HealthNet TPO

Integrating Mental Health into the Primary Health Care system of Afghanistan

ASIE/2004/097-608

External Evaluation Report
December 2008
Table of contents

Acknowledgement
Abbreviations

1. Executed summary pp. 4-6
2. Outline and action plan of evaluation process pp. 7-8
3. Review and evaluation of planned activities pp. 9-13

3.1. Background
3.2. Objectives of the program funded by the EC (AF068)
3.3. Planned Activities
  3.3.1. The psychiatric component: HealthNet TPO is implementing trainings for basic health care providers at the different levels of the basic health system and integrates mental health activities into the BPHS
  3.3.2. The psychosocial component: HealthNet TPO is providing training and community-based psychosocial interventions with community leaders/members.
  3.3.3. Coordination with MoPH and other stakeholders
  3.3.4. Materials developed
3.4. Duration and covered provinces of the project

4. Assessment implemented activities and expected output of AF068 and NCE contract

4.1. Expected output 1 (part 1): the capacity building pp. 13-24
  4.1.1. General: the intervention logic and the implementation process
  4.1.2. Type and number of health facilities
  4.1.3. Capacity building through training
    4.1.3.1. Activities
    4.1.3.2. Quantitative data of mental health trainings in all provinces
    4.1.3.3. Quantitative data of mental health trainings in provinces Nangarhar and Kapisa compared to the expected results in the contract AF068
    4.1.3.4. Quantitative data of mental health trainings in the provinces Laghman, Kunar, Khost, Uruzgan and Kandahar compared to the expected results in the NCE contract
  4.1.4. Learned lessons based on data and analysis in focus groups on the trainings
  4.1.5. Learned lessons on human resources issues of the training program
  4.1.6. Recommendations on training and capacity building
    4.1.6.1. The capacity building resources
    4.1.6.2. The capacity building of health facilities at province and country level
    4.1.6.3. Human resources
    4.1.6.4. Collaboration with Health authorities

4.2. Expected output 1 (part 2) : Implementation of mental health component in health service of Health Posts, BHC, CHC, District Hospital pp. 24-30
  4.2.1. The implementation of mental health care in the community
    4.2.1.1. Psychiatric component of treatment in health facilities
    4.2.1.2. Psychosocial component of MH treatment in the health facilities
4.2.1.3. The supply of drugs
4.2.2. Referral
4.2.3. Quantitative data about number and type of mental illnesses identified in the 7 provinces
4.2.4. The effectiveness and quality of the provided care
4.2.5. Learned lessons
4.2.6. Recommendations regarding the implementation of mental health care in the community

4.3. Expected output 2: A model for culturally appropriate community based psychosocial services in Afghanistan is developed and implemented pp.30-38
4.3.1. General
4.3.2. Implementation of psychosocial interventions in the communities
   4.3.2.1. Activities
   4.3.2.2. Quantitative data of psychosocial trainings and interventions in all provinces
   4.3.2.3. Quantitative data of psychosocial trainings and interventions in provinces Nangarhar and Kapisa compared to the expected results in the contract AF068.
   4.3.2.4. Quantitative data of psychosocial trainings and interventions in the provinces Laghman, Kunar, Khost, Uruzgan and Kandahar compared to the expected results in the NCE contract.
4.3.3. Learned lessons
4.3.4. Recommendations regarding the implementation of community based psychosocial interventions

4.4. Expected output 3: Capacity of provincial health authorities in planning and management of mental health activities on provincial and district level is enhanced pp. 38-39
4.4.1. Learned lessons
4.4.2. Recommendations regarding planning and management of mental health activities on provincial and district level

4.5. Expected output 4: Mental health policy, planning and implementation capacity of the central Ministry of Health strengthened. pp. 40-42
4.5.1. Learned lessons
4.5.2. Recommendations regarding Mental health policy, planning and implementation capacity of the central Ministry of Health

4.6. Expected output 5: The implemented mental health and psychosocial activities are monitored, evaluated and researched. pp. 42-43
4.6.1. Project management at central and provincial level
4.6.2. Monitoring and Evaluation
4.6.3. Recommendations

5. Effectiveness, efficiency and sustainability of the achieved results pp. 43-44

Annexes
1. Terms of reference
2. List of persons met
3. List of documents
Acknowledgements

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The atmosphere during individual and focus group meetings with HN TPO staff, teamleaders, trainers and supervisors was open, cordial and thoughtful. Difficulties were presented and discussed in a professional manner. Additional information the evaluator asked for assessing in detail the achieved activities was collected and presented accurately. The evaluator has also much appreciated the meetings with the national and provincial authorities and the EC who oriented the evaluator and helped to focused on core questions. The visits to doctors, nurses, midwives, CHS, CHW at the health facilities and to training sessions were highly important to appreciate the reality of the project at grass root level and in daily practice.

At the end of the field visit a debriefing was presented to the Country Manager/Head of mission and the Program manager. The evaluator is thankful for the reactions and constructive feedback when he shared reflections and analysis during the mission.

Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>BHC</td>
<td>Basic Health Centre</td>
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<td>BPHS</td>
<td>Basic Package of Health Services</td>
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<td>CG</td>
<td>Core Group</td>
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<td>CHC</td>
<td>Comprehensive Health Centre</td>
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<td>CHW</td>
<td>Community Health Worker</td>
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<td>DH</td>
<td>District Hospital</td>
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<td>EC</td>
<td>European Commission</td>
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<td>EPHS</td>
<td>Essential Package of Hospital Services</td>
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<td>HCC</td>
<td>Health Centre Committee</td>
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<td>HCSP</td>
<td>Health Care Support Programme</td>
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<td>HIS</td>
<td>Health Information System</td>
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<td>HN TPO</td>
<td>HealthNet Transcultural Psychosocial Organization</td>
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<td>HQ</td>
<td>Headquarters</td>
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<td>IEC</td>
<td>Information, Education &amp; Communication Materials</td>
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<td>MCH</td>
<td>Mother and Child Health</td>
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<td>MD</td>
<td>Medical Doctor</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>NHS</td>
<td>National Health Strategy</td>
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<td>NGO</td>
<td>Non-governmental Organisation</td>
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<td>PCC</td>
<td>Provincial Coordination Committee</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PM</td>
<td>Project Manager</td>
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<td>TA</td>
<td>Technical Advisor</td>
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<td>TOR</td>
<td>Terms of Reference</td>
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<td>ToT</td>
<td>Training of Trainers</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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1. Executed summary

This report presents the findings about the activities, learned lessons and recommendations that are the result of the evaluation of the project ‘Integrating Mental Health into the Primary Health Care system of Afghanistan’ with contract number ASIE/2004/097-608. The project covers a period of 36 months with a no-cost extension of 1 year. The evaluation is based on the Terms of Reference that have been prepared by HN TPO. The evaluation included a desk-review of the contracts and reports of the project and a field visit in October 2008.

Interviews, focus groups and discussion meetings were held with executives and senior staff of HN TPO Afghanistan at the offices in Kabul and Jalalabad, health authorities in the MoPH in Kabul and province of Nangarhar, the Delegation of the European Union and health facilities at the different levels of the health system.

The project covers the implementation of mental health and psychosocial care in 7 provinces (Nangarhar, Kapisa, Laghman, Uruzgan, Khost, Kunar and Kandahar. The evaluator has considered the output of the original project and the no-cost extension as a whole. The results have been assessed and compared with the expected output described in both contracts. The report follows the plan and logical frame of the 5 objectives. Learned lessons and recommendations are summarized for each of the objectives separately.

The overall conclusion of the evaluation is that 5 specific objectives and the expected output have been achieved and in nearly all the components beyond the expected results. This is a remarkable result in particular if one considers the difficult and insecure context, caused by the ongoing war, in which the project had to be managed and implemented. The evaluator was struck by the strong moral and high motivation of the HN TPO staff and healthcare providers and the way they are able to cope with the burden of danger and stress in their daily situation.

The mental health component – the first specific objective - has been introduced in the primary health care system in the 7 provinces. After having participated at a capacity building training program, doctors, midwives, nurses and community health workers have integrated and applied the learned knowledge and skills in their health facilities. This was followed by supervision on-the-job.

Compared with the expected results, in all provinces much more doctors, nurses/midwives and CHW/CHS have been trained than expected; in all 7 provinces together 296% for the expected number of doctors, 131% of the nurses/midwives, 162% of CHW/CHS have been trained.

All the components of the mental health program were integrated in the health system, and all the facilities in all districts of the 7 provinces were covered. In the project period 188,168 patients have been identified and treated for their mental illness. 81% of the identified and treated cases are common mental disorders (67% depressive disorders and 14% anxiety disorders). Experience has learned that two years after the onset of the training, the amount of cases doubles. The evaluator estimates 180,000 to 200,000 cases to be treated in 2009 for the 7 provinces as a whole assuming that the implementation of MH services in the BPHS is continued. This is 6.8% of the population of these provinces.

The integration of mental health into the Basic Package of Health Services was enabled as no extra personnel had to be appointed. The results show that the model and the strategy for implementing mental health into the regular public health system is very effective. Equity, accessibility and coverage of mental health care for the population are guaranteed by this model.

The community-based mental health approach rests on the adequate functioning of referral and feedback guidelines and practices in particular between the health facilities and the
community, in particular involving the community health worker. This feedback and connection between facilities and community health worker is not well established. Recommendations are made on different aspects of the mental health implementation.

The psychosocial component - the second specific objective - of the project concerned a model for culturally based psychosocial service provision. The expected output of the training plan has been more than achieved. HN TPO has been successful in training the expected number of community health workers. The implementation of psychosocial services in the community shows a more diverse picture. Nearly 4 times more psycho-education sessions have been given to community groups than expected. Case management and self-help support groups were more or less successfully implemented. In particular self-help groups for male participants met strong cultural resistances. In the course of the project the format and the aim of these self help groups has been adapted. The evaluation has identified difficulties the project faced to introduce and implement in a sustainable manner with the community health workers/ community key persons the various psychosocial interventions beyond awareness raising (psycho) education sessions. Various reasons of this weakness are analysed in the report. The recommendations include capacity building, organisational, health systems and financial aspects. They focus on the tasks and role of key figures in the BPHS improving the linkages between the community and enabling sustainable community activities. The aim is to improve the participation of the community in developing and implementing forms of primary prevention, self-help and ways of coping with the multiple stressors in the Afghan context.

HN TPO expatriate and afghan trainers/supervisors have developed detailed, practice-oriented, effective training programs and manuals/handouts for the various target groups: doctors, nurses/midwives, psychosocial counsellors, community health workers, community groups. These manuals are used in all provinces. Recommendations are made for refresher courses and future training program development.

The capacity building of provincial authorities – third objective - in planning mental health activities on provincial level has been achieved through participation and collaboration of HN TPO staff with health authorities regarding training, supervision and planning of mental health services. The evaluation showed that this collaboration should be improved in order to strengthen both mental health care and psychosocial interventions in the provinces. Recommendations are made on this point.

The capacities of the national Ministry of Public Health – fourth objective - have been strengthened in line with the expectations. Both logistic and technical advice as well as regular communication has been provided. The newly created Mental Health Department in the MoPH is currently developing mental health policies, strategies and guidelines. The project includes regular technical and logistic support and participation at task force meetings in the MoPH. Recommendations are made to further strengthen the development and planning of MoPH role and stakeholder organisations.

Regarding the monitoring and evaluation of mental health activities – fifth objective - the evaluation indicates that this component is still in an first phase of development. A survey and small scale client satisfaction assessment have been done.
The HN TPO office and management of the mental health project in Kabul is able to collect, document and report activities. Now that the project has reached the phase of consolidation HN TPO should give priority to develop M&E plan for its different components.

A second priority concerns a sound human resource policy and management. The multiple tasks HN TPO have been achieved during the last 4 years with a remarkable success. The organisation has to develop career planning, capacity building and effective management structure in order to consolidate and upgrade its senior technical (trainers, supervisors) staff. Suggestions are made.

