People in the community treat them kindly and help them solve their problems. One Key informant said community members don't know how to support them as “in our society people can't intervene in someone family issues”. Now the community tries to identify the problems and provide the best solution, provide them financial support, others try to attract the attention of the international NGOs to support them. They can seek help from the government, community leaders, national, international organisation and the current government.</td>
</tr>
<tr>
<td>Semi urban</td>
<td>One key informant did not answer this question. The other mentioned that these people have family violence, financial problems and bad relationships between family members. The community don't think positively of these people and don't treat them well. Community members help identify the problems and give them a solution. They motivate them and give positive advice. These people can seek help from spiritual and community leaders as well as their close relatives. Jobs should be provided for these people to keep them busy.</td>
</tr>
<tr>
<td>Urban</td>
<td>These problems are described as family violence, health and financial problems. It also mentioned that this is bad relations among brothers, wife and husband and when a father has a bad relationship with his father and children. The spiritual leaders and local leaders as well as humanitarian organisations try to help them. Those in the community treat these people</td>
</tr>
</tbody>
</table>
kindly to decrease their stress. They provide them with food and support them. Money is also collected in the community to help these people.

<table>
<thead>
<tr>
<th>People who have been raped</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Remote</td>
<td>One male key informant did not want to answer this question. This person is not respected in the community as they are not trusted and are isolated by the community, relatives as well will not continue the relationship. The person who has been raped will experience shame and become lonely, they think negatively. In normal situation, the rape is not mentioned to people and treat them like others, also find out what happen and punished the person in court. Also try to keep the person away from where the incident happened. Now they teach people that this act is forbidden in Islam and the punishment will be in the hereafter. All key informants said they can seek help from the government.</td>
</tr>
<tr>
<td>Semi urban</td>
<td>One male key informants did not want to answer this question. The others mentioned that this person would be seen without value in the community and would be disrespected in the community and isolated. The community tries to understand why this happened and help them with the problem. The person who has been raped is not left alone while the rapists is told not to repeat this action again. It is noted that if the government and Islamic law is implemented, they can prevent this from happening.</td>
</tr>
<tr>
<td>Urban</td>
<td>One female key informant interview did not want to answer this question. People who have been raped will be shamed in the community as the community does not give them respect and doesn’t give them value. Many of the community members think they are a “weak person and don’t make relationship with them”. One noted that how these people are treated in the community lead them to develop mental health problems.</td>
</tr>
</tbody>
</table>
The community members try to help find reasons for what happened and to give the person the best solution. A community gathering is hosted and the community decides what to do next. The rapist should be punished by the community as the government is not active. Those who have been raped can seek help from the government.

### Drinking problems

| Remote               | One male key informant did not want to answer this question. These people who drink and use drugs have a bad name in the community, have health problems and will be isolated in the community. One key informant said that drinking and using drugs will bring “prostitution into the community”.
|                     | In normal situations the community bans this activity as well as where it is sold and its import and export. Those who do the business are punished. Now people work in collaboration with the government to arrest those who use it, there should be public awareness on the negative impact of it.
|                     | These people can seek help from spiritual leaders and health centres. |
| Semi urban          | It was noted that in Islam the use of drugs or alcohol is the “mother of sins and is prohibited”. The person who is involved in this activity including his family will be viewed negatively in the community and the person who is using drugs and alcohol will not be healthy.
|                     | In normal situations the religious leaders try to prevent its use through religious teachings and ban its business with the help of the government. These people can seek help from their relatives, spiritual leaders and government. |
| Urban               | It was clearly stated that drinking alcohol is strictly prohibited and these people who drink are not treated well and are isolated in the community. These people have mental health and physical problems. The spiritual leaders explain this according to the religious beliefs and practices. |
In normal circumstances the whole community is against drinking and drugs and they try to prevent it. Now spiritual leaders try to teach why it is not good and give advice and prevent the business. Others try to understand why the person uses drugs and alcohol and find a solution.

Adolescents Focus Group Findings

<table>
<thead>
<tr>
<th>Mixed Problems</th>
<th>Remote Problems</th>
<th>Semi urban Problems</th>
<th>Urban Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education, low daily wage, unemployment, educated people can't find jobs, Don't have caretakers for family and “everything is on us”. Immigration, limited money for engagements, stealing, if we stay unemployed it will not be good for the community, bad behavior, no support and aids. Drought. Do hard work. Hard life.</td>
<td>Financial problems, unemployment and no jobs, limited access to health care, not able to keep warm in winter (clothes and heating lacking), drought, can't plant on land, no electricity, no support for the spiritual leaders and can’t perform their daily tasks. Corruption, no clean water, no livestock, bad behaviour.</td>
<td>Unemployment increase, no income, poverty increase, no jobs or opportunities, health problems, no work environment for women, child work, no land for planting, bad behaviour increased, can't afford daily requirements.</td>
<td></td>
</tr>
<tr>
<td>Mental health problems</td>
<td>Drug use, distressed because of family life, isolation, mental health disorder. Can't achieve what they want (feel bad and become stressed).</td>
<td>Insomnia (can't sleep quietly), mental problems, family problems, daily stress (can’t focus on our tasks)</td>
<td>Mental health problems, relationships between family members not good, anxiety, uncertain future, depression</td>
</tr>
<tr>
<td>Future</td>
<td>Feel bad when think about the future</td>
<td>Feel hopeless because the situation of our country is not good</td>
<td>Positive feeling about the future</td>
</tr>
<tr>
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</tr>
</tbody>
</table>