To conclude:
The project was effective. It has achieved its objectives, and in several parts of it far beyond the expected output - as stated in the original objectives and logical framework matrices. The local structures and health facilities as well as the population has benefited to a maximal degree. Both training staff and trained care providers in the health system and in the communities are able to implement care for mentally ill persons. The project has provided the possibility to learn and identify components of the design that need improvement. These concern mainly referral mechanisms and the link between health facility interventions and community psychosocial work. The quality of the services and effectiveness of the interventions need more detailed follow-up. The management was effective to implement the program. In some provinces supervision in health facilities and communities in rural areas is now very difficult due to the impossibility of secure travelling. It is however remarkable that the project has been able to reach such remarkable results in this difficult context.

The project was efficient. The financial resources were used properly. Some parts of the project were delayed due to difficulties of co-financing the projects in the 5 provinces. However to realize this program in 7 provinces was very ambitious given the available resources. The necessity to apply the project in all 7 provinces in due time and make reports for a high number of co-funding agencies put a huge stress on the organisation, its management and training staff. Some aspects like regular monitoring of the whole project, follow-up of psychosocial work in the communities and development of the training staff have suffered from this situation.

The project is not yet fully sustainable. The integration of mental health in the health facilities is an essential asset regarding sustainability. But refresher courses and prolonged supervision is necessary to consolidate these competences. The psychosocial community-based services are not yet sustainable. Based on the past experience, the BPHS and HN TPO have to develop in collaboration with MoPH a model and small-scale project in order to achieve more sustainability of this essential part of the program.
The financial sustainability is a matter of high concern both for the BPHS and mental health as a whole but also for the continuity and consolidation of HN TPO as resource centre in Afghanistan.

The mental health program of HN TPO has the technical capacities to consolidate and further improve the integration of community-based mental health in the BPHS. In partnership with the health authorities and other stakeholders its staff is equipped to take up a major role in addressing major challenges of the Afghan health system namely establishing a sustainable provision of mental health care for the population under extreme stress in a larger number of provinces and the integration of mental health in the essential package of hospital services. This aim is only achievable with the financial support of the EU and other international donors on a longer term. With this long term perspective and aim in mind, the evaluator recommends the EU to consider a new 4-year grant.
2. Outline and action plan of evaluation process

2.1. Context of the external evaluation:
Jaak Le Roy, psychiatrist and mental health consultant, has been appointed as external evaluator. The evaluation plan has been adapted to the current insecurity in Afghanistan. Field visits to health facilities were not allowed by the security services outside Kabul except for the city and direct environment of Jalalabad in Nangarhar province. During the whole mission strict security measures were taken by HN TPO. In order to have feedback from the project activities in the health facilities of Kapisa, Laghman, Uruzgan, Khost and Kunar, a delegation from each of these provinces with the team leader, a medical doctor, a midwife and a male nurse came to Kabul for a two-day evaluation. The HN TPO team from the Amsterdam, Kabul and Jalalabad were very helpful in creating the practical conditions and providing the information necessary for this evaluation. The evaluator has collected the data that the team leaders of the provinces have been registering during the project years. He integrated them in tables for this report to allow the assessment of the output at collective project level.

2.2. Desk review: - contracts and reports AF068 and Non Cost Extension
- reports missions expatriate consultants HN TPO Amsterdam
- manuals training program

2.3. Interviews with senior staff of HN TPO Afghanistan
Individual interviews with key senior staff at the HN TPO offices in Kabul and Jalalabad with the Country manager, Mental Health program manager HCSP Program manager.

2.4. Individual meetings and group focus discussion with the core team of Nangarhar (3 mental health and 4 psychosocial supervisors)

2.5. Focus group interviews and discussion meetings with healthcare providers (focal point, doctors, midwives and nurses from health facilities BHC, CHC, DH) from the provinces Uruzgan, Laghman, Kunar, Khost. Total 14 persons.

2.6. Focus group interviews and discussion meetings with the leaders of 4 provincial teams of the provinces Uruzgan, Laghman, Kunar, Khost. Total: 4 leaders (doctors)

2.7. Field visits to health facilities in Jalalabad and surrounding area

2.7.1. Visit of the health care facilities at all the levels of the health system:
- Information gathering by interviews with doctor, midwife, nurse, manager, patients;
- Observation of diagnostic and treatment session of doctor and patients with a mental health illness.
- Review documents: patient consultation register, patient card, psychotropic drug prescriptions, monthly collected data on numbers of patients and charts of identified illnesses.
- Visit of the premises and check of the medical/educational toolkit and pharmacy
- Discussion about strengths, weaknesses, challenges and recommendations with the staff

2.7.2. List of visited health facilities
- Nangarhar provincial hospital, especially mental health ward.
- Ghanikhil District Hospital, especially mental health Out Patient Department and the Mother and Child department
- Nahr-e-Shahi Basic Health Centre
- Batikot Comprehensive Health Centre
- Health post with Community Health Supervisor and Community Health worker

2.8. Field visit to psycho-education training activities
- Visit and observation of training session about a mental health problem during the 3-day psycho-education training program of 28 female teachers of a local community school. The training was conducted by two female psychosocial trainers of Nangarhar core team.
- Visit, observation, interview and discussion with participants of a training session during the 3-day psycho-education training program of 20 male community leaders (mullah, family elders, teachers). The training was conducted by one of the male psychosocial trainers of the Nangarhar team.

2.9. Visit to health authorities
   In the Ministry of Public Health (MoPH), Kabul.
   In the Provincial Health Directorate of Nangarhar Province, Jalalabad.

2.10. Visit to the Delegation of the European Commission
   - Review and information gathering of EC interventions and policy concerning MH and PSS in Afghanistan
   - Exchange on aims and topics of the external evaluation

2.11 Assessment with small sample of patients at the visited District Hospital and the CHC about the patient satisfaction and effectiveness through exit interview. Assessment prepared by the evaluator (EE) and a member of the M&E department of HN TPO Afghanistan. Interviews by M&E department during the on-site visit. Instruments used:
   - questionnaire established and used for earlier evaluation in Nangarhar (HN TPO) and Afghanistan (MoPH and J. Hopkins University)
   - effectiveness of the treatment: set of questions from the Social Functioning and Disability scale, measuring effectiveness and impact of treatment on daily life
3. Review and evaluation of planned activities

3.1. Background

Since the end of the Taliban Regime in Afghanistan, the country has made considerable progress in many areas of development. The health sector is one of these areas, and health sector rehabilitation has given rise to a health system which, at least in theory, provides a minimum standard of care to all Afghans. The recently revised Basic Package of Health Services (BPHS) provides standards for a four tier primary health care system and the Essential Package of Hospital Services (EPHS) provides the framework for the hospital system. The BPHS has a pyramidal structure with 4 referral levels: community level (HP) staffed with Community Health Worker (CHW), Basic Health Centres (BHC) staffed by one doctor and 2 nurse/midwife, Comprehensive Health Centres (CHC’s) staffed by two doctors, nurses, laboratory staff and Community Health Supervisor (CHS) and the District Hospitals (DH) providing a range of hospital services. These facilities are also linked with the EPHS, which above have Provincial Hospitals, and Teaching Hospitals. The three main donors are the European Commission, World Bank, and USAID.

HealthNet TPO has been operational in Afghanistan and Afghan Refugee camps in Pakistan since 1992. The focus of the organisations global activities is on providing health care structural redevelopment in the transitional stage from complex emergency to development aid. HealthNet TPO’s operations in Afghanistan have three major components; Mental Health, Primary Health Care (the Health Care Support Programme) and the Malaria and Leishmaniasis Control Programme (MLCP).

In 2002 HealthNet TPO started to be active in Afghanistan in the field of mental health care by including mental health in primary health care. The program began in Nangarhar Province by training local health staff in basic psychiatry. The EC grant AF068 allowed HN TPO to develop the mental health integration in all healthcare facilities in two provinces Nangarhar and Kapisa. A psychosocial component was added in order to provide psychosocial care within the communities.

The programme aims to develop, implement and evaluate a model for cost-effective, culturally appropriate, community based, and sustainable mental health services in two provinces of Afghanistan. The activities are aimed at several layers of the health care system: the national level, the provincial level, the basic health care level, and the community level. In the two target provinces a mental health component is introduced to all rural health facilities, from health posts to rural hospitals, and culturally appropriate community based psychosocial services will be developed and implemented. The capacity of provincial and national health authorities in planning and management of mental health activities will be enhanced. Because of the pioneering and innovative character of the proposal a research component including cost-effectiveness research is added. The main target groups are a) the health care workers in the primary health care system of the project area, b) the population in the project area suffering from mental problems, c) the MoH Directorate PHC on national and provincial level.

In the meantime as planned in the Non Cost Extension contract, the program in Afghanistan has expanded its activities to seven provinces to support the BPHS implementers in integration of mental health component of BPHS. The support include training of trainers, training primary health care staff (doctors, nurses, midwives), developing systems reporting formats, supervisory checklist, monitoring tools and training manual and guidelines. Along with the activities in the health facilities, HealthNet TPO is focusing on community
psychosocial services: community mobilizations, awareness raising, regular psycho education sessions, support and self help groups and individual case management and family mediation.

3.2. Objectives of the program funded by the EC (AF068)

The overall goal of the programme was to contribute to improvement of mental health and psychosocial services in the selected provinces of Afghanistan.

The purpose of the program was to develop, implement and evaluate a model for cost-effective, culturally appropriate, community based, and sustainable mental health and psychosocial services for the rural areas of Afghanistan.

The proposal comprised of activities at the national level, provincial level and community level. These levels are reflected in the following specific objectives:

A basic mental health component is introduced in the health care system (BHC’s, CHC’s, DH’s)

A model for culturally appropriate community based psychosocial services in Afghanistan is developed and implemented

Capacity of provincial authorities, NGO’s and other possible stakeholders in management of mental health and psychosocial activities on provincial and district level in these provinces is enhanced and the exchange between all stakeholders is reinforced

The policy, planning, and implementation capacity of the relevant Ministries are strengthened;

The implemented mental health and psychosocial activities are monitored and evaluated;

3.3. Planned Activities.

3.3.1. The psychiatric component: HealthNet TPO is implementing trainings for basic health care providers at the different levels of the basic health system and integrates mental health activities into the BPHS:

Training of trainers: The training for trainers is a two months intensive course with different components:

- Basic mental health training course for 2 weeks. In this training the focus is on diagnosis and management of common mental health problems at primary health care level.

- Basic training methodology for 2 weeks. This training is meant to teach the participants how to properly convey a message to others, how to handle a difficult participant, how to prepare a presentation and how to assess the level of knowledge of the ones being taught.

- Clinical training in a Postgraduate Medical Institute in Pakistan (2 weeks). During two weeks clinical training, the focus is to expose the participant to what they have learned during the two weeks basic mental health theoretical training about common mental disorders, learn practical skills and different treatment options based on bio psychosocial model

- Training under supervision (2 weeks): This is the last part of two months training. The participants are given the first opportunity to translate the knowledge and skills they have learned during one and half months into practice and test. The participants are conducting sessions under the supervision of master trainers from HealthNet TPO.
Each session is followed by feedback in order to improve the skills and knowledge of participants

- Mental health care activities in district hospital
In each District hospital a focal point for mental health is assigned. These so-called focal points (doctors and nurses) have got a six weeks training. The same training will be provided to the focal points of the District Hospitals in the other provinces. The focal points are active six days a week in the district hospitals. They normally see 20 to 30 cases per day.

Mental health care activities in BHC’s and CHC’s
HealthNet TPO has designed two weeks training course for doctors working in BHC’s and CHC’s. The course includes common mental disorders, diagnosis and management based on bio-psycho-social model at PHC level. A similar course has been developed for nurses and midwives. During the two weeks basic mental health training for nurses and midwives, the focus is more on the psychosocial component of people with mental health problems; issues like the proper use of medication, informing relatives how to take care of family members, the importance of psychosocial support are an important part of this training.

Mental health care activities for health post
Community health Workers (CHW’s) plays an important role to narrow the bridge between the community and the health facilities. HealthNet TPO organizes 3 day’s trainings in which mental health and psychosocial issues are an integrated part. The CHW’s are expected to raise awareness, to identify common mental cases, refer them to health facilities and take care of the follow-up of people once back in their community.

Medication supply
Psychototropic drugs are supplied to the health facilities after the health staffs are trained. The medication includes antidepressants, anxiolytics, antipsychotic and antiepileptic drugs. These drugs are part of regular drug supply to health facilities and supplied on monthly basis.

Supervision and on job training
A supervision checklist already developed by HealthNet TPO in Nangarhar is used for this purpose. It is advised to provide on job training and supervision visits to the health facilities after the staffs are trained in mental health on regular monthly basis.

Development of HMIS system:
During the program period, HealthNet TPO has developed and tested HMIS tools that can be part of the national system.

3.3.2. The Psychosocial component: HealthNet TPO is providing training and community-based psychosocial interventions with community leaders/members.

These psychosocial interventions are implemented at grassroots level and have a different aim than the educational and preventive psychosocial support that go along with the psychiatric component in the health facilities. They include training of trainers, mobilizations of key figures, psycho-education sessions for CHW’s and key figures, community mapping, support group and case management sessions. The key figures can be schoolteachers and students, Community leaders, female influential key persons, Health Workers, or other responsible figures.
The training of psychosocial workers as trainers:
This Training of trainers (TOT) aims at both increasing the training capacity of the participants and increasing the basic knowledge about mental health and psychosocial. The program consists of 5 elements, and has a total duration of two months:

- Basic mental and psychosocial training (two weeks): topics covered in the training:
  - Mental health and psychosocial in general
  - Community mobilisation techniques
  - Stress and stress management
  - Family violence
  - Basic psychology, including child psychology
  - Basic knowledge regarding mental health disorders

- Exposure to psychosocial activities in the field (one week)
The participants of the ToT are accompanying the core team members to the field to see how the activities are conducted.

- Training in training methodology (8 days)
Participants learn how to convey a message, how to handle difficult participants and/or cases, how to prepare a presentation, how to assess problems, the level of knowledge, how to report etc.

- Training under supervision (one week): The participants are given the opportunity to translate the knowledge and skills they have learned during the 4-6 weeks into practice. The participants are conducting sessions under the supervision of the Core team Jalalabad. Each session is followed by extensive feedback.

- Training in specialized psychosocial interventions (one week):
Orientation course in more specialized psychosocial interventions; conducting group sessions, counselling and case management, family mediation.

Psycho-education:
Psycho-education consists of educating the population about psychosocial and mental health problems, and explains what people in the communities can do to alleviate these problems. They also inform the population about referral options, which need not necessarily be limited to the health services. The teams work with IEC materials that are developed and tested within the program. Flip-over's, audiovisual aids, leaflets and posters are produced and used as educational tools in the project.

Group work:
Group interventions connect participants as active listeners and talkers. During group discussions people can discuss all kind of topics, not necessarily psychosocial topics. Group interventions have the advantage above individual ‘counselling’ sessions while more people can be reached at the same time, giving people the opportunity to share experiences and learn from each other.
There are different kinds of group interventions e.g. support group and discussion forums, all depending of the purpose the group comes together.

Case management
The difficult cases that can not be handled in a group sessions, are taken care of in individual sessions.
3.3.3. Coordination with MoPH and other stakeholders:
HealthNet TPO is coordinating its project activities through different platforms at provincial and national level i.e. provincial health coordination committees (PHCC) and mental health taskforce meetings held on monthly basis in Kabul.

3.3.4. Materials Developed:
- Manual for training doctors (approved by MoPH)
- Manual for training nurses and midwives
- Manual for pharmacist
- Manual for training CHW’s and CHS’s
- Manual for HMIS and HMIS tools
- Training methodology package
- Audio Video materials: Posters, flipcharts, leaflets, videos with real patients, radio spots and live discussions.

3.4. Duration and covered provinces of the project.
The AF 068 contract was planned for 3 years (2005-2007). The activities in these three years concerned two provinces: Nangarhar and Kapisa.
A no cost extension of 1 year (2008) was agreed. The objective was to implement the same set of activities as in Nangarhar and Kapisa. The 5 provinces were Laghman, Uruzgan, Khost, Kunar and Kandahar.

4. Assessment implemented activities and expected output of AF068 and NCE contract

4.1. Expected output 1 (part 1):
A mental health component is introduced in the basic package of health services in 7 provinces. The capacity building of health care providers in the health system and BPHS

4.1.1. General: the intervention logic and the implementation process

- A core concept of public, community-based mental health care is helping people to help themselves, both using health care and community forms of support and treatment that are easily accessible. All levels - Health posts, BHC, Sub centres, CHC, District Hospitals are involved and personnel at these different levels had to be trained at the same time. This model has been started in Nangarhar and based on learned lessons in similar programs of HN TPO in other fragile states, its strategies and activities have been improved and adapted to the Afghan context. The strategy and practice of building up capacities in Nangarhar and Kapisa were consequently applied in the other provinces. A future next step, which will be elaborated in the coming years, concerns the integration of MH care in the Essential Package of Hospital Services (EPHS) defining the role and tasks of the psychiatric care provided in the provincial/regional hospitals and in the tertiary psychiatric hospital in Kabul. The field visits at the health facilities and the focus group meetings during the evaluation showed that the concept and project as described in 3.1.1 has been gradually implemented.

- The mental health training and implementation was backed up from HN TPO Amsterdam by the two psychiatrists who designed and set up the program and training. The project was bi-annually visited since 2005, evaluated and followed-up by one of them.
- Regarding the mental health (MH) and psychosocial care (PSC) in the BPHS, HN TPO and the MoPH have developed capacity building activities as described in the AP068 contract, for the different role holders at the different levels of the system:

At grassroot level, the Community Health Workers (CHW) of the Health posts and Health Committees that are in direct contact with the population and its key-persons (community leaders, teachers, mullahs, and shuras) in the local community.

At primary level, the medical doctor, nurse and midwife of the BHC and sub centres and the medical doctors, nurses, midwives, community health supervisors of the CHC.

At secondary level, the medical doctors, nurses, midwives, paramedical personnel of the District Hospital.

The tasks and responsibilities regarding mental health of these role holders and of the managers of the centres, as well as the reporting procedures were integrated and described in job descriptions.

- During the 3 year of the EC contract (2005-2007) this capacity building was implemented within the province of Nangarhar and another province (Kapisa). The no cost extension of the EC enabled HN TPO and MoPH to extend the same policy and capacity building program to five other provinces (Uruzgan, Laghman, Kandahar, Khost, Kunar) and for a specific project in Baghlan with the cooperation and funding of a number of funding agencies (Cordaid, Danish Embassy, WTF, War Trauma Foundation, SAMSA, Dutch Consortium Uruzgan, Unicef...).

- An effective and sustainable mental care requires a basic awareness of mental health issues by the population. As the population is badly informed - a large part in the rural areas is illiterate and persons with severe mental illness use to be is stigmatized – education and awareness about MH issues (symptoms of the main illnesses, treatment possibilities,..) was a priority in order to motivate persons to seek adequate and available care. This educational task is realized through two channels. Firstly in the local communities (usually villages of about 1000 – 1500 persons) the CHC’s and members of health committees, male and female community key persons who have been receiving basic psycho-education training, become able to transmit and apply their acquired knowledge about MH in their local networks.

Persons suffering of mental illness can be identified and supported to seek care at a nearby BHC/CHC. Secondly in the health facilities itself, visited by a population with all types of illnesses, patients are motivated to participate at health education sessions given by the nurses and midwives. Part of the general health education is focused on mental illness. As a result patients (or family relatives) can be easier identified and helped to express these problems to the doctor of the centre.

4.1.2. Type and number of health facilities

Table 1 shows the population of the 7 provinces, the period during which the project was held. The intervention (training and implementation) in Kapisa started only at the end of the second year. This later start was due to organizational and budget issues in the Province, the readiness of the local centres to start the training, the difficulties to set up the training for the first time outside Nangarhar.

Table 1.a. shows the population of the covered provinces. Nangarhar is the largest one. As a whole the project concerned 13% of the Afghan population. The table 1.b shows the number of months in the period from the start of project till end September 2008, the duration for each province. Table 1.c. shows the distribution and numbers of the health facilities of the BPHS covered.
Table 1:
Population covered
Period activities
Type/no of health facilities
1.a

<table>
<thead>
<tr>
<th>Population provinces in project</th>
<th>Nangarhar (NA)</th>
<th>Kapisa (KA)</th>
<th>Laghman (LA)</th>
<th>Uruzgan (UR)</th>
<th>Khost (KH)</th>
<th>Kunar (KU)</th>
<th>Uruzgan (UR)</th>
<th>Total population provinces covered</th>
<th>Total population Afghanistan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nangarhar (NA)</td>
<td>1333500</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2954800</td>
<td>22500000</td>
</tr>
<tr>
<td>Kapisa (KA)</td>
<td>411000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laghman (LA)</td>
<td>378100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uruzgan (UR)</td>
<td>297200</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Khost (KH)</td>
<td>498400</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kunar (KU)</td>
<td>380000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uruzgan (UR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total population provinces covered</td>
<td>2954800</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total population Afghanistan</td>
<td>22500000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1.b.

<table>
<thead>
<tr>
<th>Period project activities</th>
<th>period</th>
<th>months</th>
<th>% total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nangarhar (NA)</td>
<td>Apr05-sept08</td>
<td>45</td>
<td>36</td>
</tr>
<tr>
<td>Kapisa (KA)</td>
<td>Nov06-ma08</td>
<td>17</td>
<td>14</td>
</tr>
<tr>
<td>Laghman (LA)</td>
<td>Dec07-sep08</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Uruzgan (UR)</td>
<td>Feb07-apr08</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>Khost (KH)</td>
<td>Jun06-sep08</td>
<td>16</td>
<td>13</td>
</tr>
<tr>
<td>Kunar (KU)</td>
<td>Feb08-sep08</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Kandahar (KA)</td>
<td>Fe07-ma08</td>
<td>14</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>125</td>
<td>100</td>
</tr>
</tbody>
</table>

1.c.

<table>
<thead>
<tr>
<th>Type of Health facilities</th>
<th>Total 7 provinces</th>
<th>NA</th>
<th>KA</th>
<th>LA</th>
<th>UR</th>
<th>KH</th>
<th>KU</th>
<th>KA</th>
</tr>
</thead>
<tbody>
<tr>
<td>District hospital</td>
<td>7</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Comprehensive HC</td>
<td>71</td>
<td>17</td>
<td>8</td>
<td>8</td>
<td>5</td>
<td>8</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>Basic HC</td>
<td>98</td>
<td>39</td>
<td>12</td>
<td>14</td>
<td>2</td>
<td>6</td>
<td>14</td>
<td>11</td>
</tr>
<tr>
<td>Sub HC</td>
<td>12</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Total no</td>
<td>188</td>
<td>62</td>
<td>22</td>
<td>24</td>
<td>8</td>
<td>17</td>
<td>26</td>
<td>29</td>
</tr>
</tbody>
</table>

4.1.3. Capacity building through training

4.1.3.1. Activities

- The capacity building was conceived according to a ‘cascade’ model. In Nangarhar, HN TPO formed a core team who were trained as trainers (TOT) by expatriate HN TPO staff and by members of the psychiatric department of Peshawar. This core team, partly
assisted/supervised by expatriate staff, conducted step by step the MH training of doctors, midwives/nurses, of all the health facilities (CHW, BHC/CHC, DH) in the province. After the training, these care providers initiated the MH care in their facilities and further capacity building was achieved through regular supervision-on-the-job by the HN TPO core team. The basic training (12 days) and supervision to the staff of the BHC/CHC/DH provided by the core team included both a psychiatric and a psychosocial component. A shorter training for CHW’s and community key persons (3 days) was developed and implemented by the core team. This training focuses on the expression of the main illnesses, the ways on how to deal with these problems and the possibilities for treatment in BHC/CHC.