**Request for Support**

| Remote | Education and employment, health services and increased mobile teams, good treatment at the clinics. Improve the knowledge of mental health. |
| Semi urban | Provide first aid treatment and help people with disabilities and poor people, increase mobile health teams, |
| Urban | Provide MHPSS, get medicine, employment opportunities, learn more about MHPSS, recruit doctors and provide medicine, reach out to the community and focus on poor people and identify those with MH disorders and provide treatment for them |

<table>
<thead>
<tr>
<th>Females adults</th>
<th>Remote</th>
<th>Semi urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems</td>
<td>Increased unemployment, limited education for girls, no care-taker for the family, bad behaviour, poor economy, illegal activities, death, conflict, disabilities and immigration.</td>
<td>Poverty, health problems, bad living conditions, no schools, no employment, no health clinics, family health issues, no shelter, no aid, displacement.</td>
</tr>
<tr>
<td>MH problems</td>
<td>Worry about life, mental health problems, depression, mental health disorders (due to the conflict and other problems most of the people are not normally mentally ill), can't memorise, think too much about problems, isolation.</td>
<td>Low knowledge about mental health problems, anxiety, hopelessness, depression, worry about children’s future and what will happen to them, thinking too much about the problems.</td>
</tr>
<tr>
<td>Impact on lives</td>
<td>Daily lives are impacted, can’t focus on daily tasks, suicide, can’t live independently- dependent upon others, safety and security.</td>
<td>People become sick mentally, poor health, affect family mental health, can’t achieve daily tasks, limited social life, limited education.</td>
</tr>
<tr>
<td>-----------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Coping</td>
<td>Exercise and sports, stay with friends, try to control the symptoms (MH), increase public awareness, work on agriculture, have patience and cope with difficulties, attempt to find job, try to find other opportunities.</td>
<td>Recitation, study.</td>
</tr>
<tr>
<td>Future</td>
<td>Future is indefinite, use energy positively and work hard to have bright future</td>
<td>Feel sad and hopeless about the future</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Requested Support</th>
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</thead>
<tbody>
<tr>
<td>Remote</td>
</tr>
<tr>
<td>Semi urban</td>
</tr>
</tbody>
</table>
**Adults Focus Group Findings**

<table>
<thead>
<tr>
<th>Males</th>
<th>Remote</th>
<th>Semi urban</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems</td>
<td>Limited access to education, family violence, political instability, poor economy, decreased currency, immigration, no jobs in government or military (worked with the previous government), unemployment, universities are closed.</td>
<td>No access to education, unemployment, disabilities, family problems, poverty, increase of violence, children malnutrition, scarcity of food for children, have no facilities for good life, universities are closed, no clean water to drink.</td>
<td>Immigration, no education, child work, family problems, unemployment, illegal work, no concrete road, low literacy levels, way to houses are destroyed, shelter (houses is not in good condition), poor living condition, disabilities</td>
</tr>
<tr>
<td>Mental health</td>
<td>Lack of respect (people don’t respect us because we are unemployed), anxiety, can’t focus on task, thinking too much, mental health disorders.</td>
<td>Not enough medicine and doctors for mental health, bad relations in families, anxiety, can’t focus on task, become angry quickly.</td>
<td>Drugs, can’t sleep, anxiety, forget things very quickly, feel sad.</td>
</tr>
<tr>
<td>Impact</td>
<td>No areas to play, future is badly impacted, daily tasks, unable to work, family life,</td>
<td>Changed professionals, ability to do jobs, social life, daily life can’t do.</td>
<td>Family life, health, mental health, jobs, daily life</td>
</tr>
<tr>
<td></td>
<td>distrust relationship, health, mind and mentality (political instability), security and safety, community life.</td>
<td>Get support from local resources (wood from mountains), get a job, use national medicide, planting, help each other, send request to organisations for job, study.</td>
<td>Help each other, search for drugs, use medicine, try to go to school, ask someone</td>
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</tr>
<tr>
<td><strong>Coping</strong></td>
<td>Use available resources, go to other places for education, try to change our minds, agriculture, request help, create jobs, motivate themselves and keep busy, negotiation, have patience.</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td><strong>Future</strong></td>
<td>Feel bad</td>
<td>Feel happy</td>
<td>I will try to improve my life</td>
</tr>
</tbody>
</table>