- At the beginning, in collaboration with the expatriate teachers, the core team developed the manuals and the educational tools to be used in the training programs and in the health education sessions in the health facilities.

The no cost extension enabled the extension of the project to the other provinces. A small provincial team (1 or 2 doctors, and in some provinces 2-3 psychosocial workers) was created in each province and trained as future trainers by the Nangarhar core team. The Nangarhar and later on the provincial team supervised doctors, midwives, nurses and provincial health authorities in the province. After a time, the training activities by the trained provincial core teams for healthcare personnel (health posts, BHC/CHC, DH) and for community members/key persons (psycho-education) in the province were handed over to the NGO’s active in that province.

The capacity building in Kapisa province and in the 5 additional provinces obliged the whole Nangarhar team to combine their training and supervising tasks in the Nangarhar & Kapisa province with the training and supervision tasks in the other provinces.

- The training program has been made possible through co-funding and partnership in different provinces from PSO Netherlands, War Trauma Foundation Netherlands, Caritas Austria, SAMSA, Danish Embassy, Dutch Government, Cordaid, Afghan Health Development Services, Aid Medical International.

4.1.3.2. Quantitative data of mental health trainings in all provinces

Table 2 shows the number of training days per training, the number of trainings and the numbers of trainers trained, in total 47 trainers. In Nangarhar and Kapisa 24 were trained including the focal points f the district hospitals. In the 5 other provinces 23 persons. Khost team had only one doctor trained due to the difficulties of co-funding. In the other provinces between 4-7 trainers and focal points were trained.

The number of days for the training, mentioned in table 2 and 3, correspond with the logical frame work of the contract.

<table>
<thead>
<tr>
<th>No</th>
<th>Type of training</th>
<th>No days/training</th>
<th>No trainings</th>
<th>No beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>ToT for Nangarhar mental health medical team</td>
<td>40</td>
<td>4</td>
<td>11</td>
</tr>
</tbody>
</table>

J. Le Roy / Final report AF68 / December 2008
In table 3.a are compiled all the mental health trainings for healthcare personnel in Nangarhar (NA), Kapisa (KA), Laghman (LA), Uruzgan (UR), Kunar (KU), Khost (KH) and Kandahar (KA).

Most of the trainings are in Nangarhar (72 of 151) where the project started and lasted the whole project period. As the first mental health activities already were introduced in 2002 and the offices based in Jalalabad, the project was able to train high numbers of groups of trainees in order to cover all the 62 facilities. The total number of refresher trainings is 5 on 23 for doctors and 13 on 28 for nurses and midwives. Due to the short period of the project in the 5 provinces (NCE) and priority given to cover the whole province as much as possible, refresher trainings were very limited.

Table 3.a
Period Jan2005 to Sep 2008
Mental health training
Training and interventions 7 provinces

<table>
<thead>
<tr>
<th>No</th>
<th>Type of training and interventions</th>
<th>NA</th>
<th>KA</th>
<th>LA</th>
<th>UR</th>
<th>KU</th>
<th>KH</th>
<th>KA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Basic mental health training for doctors of BHC/CHC/DH</td>
<td>10</td>
<td>10</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>23</td>
</tr>
<tr>
<td>2</td>
<td>Refresh mental health training for doctors</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>Basic mental health training for Nurses/midwives BHC/CHC/DH</td>
<td>10</td>
<td>10</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>28</td>
</tr>
<tr>
<td>4</td>
<td>Refresher mental health training for Nurses/midwives</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>5</td>
<td>Basic mental health training for CHS's BHC/CHC/DH</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>6</td>
<td>Basic mental health training for CHW's (male and female)</td>
<td>3</td>
<td>72</td>
<td>11</td>
<td>13</td>
<td>8</td>
<td>20</td>
<td>7</td>
<td>151</td>
</tr>
</tbody>
</table>
Table 3b shows the number of trainings for each target group and their number of beneficiaries.

350 doctors have received the basic training and apply the learning’s in their health facilities. With total of 188 facilities (table 1) an average of 1,9 doctor per facility is able to practice the basic mental health intervention. An average for all the provinces of 31 % of them participated at a refresher training; in Kapisa 72% and in Nangarhar 36%.

418 midwifes and nurses followed the basic mental health training. This corresponds with an average of 2,2 nurses/midwifes per health facility. 57% of them received a refresher training. Except for Kunar, all provinces organized regular refresher training for nurses/midwifes. 2539 Community Health Workers (CHW male and female) and 151 Community Health Supervisors (CHS) were basically trained. All the communities of all 7 provinces have now a CHW who acquired basic skills to identify illnesses and raise awareness for mental health in their community. The training of 151 CHS, based in CHC, DH and some BHC, are responsible for supervising the CHW and the application of the public health services in the communities belonging to their work area. They also cover all the facilities and communities.

4.1.3.3. Quantitative data of mental health trainings in provinces Nangarhar and Kapisa compared to the expected results in the contract AF068.

In order to evaluate whether the number of persons in the health facilities have been trained as expected, the collected data from Nangarhar and Kapisa (AF068, table 4a) and from the 5 other provinces (NCE, table 4b) which have been presented in table 3a and 3b are compared with the numbers in the logical frame of the contracts.
Table 4a
Mental health training in Nangarhar and Kapisa
Expected and realised numbers of beneficiaries
if numbers not indicated in the Logical frame: *
if numbers expected but not collected: #

<table>
<thead>
<tr>
<th>HEALTH FACILITIES personnel</th>
<th>Total E</th>
<th>Total R</th>
<th>% R/E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provincial team members/focal points trained</td>
<td>30</td>
<td>24</td>
<td>80</td>
</tr>
<tr>
<td>Doctors trained (10 days)</td>
<td>56</td>
<td>181</td>
<td>323</td>
</tr>
<tr>
<td>Doctors refreshed (4 days)</td>
<td>*</td>
<td>91</td>
<td>30</td>
</tr>
<tr>
<td>Nurses midwives trained (10 days)</td>
<td>112</td>
<td>206</td>
<td>89</td>
</tr>
<tr>
<td>Nurses midwives District Hospital (3 days)</td>
<td>120</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses/midwives refreshed (3 days)</td>
<td>*</td>
<td>111</td>
<td>47</td>
</tr>
<tr>
<td>CHW's &amp; CHS's trained (3 days)</td>
<td>1000</td>
<td>1262</td>
<td>126</td>
</tr>
<tr>
<td>Total</td>
<td>1318</td>
<td>1874</td>
<td>142 %</td>
</tr>
</tbody>
</table>

Have been trained in Nangarhar and Kapisa
- 80% of the expected 30 provincial team members and focal points
- more than three times (323%) of the expected doctors; 30% of them also received a refresher training.
- 183 % of the expected nurses/midwives of the BHC/CHC; 47% of them received a refresher training. Nurses/midwives of the District hospitals got the same training as those in the CHC/BHC’s. Total 89% of the total expected number of trained nurses/midwifes (206 on 232).
- 126 % of the expected 1000 CHW’s

All the categories in Nangarhar and Kapisa have benefited from the training with a minimum of 80% to 323% and an average of 145% of the expected number of beneficiaries. 30 % of the doctors and 47% of the nurses got a refresher course. The refresher courses were not expected in the AF068 logical frame. The project trained in average more professionals than expected. The high number is an important asset for the implementation and durability of the mental health services in the BPHS. The project decided that refresher courses would be necessary and 1/3 to ½ of them did the refresher course. The table indicates the numbers of doctors and nurses/midwives that still should benefit from a refresher course in the future in Nangarhar and Kapisa.

4.1.3.4. Quantitative data of mental health trainings in the provinces Laghman, Kunar, Khost, Uruzgan and Kandahar compared to the expected results in the NCE contract.

Table 4b
Mental health training in five other provinces
Expected and realised numbers of beneficiaries
if numbers not expected in Logical frame: *
if numbers expected but not counted: #

HEALTH FACILITIES personnel
External Evaluation of the Project
‘Integrating Mental Health into the Primary Health Care system of Afghanistan’

<table>
<thead>
<tr>
<th></th>
<th>Total E</th>
<th>Total R</th>
<th>% R/E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provincial team members/focal points trained</td>
<td>14</td>
<td>23</td>
<td>164</td>
</tr>
<tr>
<td>Doctors trained (10 days)</td>
<td>62</td>
<td>169</td>
<td>273</td>
</tr>
<tr>
<td>Doctors refreshed (4 days)</td>
<td>62</td>
<td>14</td>
<td>23</td>
</tr>
<tr>
<td>Nurses/midwives trained (10 days)</td>
<td>85</td>
<td>212</td>
<td>249</td>
</tr>
<tr>
<td>Nurses/midwives refreshed (3 days)</td>
<td>228</td>
<td>111</td>
<td>49</td>
</tr>
<tr>
<td>CHW’s &amp; CHS’s trained (3 days)</td>
<td>665</td>
<td>1.428</td>
<td>215</td>
</tr>
<tr>
<td>Total</td>
<td>1054</td>
<td>1957</td>
<td>186%</td>
</tr>
</tbody>
</table>

Have been trained in the 5 other provinces:
- 164 % of the 14 expected provincial team members and focal points
- 273 % of the 62 expected doctors; 23% got a refresher training.
- 249 % of the 85 expected nurses/midwives; 49% got a refresher training
- 215 % of the 665 expected CHW’s.

This table shows as in 4a that more persons of the target groups have been trained than expected and in these 5 provinces even more than the double. The number of refreshed doctors and nurses show similar percentages as in 4a.

Note: Four refresher trainings were conducted for doctors, nurses and midwives in Nangarhar and Laghman in Nov/Dec 2008 after the external evaluation has taken place. The data of these trainings are not included in this report.

4.1.4. Learned lessons based on data and analysis on the trainings

- The training of trainers given by the expatriate HN TPO experts/consultants, the teaching staff of the Peshawar hospital and Nangarhar core team, has enabled the constitution of a group of trainers who can train health personnel in their provinces both for mental health and psychosocial services. Only the Khost has only one trainer supervisor. The teams have actually the following set-up:
  - Nangarhar: 7 trainers supervisors (2 doctors; 5 psychosocial workers); the team had 10 team members till 3 months ago. 3 (1 doctor and 2 psychosocial workers) recently resigned. One of the doctors is team leader.
  - Kapisa: 5 trainers supervisors (2 doctors; 3 psychosocial workers). One of the doctors is team leader.
  - Kunar: 4 trainers supervisors (1 doctor team leader; 3 psychosocial workers); 1 doctor left.
  - Khost: 1 doctor trainer supervisor, no psychosocial worker.
  - Laghman: 4 trainers supervisors (1 doctor team leader, 3 psychosocial workers)
  - Uruzgan: 4 trainers supervisors (2 doctors, 2 psychosocial workers)
  - Kandahar: 1 doctor mental health focal point on AHDS pay list

One can conclude that the ‘cascade’ training format has enabled the formation teams of trainers/supervisors who can train and supervise health personnel in the provinces.

- HN TPO expatriate and afghan trainers/supervisors have developed detailed, practice-oriented, effective training programs and manuals/handouts for the various target groups: doctors, nurses/midwives, psychosocial counsellors, community health workers, and community groups. These manuals are used in all provinces.

- Compared with the expected results, the percentages show that in all provinces much more doctors, nurses/midwives and CHW/CHS have been trained than expected.
If we add the expected and realized numbers from both the AF068 contract and the NCE, in all 7 provinces together 296% for the doctors, 131% of the nurses/midwives, 162% of the CHW/CHS have been trained. This is a very remarkable result exceeding all expectations given the currently unstable, insecure and difficult context of the country in which the training and implementation had to be performed. It is also a measure of the high motivation, training skills and planning of the different teams, in particular the Jalalabad core team who carried the largest bulk of the training tasks. The expected coverage and implementation of mental health training of the BPHS personnel at the different levels and in all provinces is reached. In fact as more professionals are trained than expected, it means a strong asset for the implementation of mental activities in the BPHS.

- The care providers, both doctors, nurses/midwives and CHS, in all health facilities as well as the CHW of all communities belonging to the health areas, have received a basic training which enables them to identify and provide the adequate treatment and psychosocial education of the mentally ill persons. As they remain integrated within the health system their skills and knowledge can have a lasting effect and impact.

- The refresher training which allows the strengthening and development of their skills is not yet done for 71% of the doctors and for 50% of the nurses/midwives. Refresher courses have to be offered in the coming year in order to reach all those who have been trained.

Note: Four refresher trainings were conducted for doctors, nurses and midwives in Nangarhar and Laghman in Nov/Dec 2008 after the external evaluation has taken place.

- The supervision of the doctors and nurses/midwives done by the provincial teams is organized monthly. The supervisor visits the premise and supervises the treatment of cases on the job. These sessions are registered at the provincial level. It was reported by the teams that all facilities were visited regularly. However, due to the security problems supervisors can not travel regularly to all districts. Also the regular supervision of health facilities in Nangarhar has been sometimes reduced when the Nangarhar core group had to give priority to training the other provinces. Refresher courses and supervision are necessary instruments to consolidate the capacity building, support the healthcare providers usually faced with high numbers of patients, supervise the referral of patients and guarantee the quality of the mental healthcare. Reduced or unavailable funding for supervision of mental health activities after the project ends will have a negative impact on the sustainability of the achieved quality of care. It is expected that for another number of years the mental health supervision on the job will depend on the supervision by the HN TPO staff. The take over by the supervisors of provincial health authority which is only done in a limited number of situations can be extended during the coming years to all provinces and districts.

- The field visits and meeting with doctors and nurses/midwives in focal group sessions indicated that:
  - the training was experienced as very beneficial. The participants were satisfied and the doctors can adequately perform an assessment/diagnosis, differential diagnosis and treatment/management of patients with mental disorders.
  - knowledge and skills, especially communication skills, were acquired. The training was effective and practical for both mental health and psychosocial components and the content was adapted to the tasks/roles/job descriptions in the BPHS (doctors, midwives-nurses, CHS, CHW).
- supervisors regularly visited the health facility and provided on the job supervision directly related to difficult cases, the management of the medical care and the psycho-education/health education of the nurses/midwives. The health personnel felt very supported by the supervisors and helped to solve difficult problems.

- refresher courses are needed and asked, especially on the following disorders: bipolar disorder, common mental disorders (depression, anxiety, somatic problems/conversion), epilepsy, psychosis, drug abuse) and on psychosocial interventions (supportive individual and family counselling, family violence intervention, school mental health services). Drug abuse both by males and females is becoming a serious public health issue in some provinces and knowledge about treatment modalities/facilities is much needed.

Previously (before 2005) most of these patients did not receive any care for their illness. They were stigmatized, remained secluded or chained (psychotic patients) in their homes. Those with common mental disorders and epilepsy were not treated at all or received inadequate care. The patients, in particular with more severe disorders (psychosis, epilepsy), that previously were send to the psychiatric hospital in Kabul can now be treated in the local health facilities situated in their community environment.

4.1.5. Learned lessons on human resources issues of the training program

- The Nangarhar HN TPO core group of experienced and available trainers has been reduced as a consequence of the departure of 3 experienced trainers (1 doctor and 2 psychosocial workers. This staff continued to provide their own province-based training/supervision and psychosocial interventions in Nangarhar and Kapisa while at the wider project level (NC in 5 provinces) they had to organize and provide the training and supervision in the 5 new provinces. This leads to an overstretch of the core team which is at risk of burnout.

-Due to the extension, the capacity building project has reached a country level which needs an accommodation of the human resources policy both at the level of the expertise and the organizational embedding of the capacity building in the HN TPO structure at country level. It is felt by the experienced trainers as particularly relevant that their knowledge both their specific and general, theoretical and practical, needs to be consolidated, upgraded and broadened. This would help them to develop the program and continue to adapt it to the local needs and cultural context. They also expect this, as in their role as trainers and supervisors, in particular during refresher activities and contacts with the more experienced trainees, they are now confronted with new questions and difficulties about treatment that the trainees present to them. They are now very experienced to provide basic training but feel insecure and not capable to develop the program and transmit more comprehensive knowledge beyond the reached level.

4.1.6. Recommendations on training and capacity building

4.1.6.1. The capacity building resources

Recommendations to HN TPO, health authorities, EU and other donor agencies
Nangarhar and Kapisa
- A large number of trained/informed doctors and midwives/nurses, CHS and CHW as well as community key persons need a refresher course and further supervision. The training of psychosocial interventions in the community (CHW) should be regularly followed by
supervision. This supervision in the health facilities cannot always regularly be provided due to absences for other training and workload. A solution has to be found to prevent ruptures in the regular and sustained supervision.

- Yearly action planning of refreshment and supervision as well as adequate staff and resource planning is to be developed both at province and country level.

Other provinces
- The other provincial teams are in more recent stage of development. It has to be considered how these competences and trainers can be anchored in the HN TPO organization/provincial health authorities so that further development of the training of health facilities, in particular the supervision, in these provinces could be strengthened.
- A provincial core team should at least have two doctors and two psychosocial workers (male/female) in order to be able to cover the training/supervision tasks and to be sustainable on a longer term.

4.1.6.2. The capacity building of health facilities at province and country level

**Recommendations to HN TPO, health authorities, EU and other donor agencies**
- In order to sustain and guarantee the quality of the services, refresher courses are a priority and should be spread over the provinces. In these courses some topics concerning the most prevalent common mental disorders, epilepsy and drug abuse have to be developed more in depth as well as solution oriented counselling skills trained.
An action plan has to be developed by Provincial health authorities and HN TPO to continue the supervision of the doctors and nurses on mental health cases for a further duration of two years to strengthen the acquired competences and sustain the quality of care.

4.1.6.3. Human resources

**Recommendations to HN TPO and EU**
- A core group of master trainers has to be built around the experienced ones; the experienced ones in a supervisory role for the less experienced ones.
- The differentiation of senior and junior trainers should be reflected in a clear set of tasks, responsibilities anchored in the organization at a central level, capacity building and career planning.
- The upgrading and capacity building of the senior trainers should lead to a formal and certified recognition.
- These senior trainers can form the core of a capacity building team at country level and enable HN TPO to become a resource centre at the service of further development in the provinces and teams in collaboration with the MoPH and other mental health capacity building NGO’s.
- The combination of tasks in Nangarhar with tasks in the training and supervision in other provinces in the past year has led to an overload of work. In addition to the above mentioned issues, the team is in a state of overstretch, dissatisfaction and feelings of loss. The risks are burn-out, loss of quality of the training or further loss of experienced team members. Both structural solutions and coaching for the team of trainers regarding the amount of tasks they are able to perform. This supposes a clearer distinction between the tasks and the persons of the team involved actually based in Jalalabad and the tasks and persons involved in the capacity building at country level.
- Based on the lessons learned, the team of senior trainers should work with expatriate HN TPO trainers on a proposal for the management concerning:
  - capacity building pathway and content for further education for senior trainers
4.1.6.4. Collaboration with Health authorities

**Recommendations to HN TPO, health authorities, EU**

All the provincial teams should regularly communicate and develop working relationships with the provincial health authorities, integrate provincial health authority members in the training and in the combined supervision. A representative of the team has to participate at local platforms of the provincial BPHS package as the capacity building/supervision of the health workers and related policies/strategies are part of the health authority’s responsibility.

4.2. Expected output 1 (part 2): Implementation of mental health component in health service of Health posts, BHC, CHC, District Hospital.

4.2.1. The implementation of mental health care in the community

4.2.1.1. Psychiatric component of treatment in health facilities

At the community level the trained CHW’s with the support of psychosocial workers of HN TPO organize health education sessions in order to create awareness amongst the community members, health committees and key persons about MH illnesses and problems. This education focuses on the expression of the main illnesses, the ways on how to deal with these problems and the possibilities for treatment in BHC/CHC. When the CHW’s identified persons in the community with mental health problems, they refer the person to the CHC/BHC. For that purpose a simple referral sheet is used on which the CHW notes the type of illness using a set images expressing the main illnesses (depression, anxiety, psychosis, epilepsy, mental retardation, conversion disorder,).

The trained medical doctors and the midwives and nurses of the BHC and CHC’s are able to identify and assess MH illnesses amongst the general patient population coming to their centre. The doctors offer treatment according to the HN TPO guidelines with prescription of psychotropic drugs. After his assessment, the doctor notes his diagnosis and proposes a treatment to the patient according to the HN TPO guidelines. Following this session, the patient is immediately referred to a nurse or midwife of the centre for an individual session during which he/she informs the patient (eventually with a family member) about the illness, the treatment modalities, medication and adequate attitudes towards the patient.

At patient group level, the midwives and nurses in the CHC/BHC offer education about mental illness, integrated in the general health education program for groups of male and female patients of the health centre. These sessions enabled patients as well as the health educators to become aware of mental health problems of participants. These persons were then referred to the doctor of the centre for assessment and treatment.

At the secondary level of the BPHS, in the District Hospital, a doctor- focal point acts as a specialized provider of care for psychiatric cases in the DH OPD as well as trainer of doctors/midwives/nurses in the area. In the DH the patients with mental illnesses had been referred by CHC/BHC’s of the district or by doctors or nurses/midwives of the other OPD’s in the DH (mainly maternal, child and obstetric care) who themselves after their basic MH health training had identified these illnesses.
4.2.1.2. Psychosocial component of MH treatment in the health facilities

The midwives and nurses in the visited health facilities reported that they had no time (due to high numbers of patients) to do more than illness/treatment oriented psycho-education with patients and their family (life attitudes, treatment monitoring, side effects,...). They also are not allowed, according to their job description, to perform outreaching home visits even when it would seem very helpful. The psychosocial workers of the HN TPO team regularly offered supportive counselling (case management), when they visited the facility for supervision, to some of the mental health patients who needed support beyond the treatment of the doctors and psycho-education of the nurses/midwives. These supportive counselling was mostly oriented to solve and mediate conflicts in the family network that caused prolonged psychological and other violence, in particular against woman. Usually such interventions need a regular follow-up in order to be effective. The CHS who are connecting the CHS work in the communities with the health facilities neither have time nor enough skills to intervene with families.

4.2.1.3. The supply of drugs:

In the 5 provinces this supply was not always functioning fast enough when the project implementation in the 5 provinces started. The drug supply for which HN TPO is responsible is regularly provided to the health facilities. There were serious problems in Kapisa and Kunar with the drug supply by the BPHS implementers in these provinces (MoPH in Kapisa and AMI in Kunar).

4.2.2. Referral

The evaluator has been attentive to the referral procedures as they are an important tool to make the system function in a coherent and transparent manner, both for the managers, the health care providers, the patients and the public in general.

- Between community grassroots level and BHC/CHC level:
  The MH awareness activities that nurses, midwives and community health workers provide in their contact with the population in the health centres or in the community is making the access to MH treatment easy and acceptable for the ill person and his/her family. The medical doctors report that the identification of cases and referral to the health centre by the trained community health workers are effective. The CHW uses a very simple and effective sheet which indicates the type of mental illness. However the feedback from the BHC/CHC to the CHW happens rarely and this situation does not help the CHW to improve his capacities as core person in the process nor to follow up the treatment in the community. The CHW does not know either what is expected from him/her, except eventual educational support regarding the medical treatment. It depend on the qualities and initiative of the CHW himself whether he will support the patient by individual or family counselling (case management) in the follow up of the patient in his community environment. A simple document that would inform about the diagnosis, provided treatment and suggestions/advice for further follow-up is requested by the CHW. This referral back is an essential link between the health facilities and the people in the community. Actually it is lacking.