**Request Support**

<table>
<thead>
<tr>
<th>Remote</th>
<th>Hire mental health specialists, increase job opportunities, provide medication, support for mental disorders.</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi urban</td>
<td>Get medicine and health services, increase health service and education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>urban</td>
<td>MHPSS sessions, medicine, jobs.</td>
<td></td>
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</tbody>
</table>

**Mixed adult group urban areas**

<p>| Problem | Education, poverty, no aid from organisation, economy, family problems, no salary of teachers, immigration, scarcity of food, no land for planting, debt (borrowing from others) | Can’t remember things, drugs, bad behaviour, depression, mental health problems, anxiety, distress, think too much.                                                                 |                                                                                                                                               |</p>
<table>
<thead>
<tr>
<th>Impact</th>
<th>Current life, relationships with others, health, daily tasks, unity, economy, education, improvement and development of the society are limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coping</td>
<td>Borrow from others, study, find a job, strive to change mind, make selves busy, motivation, focus on study (only one coping mechanism was seen as helpful the rest were not seen as helpful)</td>
</tr>
<tr>
<td>Future</td>
<td>Fear - “I am scared”</td>
</tr>
<tr>
<td>Support</td>
<td>Get good treatment, mhpss sessions, job opportunities, recruitment of mental health doctors, increase the number of clinics, and hire more mental health doctors, identify the exact problems and find the exact solutions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Men living with disabilities - urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem</td>
</tr>
<tr>
<td>MH</td>
</tr>
<tr>
<td>Impact</td>
</tr>
<tr>
<td>Coping</td>
</tr>
<tr>
<td>Future</td>
</tr>
</tbody>
</table>
Support

Job opportunities, talented doctors, children's education, emergency aid, specify their needs and provide their services and reach out to the society from the bad situation.

Children Focus Group Findings

<table>
<thead>
<tr>
<th></th>
<th>Remote</th>
<th>Semi urban</th>
<th>urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling safe, sad and happy</td>
<td>Most of the children reported on natural children worries and actions such as being scared of the roof, or feeling alone, and playing and having the family together as making them feel happy.</td>
<td>Two of the 5 children said they are scared of car accidents, mentioning falling from a tree, not being able to play, and becoming sick. Others said they didn’t have good and enough food, while playing and being with their parents made them happy.</td>
<td>One out of the 5 said part of their house was destroyed, the others mentioned the dark, the cemetery and the yard. They mentioned they don’t like being alone and not being able to play. All mentioned the yard or a garden as being a place to play and be free as a place they felt happy.</td>
</tr>
<tr>
<td>School</td>
<td>All the children enjoyed school and felt safe there, as this was where they could play with their friends, have a bright future.</td>
<td>All feel happy at school as they feel safe there, “no one can abuse us”, meet friends, learn new things and play with friends and study for the future.</td>
<td>All children feel happy and safe at the school as they are able to study and play there with their friends.</td>
</tr>
<tr>
<td>Games</td>
<td>One liked to play shooting, most of the others enjoyed the</td>
<td>All enjoyed games and played with their friends</td>
<td>All mentioned some form of game and</td>
</tr>
<tr>
<td>Sad and angry</td>
<td>Many of the responses to why children feel sad and angry were natural responses, such as not being able to go to school and not being able to play. However some other children (3 out of the 5) said they become upset because of: someone using bad words, destroying their school, when their family is sad, and when others talk about things they don’t like and due to the current situation.</td>
<td>One child mentioned when they feel hungry they become sad, while another said that when someone becomes angry they become sad. Another mentioned when they don’t have shoes.</td>
<td>All the children mentioned either about losing a game, fights in the game, not being able to answer a question at school, not finishing their homework or not being allowed to join a game.</td>
</tr>
<tr>
<td>Makes them scared</td>
<td>2 out of the 5 children drew something relating to</td>
<td>Two of the children drew a gun while the third drew a car</td>
<td>3 of the 5 children drew a gun as something that</td>
</tr>
<tr>
<td>Social Support</td>
<td>Future</td>
<td></td>
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</tr>
<tr>
<td>the conflict and war as something that makes them sad, (mines, guns). The third drew when someone asks for help and the other doesn’t help you.</td>
<td>One child out of the 5 said that he has hopes for the future but doesn’t think they will achieve it. The rest of the children had hopes of different careers and goals. While also wanting to service the community.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accident. The other two drew a fish and a carrot.</td>
<td>All the children had a positive goal for their future.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>makes them scared, the other two drew a scorpion and a dog.</td>
<td>All the children had a positive goal for their future.</td>
<td></td>
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</tr>
<tr>
<td>Of the three responses, all said go to their parents while the one added to go and play. Other support were the neighbours, religious leaders, teachers, friends, and elders.</td>
<td>One mentioned that when they become sad at home they go to their friends. The others mentioned go to their parents other help were neighbours, grandfather</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Social Support**

One child goes to a safe space and to their friends, the others also quoted going to family or friends.

**Future**

All the children had a positive goal for their future.