- Between the community, CHC/BHC and the District Hospital
  When they cannot be effectively treated in the BHC/CHC patients are referred to the MH focal point in the DH. In situations where the distance from the community to the BHC/CHC
is much longer than between the community and the DH, patients often go directly to the DH. Guidelines and referral documents that could be used to clarify the roles of each level, the pathways (with eventual exceptions) as well as improve the referral processes (both ways) have to be developed.

4.2.3. Quantitative data about number and type of mental illnesses identified in the 7 provinces.

The following table 5 shows:
- Distribution of number of patients:
Nangarhar health facilities provided care to 74% of the total number of identified patients. The detailed data of Nangarhar (not in this table) indicate that the number of patients treated were in 2005 (28306), in 2006 (18759), in 2007 (45432), in 2008 (jan-sept: 45585). The numbers are, compared with the first two years, doubling from the third year on. It shows that the effect of the training and implementation at all levels makes a significant jump 1.5 to 2 years after the start of the project. It can be assumed that with adequate follow-up and supervision in the other provinces the numbers of identified persons will increase in a similar way. This is confirmed by the data registered in the third quarter 2008 for Kapisa (9050), Laghman (3419), Khost (8114) and Kunar (2349). The three last ones are only in their second year of the implementation and show already a remarkable increase of the output.
- Estimation number cases in 2009:
If we use the data of the last quarter reported by all the provinces we can make an estimation of the number of cases identified and treated. If the implementation continues to be performed in the same way as in 2008 between 180000 – 200000 mental health patients per year will be identified and treated in these provinces in 2009.

Table 5
Jan 2005 to Sep 2008
Registered number and type of mental health cases treated

<table>
<thead>
<tr>
<th>Mental disorders</th>
<th>Nangarhar</th>
<th>Kapisa</th>
<th>Laghman</th>
<th>Uruzgan</th>
<th>Khost</th>
<th>Kunar</th>
<th>Kandahar</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression disorder</td>
<td>99902</td>
<td>4514</td>
<td>2466</td>
<td>4498</td>
<td>8482</td>
<td>1619</td>
<td>3807</td>
<td>125288</td>
<td>66.6</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>16616</td>
<td>3576</td>
<td>860</td>
<td>1374</td>
<td>3375</td>
<td>1094</td>
<td>1107</td>
<td>28002</td>
<td>14.9</td>
</tr>
<tr>
<td>Psychosis</td>
<td>5598</td>
<td>1596</td>
<td>255</td>
<td>134</td>
<td>221</td>
<td>34</td>
<td>212</td>
<td>8050</td>
<td>4.3</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>12834</td>
<td>1692</td>
<td>729</td>
<td>445</td>
<td>1191</td>
<td>244</td>
<td>650</td>
<td>17785</td>
<td>9.5</td>
</tr>
<tr>
<td>Mental Retardation</td>
<td>1298</td>
<td>408</td>
<td>110</td>
<td>93</td>
<td>233</td>
<td>20</td>
<td>84</td>
<td>2246</td>
<td>1.2</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>445</td>
<td>278</td>
<td>54</td>
<td>73</td>
<td>330</td>
<td>32</td>
<td>43</td>
<td>1255</td>
<td>0.7</td>
</tr>
<tr>
<td>Conversion disorder</td>
<td>497</td>
<td>80</td>
<td>29</td>
<td>335</td>
<td>38</td>
<td>10</td>
<td>989</td>
<td>4553</td>
<td>2.3</td>
</tr>
<tr>
<td>Others</td>
<td>3389</td>
<td>480</td>
<td>133</td>
<td>49</td>
<td>326</td>
<td>69</td>
<td>107</td>
<td>4553</td>
<td>2.3</td>
</tr>
<tr>
<td>Grand Total</td>
<td>140082</td>
<td>13041</td>
<td>4687</td>
<td>6695</td>
<td>14493</td>
<td>3150</td>
<td>6020</td>
<td>188168</td>
<td>100%</td>
</tr>
</tbody>
</table>

% of total 7 prov 74    7   2.5  3.5   8   1.7  3.2

Estimated Based on
number of cases data last quarter each province

<table>
<thead>
<tr>
<th>Mental disorders</th>
<th>Nangarhar</th>
<th>Kapisa</th>
<th>Laghman</th>
<th>Uruzgan</th>
<th>Khost</th>
<th>Kunar</th>
<th>Kandahar</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last quarter</td>
<td>15100</td>
<td>9050</td>
<td>3419</td>
<td>5259</td>
<td>8114</td>
<td>2349</td>
<td>2066</td>
<td>45357</td>
</tr>
<tr>
<td>Per 2009</td>
<td>60400</td>
<td>36200</td>
<td>13676</td>
<td>21036</td>
<td>32456</td>
<td>9396</td>
<td>8264</td>
<td>181428</td>
</tr>
</tbody>
</table>

- Distribution of types of illnesses: Depression is the illness of 2/3 (67%) of all mental health patients, followed by anxiety disorder (15%), epilepsy (9.5) and psychosis (5%). The large majority (82%) of the patients suffer from a common mental disorder, depression or anxiety disorder. These data confirm earlier research in Afghanistan that the prevalence of common mental disorders is high. Consequently attention has to be given to this phenomenon when establishing training and treatment programmes as well research.

4.2.4. The effectiveness and quality of the provided care

Quality of healthcare has different dimensions which can be monitored and evaluated on observations and report. Effectiveness both to measure the impact of mental health and psychosocial interventions at the level of the patient (symptoms, complaints, social ability, etc) and at the level of the community is more difficult to assess as adequate tools and procedures need to be in place.

- Duration of consultations
The duration of consultations a doctor has with patients in the BHC/CHC is, based on the observation during the field visits, short. With a case load of 60-80 consultations, if one includes all cases in an outpatient setting during one day (from 8 to 13 h) the average is 5 minutes per case. For new cases the assessment and medical prescription may take 15 minutes while the older cases less than 5 minutes. As indicated above the explanation and educational guidance regarding treatment is done by nurses/midwives. When looking in more detail, therefore both the time of the doctor and the nurse/midwifes per case should be added. It is clear that long waiting cues behind the consultation door puts pressure and stress on the consultation. The consultant doctor seemed to deal well with this stress. It is not difficult to imagine that this is not always the case. In particular with MH cases where the assessment and (differential) diagnosis is difficult to do, it is possible that the quality of the intervention is not adequately managed. In the District Hospital the focal point who receives only patients, previously identified as MH cases, takes 20-25 minutes for a new patient and 5-7 minutes for older ones. He usually has 20 patients in a morning, 8 new cases and 12 old cases.

- Quality of the treatment: As indicated earlier, the quality of the interventions depend on the supervision of the care providers at the different levels (CHW- BHC/CHC- DH). This on-the-job supervision enables the supervisor to assess better the quality of the attitudes, diagnostic and treatment practices.

- Duration of the treatment
During the visits at the health facilities the doctors reported similar findings concerning the duration of the treatment. In general a depressive patient needed 9 months (one session a month) of treatment with a positive result in 2/3 of the cases. In 1/3 of the cases the treatment is more prolonged up to 18 months or the patient is referred to the DH. For the psychotic and epileptic illnesses more time was reported (one and a half year). The doctor was able to give
these averages based on his case register but the duration and effectiveness for all patients is not collected.
A systematic evaluation of the treatment outcome does not yet exist and a simple tool should be developed in the future.

- Satisfaction of the treatment
Researchers from J. Hopkins University have done in 2007 an assessment of the client satisfaction treated in the health facilities in collaboration with the BPHS. MH as well as other disorders of patients was not distinguished in this study. Mainly attitudes of the health care providers, the supply and explanation about the treatment and drugs were measured. The study reported a decrease in satisfaction in the past two years in most of the provinces. This decrease was explained partly as the result of the enhanced health education and expectation of the patients about treatment possibilities. The M&E department of HN TPO has recently done a study using the same questionnaire with a small sample in health facilities in Nangarhar (18 cases, only one case was probably a MH patient) and found high levels of satisfaction. This study was done with patients of the general OPD population. There was no at random selection of the evaluated facilities. It is possible that the health facilities chosen for this study were amongst the best supervised ones.

- Effectiveness of the treatment
Suggested and prepared by the evaluator, a member of the M&E department has repeated this small study during the field visits with patients diagnosed with a mental health illness present that day at the CHC (sample: at random 20 patients after their consultation; no distinction made between mental health and other disorders) and DH (18 MH cases of the focal point;). For the District Hospital sample a number of questions assessing the effectiveness and level of social functioning (from the international Disability and Social Functioning Scale) were added to the patient satisfaction questionnaire. The aim was to have some indication of how the patient perceived his mental health state and social abilities before and at his point of his treatment. All 38 patients responding to the client satisfaction questions were very satisfied. The only critique mentioned a problem with the regular drug supply. For the 18 MH patients of the DH (these patients had visited the doctor between 3 and 10 times) a clear improvement in the perceived emotional and mental state was found in all the cases. The patients reported an important decrease of perceived complaints and increase in the capability to perform regular work, household tasks and social contacts. This or a similar simple effectiveness tool, easy to apply for non professionals and not intrusive for the patients, could be further tested and eventually integrated as feedback tool for the doctor/nurse and at project level in an M&E policy and action plan.

4.2.5. Learned lessons

- In all the health facilities of the provinces and at different levels doctors, MW/nurses, CHS are now implementing MH PSS as one of the seven components of the BPHS.
- Numbers of identified cases and disorders were not included in the logical frame of the EC contract and NCE. The evaluator has collected the data of all provinces in order to have a better view on the total output of the project. These are presented as a whole in the evaluation report. They show the high number of identified and treated number of cases during the 4 years of the project. The data also show that a significant increase in numbers of patients happens 1,5-2 years after the program started in the provinces.
- It is possible to estimate based on the data of the last quarter, that in 2009 180000-200000 patients in the 7 provinces as a whole will be seeking mental health care. This is 6,8% of the number of inhabitants (table 1a) of these provinces.
- Experience has learned that two years after the onset of the training, the amount of cases doubles. An estimation can be deducted from these figures. The evaluator estimated 180,000 to 200,000 cases to be treated in 2009 for the 7 provinces as a whole (population total 2,954,800) assuming that the implementation of MH services in the BPHS is continued. This is 6.8% of the population of these provinces. Estimations at provincial level can be made with the data. War and poverty have had profound effects on the mental health status of the Afghan population. Based on a recent study found high levels of psychological distress (between 18% of the male and 60% of female population of the Eastern province of Nangarhar are mentally distressed and/or depressed, one can expect that a higher number of patients will seek care for their common mental disorder in the future years.

- Reporting of all health facilities levels, visited by the evaluator, and collected data show that 81% of the identified and treated cases are common mental disorders (67% depressive disorders and 14% anxiety disorders).

- The daily practice show that the consultations in the health facilities by doctors are short and that the additional educational meeting and guidance of the patient with a nurse/midwife is a necessary compliment of the treatment. The high workload may hamper the quality of the treatment management especially in difficult cases.

- Although a country study of the BPHS on satisfaction showed decreasing satisfaction about the care, the small studies in Nangarhar facilities before and during the evaluation showed high satisfaction. The small pilot measuring the effectiveness showed substantial improvement in all cases.

4.2.6. Recommendations regarding the implementation of mental health care in the community

Recommendations to health authorities, EU and other donor agencies

- High number of common mental illness cases (depression and anxiety) detected
The high numbers of detected cases correspond with the daily experience of the doctors and nurses in the health facilities faced with a high number of cases to be consulted each day. The success of the project should be reflected in a future human resources policy package of the BPHS guaranteeing the availability, access and quality of mental health services in the facilities.

- Community-based mental health approach relevant and not limited to psychiatric care
The high number of common mental disorders, which are linked to the many different social stressors communities/persons are faced with, forms a challenge for the public health program development. The risk is that with limited resources of the health facilities/BPHS the mental health care becomes reduced to alleviation of symptoms through the prescription of psychotropic drugs. It is strongly recommended to prevent this risk by consolidating the integration of medical and psychosocial parts of mental health care. The community-based, integrated and culturally sensitive HN TPO approach has shown to be highly relevant as it focuses on developing the strategies and resilience people can develop to help themselves within a community context. The psychosocial component has an important part when further developing in Afghanistan the MH in order to offer an adequate response. International mental health policies (WHO) and research indicate that the treatment strategy of these common mental disorders has a sustainable effect when it involves psychosocial interventions which influence social and community based determinants, strengthen the resilience at family/group level and support relation- and solution oriented types of coping.

- The regular supply of drugs should be safeguarded by all acting agencies involved.
Recommendations to HN TPO, health authorities, EU

- Data collection cases and incidence of illnesses
Data collected at provincial level should be integrated in a monitoring system at country level. Analysis of such data may be helpful to assess the effect of an implementation policy in a previous period. The monitoring at country level can provide learned lessons which can be integrated in the strategy and policies for the next years. These combined data can be further developed and used for M&E at project management, BPHS management, MoPH and Provincial Health Authority level.

- A transparent and coherent referral system between the health facilities in the BPHS themselves and with the community-based CHW has to be developed in the near future. Guidelines for referral practices should be integrated in the training program and the management of the whole system as well as the necessary documents and sheets provided. They should help the providers in their tasks and roles for each level as well as improve the referral processes (both from ‘top to bottom’ and ‘bottom to top’ in the health system ‘pyramid’). As in the next phase mental health care will be integrated in the Essential Package of Hospital Services (EPHS)- this relates to the psychiatric departments of provincial hospitals and the psychiatric hospital in Kabul – the design of the referral system should integrate and connect the MH services of both BPHS and EPHS. It would be coherent that these EPHS hospital settings provide specialised care which is not available at district level and also have a supervisory/capacity building/research role at the service of the BPHS services.

- With respect to the efficacy, effectiveness and general quality of the treatment, it is recommended to develop a model and tools which would allow regular monitoring and evaluation of MH treatment in a systematic way. This model should not only include the measurement of the satisfaction but also the effectiveness of the provided intervention. This would help to adapt the management of the workload, the turnover of the client population, improve the allotted time per case and the efficacy. The effectiveness assessment will provide more reliable tools to identify weaknesses and strengths of the treatment of the patients as a whole or subgroups of the patient population. It is recommended that a basic tool would also be included in the case register of the treated patients which allows a simple systematic feedback for the care provider and patient/family, referral person, and the responsible persons in the health system at provincial level. These findings are also important for the current capacity building and supervision in the facilities as well as for the training program development and research projects.

- The list of essential drugs for MH needs an update and the inclusion of some new drugs should eventually be considered.

4.3. Expected output 2: A model for culturally appropriate community based psychosocial services in Afghanistan is developed and implemented

4.3.1. General

As in other low income and fragile states, HN TPO has introduced in Afghanistan a mental health program in which the mental health and psychosocial dimensions are integrated. The psychosocial component not only covers the attitudes, skills and health education within the mental health provision in the health centres but more in particular psychosocial interventions
in the community. These interventions focus on supporting community members and leaders to be aware and find coping strategies to help the population respond to the many challenges and stress factors. They address groups within the community that are more vulnerable and more at risk for developing mental distress or mental disorders. Such vulnerable groups are Afghan children and woman, in particular victims of family violence, of conflicts and war that the country has experienced since 30 years. The AF086 project has integrated in its training programs psychosocial interventions needed to support communities in a culturally sensitive manner. The start of the project was difficult as the model had to be adapted to the cultural and specific situation of communities in the country. The first expatriate expert has not been able to take up that challenge and resigned at the end of the first year, which caused a delay in the set-up of the intervention. A second psychologist and psychosocial expert of HN TPO Amsterdam developed and provide with other expatriate experts of HN TPO the psychosocial community-based part in the training and intervention. Regular back up, follow-up and advice was provided.

4.3.2. Implementation of psychosocial interventions in the communities

4.3.2.1. Activities

The number of persons from the core group was trained as psychosocial worker and trainers for the community-based psychosocial interventions. The basic MH training for CHW that was developed included both the basic psychiatric knowledge and the application of psychosocial interventions in the community (community mobilization, community mapping, community psychosocial awareness, case management (individual supportive counselling) and support (self-help) groups. The trained psychosocial workers of Nangarhar gave basic psycho education to a variety of health committees, community leaders and key persons. These trainers and a number of psychosocial officers of the Nangarhar team also helped and supervised the CHW’s to apply the interventions in their community, for example to organize MH education meetings and support groups for woman and man separately. The same model was introduced and is practiced in the 5 additional provinces. The HN TPO team has also trained and supervised psychosocial workers who were involved in a psychosocial support project with traumatized children and adults in Baghlan.

4.3.2.2. Quantitative data of psychosocial trainings and interventions in all provinces

The figures regarding the training of the core group of psychosocial trainers as well as those of the CHW is not mentioned in the Table 6 as they were included in the tables 2, 3a and 3b. The tables showed that the number of trained CHW’s was higher than the number expected in both AF068 and NCE.

The following tables are made to identify the output both of the training and the psychosocial interventions at community level for all the Nangarhar/Kapisa and for the 5 additional provinces. A comparison is made between expected numbers and realized numbers. Table 6 a (number of trainings and training days) and table 6 b (number of beneficiaries) show the output of the psychosocial community-based program for all the provinces. The number of training days corresponds with the logical frame.

Table 6 a
Period Jan2005 to Sep 2008
Psychosocial
PSTraining and interventions 7 provinces

<table>
<thead>
<tr>
<th>Number training days (no d) per training- number of trainings (no t)</th>
<th>NA</th>
<th>KA</th>
<th>LA</th>
<th>UR</th>
<th>KU</th>
<th>KH</th>
<th>KA</th>
<th>Total no t.</th>
</tr>
</thead>
<tbody>
<tr>
<td>N o</td>
<td>Type of training and interventions</td>
<td>No days</td>
<td>No Train.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Basic mental health training for health committees in the community</td>
<td>3</td>
<td>14</td>
<td>11</td>
<td>5</td>
<td>14</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Basic mental health training for Teachers</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>7</td>
<td>5</td>
<td>6</td>
<td>33</td>
</tr>
<tr>
<td>9</td>
<td>Mental health training for students</td>
<td>3</td>
<td>4</td>
<td></td>
<td>10</td>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 0</td>
<td>Mental health training for Village Volunteers</td>
<td>3</td>
<td>69</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 1</td>
<td>Mental health training for Community leaders</td>
<td>3</td>
<td>22</td>
<td>9</td>
<td>1</td>
<td>28</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>1 2</td>
<td>Psycho-education for female community members</td>
<td>3</td>
<td>24</td>
<td></td>
<td></td>
<td>24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 3</td>
<td>Psycho-education female influential community members.</td>
<td>3</td>
<td>20</td>
<td></td>
<td></td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 4</td>
<td>Mental health education in health facilities BHC/CHC/DH</td>
<td>1</td>
<td>263</td>
<td>35</td>
<td>8</td>
<td>30</td>
<td>45</td>
<td>45</td>
</tr>
<tr>
<td>1 5</td>
<td>Community mobilisation / awareness with key persons in communities.</td>
<td>5</td>
<td>35</td>
<td>15</td>
<td>6</td>
<td></td>
<td></td>
<td>56</td>
</tr>
<tr>
<td>1 6</td>
<td>Case management with community members</td>
<td>0.3</td>
<td>100</td>
<td>66</td>
<td>7</td>
<td>7</td>
<td>2</td>
<td>24</td>
</tr>
<tr>
<td>1 7</td>
<td>Support group with female community members</td>
<td>6</td>
<td>92</td>
<td>8</td>
<td>6</td>
<td>4</td>
<td>6</td>
<td>116</td>
</tr>
<tr>
<td>1 8</td>
<td>Discussion groups with male community members</td>
<td>1</td>
<td>6</td>
<td>10</td>
<td>21</td>
<td>1</td>
<td></td>
<td>8</td>
</tr>
</tbody>
</table>

Table 6b

<table>
<thead>
<tr>
<th>Number of beneficiaries</th>
<th>NA</th>
<th>KA</th>
<th>LA</th>
<th>UR</th>
<th>KU</th>
<th>KH</th>
<th>KA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>N o</td>
<td>Type of training and interventions</td>
<td>No Beneficiaries</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Basic mental health training for health committees in the community</td>
<td>207</td>
<td>216</td>
<td>110</td>
<td></td>
<td>207</td>
<td>740</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Basic mental health training for Teachers</td>
<td>114</td>
<td>180</td>
<td>70</td>
<td>99</td>
<td>86</td>
<td></td>
<td>549</td>
</tr>
<tr>
<td>9</td>
<td>Mental health training for students</td>
<td>75</td>
<td></td>
<td></td>
<td></td>
<td>185</td>
<td>260</td>
<td></td>
</tr>
<tr>
<td>1 0</td>
<td>Mental health training for Village Volunteers</td>
<td>124</td>
<td>7</td>
<td></td>
<td></td>
<td>124</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>1 1</td>
<td>Mental health training for Community leaders</td>
<td>403</td>
<td>14</td>
<td>15</td>
<td></td>
<td>554</td>
<td>986</td>
<td></td>
</tr>
<tr>
<td>1 2</td>
<td>Psycho-education for female community members</td>
<td>382</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>382</td>
</tr>
</tbody>
</table>
4.3.2.3. Quantitative data of psychosocial trainings and interventions in provinces Nangarhar and Kapisa compared to the expected results in the contract AF068.

In a similar way as for the MH activities the tables 7 a (Nangarhar & Kapisa) and 7b (5 provinces, not included the Baghlan training) compare the realized output with the expected output. Figures between brackets are estimates based on the feedback during the evaluation but not registered.

<table>
<thead>
<tr>
<th>Table 7a.</th>
<th>Psychosocial activities in Nangarhar and Kapisa</th>
<th>Expected</th>
<th>Realized</th>
<th>% R/E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psycho-education community members by CHW</td>
<td>100000</td>
<td>(Estimate 150,000)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community groups psycho-education (3 days) (Health committees, teachers, village volunteers, community leaders, influential female persons) by core group members</td>
<td></td>
<td>820</td>
<td>3148</td>
<td>383</td>
</tr>
<tr>
<td>Mental health psycho-education in health facilities (1 day) by core group members</td>
<td></td>
<td>2400</td>
<td>5086</td>
<td>212</td>
</tr>
<tr>
<td>Community mobilisation and awareness (5 days) by core group members</td>
<td>*</td>
<td>837</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case management community members in community by core group members by CHW’s (individual counselling)</td>
<td>320</td>
<td>166</td>
<td>52</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10000</td>
<td>(76,000)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support (female) and discussion (male) groups by core group members &amp; CHW’s</td>
<td>7700</td>
<td>823</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Mental Health education by nurses/midwives to patients facilities (1 hour) estimation: 4 groups of 20 OPD patients/month per BHC/CHC/DH in 2 provinces for 31 months</td>
<td>*</td>
<td>297,600</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As indicated above the CHW’s have been helped to introduce and supervise basic awareness/psycho-education sessions in their community. A sound monitoring system and registration of the number of these sessions given by the CHW’s had not been developed. It is not possible to give reliable data for the number of community members that participated at awareness sessions of the CHW’s. However, considering the large number of CHW’s (1262
instead of 1000 planned) trained (table 4 a & b) and the feedback by psychosocial trainers/assistants it was estimated that all these CHW’s gave in the period of 4 years in average at least 4 awareness sessions in their community for 25 participants each. They reached 120.000 community members in total.

Nearly 4 times more (383%) 3-day psycho-education sessions have been given to community leader groups than expected. More than 2 times (212%) the expected number of 1 day psycho-education for community groups meeting in health facility compounds have been implemented.

The provincial team members (core group) also themselves assisted by CHW’s performed a 5-day community mobilization involving 837 persons. This was not expected but developed during the project.

The number of case management sessions by the core group members was half the number expected (52%). The core group members were faced with the culturally determined difficulties to intervene within families and to set up self help groups (11%).

4.3.2.4. Quantitative data of psychosocial trainings and interventions in the provinces Laghman, Kunar, Khost, Uruzgan and Kandahar compared to the expected results in the NCE contract.

Table 7b shows a similar picture with an output of psycho-education to groups of community leaders in communities and health facilities.

The individual case management sessions were rare and the support groups in these provinces happened nearly 3 times more than expected. It is possible that the learned lessons from the earlier phase in Nangarhar where a culturally feasible group methodology had been experimented had been well transmitted in the provinces.

<table>
<thead>
<tr>
<th>Psychosocial activities in 5 provinces</th>
<th>Expected</th>
<th>Realized</th>
<th>% R/E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community groups psycho-education (3 days) (health committees, teachers, village volunteers, community leaders, influential female persons) by provincial team members</td>
<td>525</td>
<td>1326</td>
<td>252</td>
</tr>
<tr>
<td>Mental health psycho-education in health facilities (1 day) by provincial team members</td>
<td>900</td>
<td>2619</td>
<td>291</td>
</tr>
<tr>
<td>Community mobilisation and awareness (5 days) by provincial team members</td>
<td>*</td>
<td>119</td>
<td></td>
</tr>
<tr>
<td>Case management community members in community by provincial team members by CHW’s (individual counselling)</td>
<td>*</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Support (female) and discussion (male) groups by provincial team members &amp; CHW’s</td>
<td>208</td>
<td>578</td>
<td>277</td>
</tr>
<tr>
<td>Total</td>
<td>1633</td>
<td>4682</td>
<td></td>
</tr>
<tr>
<td>Mental Health education by nurses/midwives to patients facilities (1 hour) estimation: 4 groups of 20 OPD patients/month per BHC/CHC/DH in 5 provinces for 31 months</td>
<td>*</td>
<td>153.123</td>
<td></td>
</tr>
</tbody>
</table>
4.3.3. Learned lessons

- In the above report about health facilities, it has already been indicated that additional individual counselling focusing on the underlying social causes of the illness, for example family violence and conflicts, was rare both due to time constraints and lack of experience. In the facilities where HN TPO psychosocial officers intervened with psycho education sessions and supportive counselling was provided when this was indicated needed.

- At the community level, the HN TPO psychosocial officers have been successful in training CHW’s and implementing with them a high number of psycho-education sessions with community leaders. Many communities have participated at community mobilisation with focus groups discussing relevant public issues of the community. This is a remarkable result and it can be assumed that a high level of awareness was reached at this level. This awareness has been shared and spread by these leaders to community members in schools, health committees, shuras, mosques, and informal gatherings.

- The evaluation both based on the data and the focus groups with the psychosocial supervisors of the Nangarhar and team leaders of the other provinces also indicated the difficulties to initiate and continue self-help supportive groups in the community. Due to traditional cultural norms, which are more or less rigid in the different provinces, supportive groups were not acceptable by male community members. Sharing of emotions and feelings, in particular difficult ones as sadness and grief, could not be expressed by man in public spaces. Only such groups could be formed and settled, also with some difficulties, with woman (5-8 sessions). This problem was raised and discussed with the expatriate psychosocial consultant. In the course of the project the format and the aim of these self-help groups has then been adapted. The groups with male participants were redesigned as a discussion forum type of meeting in which community life and problematic health issues were explored and solutions debated.

- During the focus group discussions on psychosocial interventions in the community, the psychosocial supervisors of the HN TPO teams in Nangarhar and the other provinces as well as with the doctors, midwives and nurses of health facilities identified a weakness in the project implementation. According to them, running a supportive group counselling implies special skills, which probably had not been sufficiently trained in the basic training of the CHW’s and CHS. The supervision of these activities was not systematic either (due to high workload of the supervisors, difficulties travelling to communities). As visits to community sites were often not possible for security reasons (more difficult to go to remote villages than to health facilities), the supervision process of CHW’s was irregular during some periods. Although it was considered as their task, the CHW’s were not able to set up and facilitate such a group without the direct and continuous support of the psychosocial supervisor or officer of the HN TPO team. The supervisors and health facility personnel reported that in practice CHW’s performed rarely ongoing case management/counselling with families or groups in the community. The CHS who according to the project design were supposed to be able to take over the training and supervision of the CHW, did not initiate or follow up group or family counselling nor follow up other forms of psychosocial group activities. During the evaluation, this weakness was often pointed by the interviewees. It was suggested that a psychosocial officer/counsellor should be appointed in each CHC, be trained to perform psychosocial work in the communities as well as support and supervise the CHW and other community key persons. As psychosocial officers and assistants of the HN TPO teams who
use to do psychosocial interventions in the project period will have to handover this task to the BPHS/community, these activities should be consolidated more in the communities.

- Besides the skill and supervision argument, individual and in particular group work (counselling and self-help) is also not much practised by CHW’s because of financial reasons. During a visit to a community, a CHW told that he needed more skills and supervision as well as incentives to develop regularly group oriented work (mobilisation of community activities beyond the community mapping phase or the psycho-education activity, support groups). In the current situation he was only able to do MH awareness, case identification and referral to health facilities and 1 counselling case per three months. CHW’s are volunteers. This does not seem to fit with their large job description. Consequently they requested regularly to the psychosocial supervisors or to the CHS financial incentives for their work with individuals and support/discussion groups. The trainer/supervisor faced with such statement had no incentive to offer except capacity development.

- The evaluator was not able to assess the sustainability and effectiveness of the community based interventions as visits to community activities and meetings with beneficiaries was not allowed for security reasons. Reports from the psychosocial workers indicated that in most cases the community interventions which are supposed to lead to participatory intersectoral initiatives in communities have not been sustainable beyond the awareness raising and community mapping phase.

-To summarise, the difficulties and gaps in the work of CHW’s who are supposed to act as key figure in the implementation of an integrated community-based MH and PS program, have several reasons. Firstly, the lack of focused and prolonged training and regular supervision concerning the different interventions that are beyond the basic awareness activities and case identification. Secondly the high number of tasks of the CHW defined by the BPHS -TB detection, vaccination activities and other basic activities- for the other 6 components of the BHPS. Thirdly, they are volunteers but they receive an incentive (for example for a TB case 2 USD) for some activities while not for the MH tasks (identification of mental illness in the community and psychosocial support). Logically they give priority to these rewarded interventions than to the more time consuming group community actions. Fourthly are the lack of experience as counsellors/mediators and probably a lack of accredited authorisation to intervene in private affairs, in cases of conflicts, violence and maltreatment in and between allied families. Finally the Community Health Supervisor who is supposed to make action plans and supervise with the CHW’s in his area has received a basic training like the nurses and the midwives. But he also lacks time and is not equipped to hold a supervisory role when it concerns community interventions and mental health case management in the community. As core person in the BPHS who links the community with the health system (both for the psychiatric and the psychosocial components), the CHW only performs part of the tasks as defined in the project. The lack of back referral from the medical staff, the workload/volunteer ship and limited training, the absence of guidance by the CHS are causing a structural gap in the linkage between community-based and clinic-based MH and psychosocial interventions. These activities are however important as they are oriented towards creating group activities and community based intersectoral activities that could improve the resilience in dealing with the socially based stress factors, help to develop new coping mechanisms, community resources and more healthy interpersonal relational patterns.
4. 3.4. Recommendations regarding the implementation of community based psychosocial interventions

Recommendations to health authorities, EU and other donor agencies

International research shows the strong relationship between mental disorders and psychosocial problems. Psychosocial problems may lead to the expression of mental disorders in people who have an already pre-existing vulnerability for these diseases, due to hereditary factors or somatic illnesses. Especially at risk are children and adolescents, experiencing disrupted nurturing and traumatized by war and violence, and women overburdened in the family or suffering from domestic violence and discrimination. Reduction of psychosocial problems and stressors is important to prevent the expression of mental disorders and to improve their outcome. These problems and stressors are caused by a multiplicity of interwoven causes related with war, unemployment, low levels of education, difficult socio-economic/agricultural development and cultural and religious factors. While these have to be tackled at country level, community-based bottom-up solutions and strategies can have a direct impact on the health and wellbeing of persons. These solutions and strategies are most effective when they are intersectoral. They are, compared to the implementation of mental health in the facilities, more difficult to set up as they involve non-governmental and governmental local and national organisations, ministries, structures and policies that are not used to work in joint multi-sectoral projects. A recent study has shown the high prevalence of depression amongst the afghan population and is an indicator for the high priority that should be given to psychosocial interventions in the communities. The psychosocial part of the project has made an important first step and provided lessons for designing and developing future strategies. In a next phase, priority has to be given to building a comprehensive model for community-based interventions. A more detailed study about the applicability and effectiveness of the interventions as well as about the socio-cultural dynamics of communities and families would provide insights and tools for model building, training programs and action designs.

Recommendations to HN TPO, health authorities, EU and other donor agencies

- At the community level of the BPHS some recommendations can be done so far which will improve the effectiveness and sustainability of psychosocial interventions as they have been conceived within the health system planning/organisation.
  
  1. The role of the Community Health Worker

A close review of the applicability of the psychosocial interventions is necessary. In particular the training and task description for CHW regarding feasible interventions with the community. In order to play his key role, the CHW needs to develop skills to facilitate sustainable community processes and initiatives, using participatory approaches. Basic group and family work techniques are part of the skills to be trained. CHW’s should receive a form of incentive to implement and be accountable for MH and psychosocial interventions. The follow-up, support and supervision of the CHW for these tasks by a psychosocial counsellor should be more regular and structurally embedded in the health system.

  2. The role of a psychosocial counsellor-nurse in the BPHS

As competence, supervision and expertise of such psychosocial counselling expertise needed is not structurally available in the health system, it should be developed, designed and implemented in order to improve the psychosocial dimension of the mental health provision. This can be applied and evaluated as a pilot project in a selected number of districts and provinces in which the mental health program has yet been implemented.
Taking into account the efficacy and sustainability within the health system and based on the evaluation in the health facilities, the evaluator recommends to create a new function and job description in the BPHS/EPHS for a psychosocial counsellor-nurse.

a. In the District and Provincial Hospitals a psychosocial counsellor-nurse could provide psychosocial care and counselling for selected cases and work closely with the focal points and the staff in the psychiatry unit. He/she also could act as supervisor of community based psychosocial activities in the facilities of the concerned health area.

b. In the CHC/BHC a psychosocial counsellor-nurse (ideally male and female) could provide psychosocial care and counselling to patients and families in the facility. He/she should be able to counsel families with sensitive issues like violence, conflicts, forced marriages and other family-based problems which are causing or sustaining the mental distress/disorder. Such psychosocial counselling includes out-reaching activities to the homes and communities in which the identified patient lives. As representative of the healthcare facility the psychosocial counsellor-nurse has an easy access to the community leaders in order to intervene with the CHW or with other key persons in the community (mullahs and family elders) to elaborate effective changes. He/she can also advice the CHW and monitor the connection between the CHW and the health facility on mental health cases.

A number of nurses trained by the HN TPO program so far could be selected for these jobs and receive an advanced training and supervision in psychosocial interventions and counselling.

- Psychosocial officer/counsellor outside the BPHS

It is also recommended to pilot psychosocial community based strategies and practices outside the health system. Such social community worker has to be trained to set up and implement all psychosocial interventions as they have been developed in the community based psychosocial program of HN TPO. They also should be able to set up and monitor new community-based development actions and interventions in partnership with community members and actors from other sectors/ministries (rural development, income generation, environment, woman/children activities and education projects with locally implemented NGO’s). This new approach using participative action learning methodology can be set up and practiced in a number of pilot communities and an appropriate model developed.

- Collaboration between the HN TPO psychosocial supervisors with other capacity building NGO’s/organisations working in the area of community participation should be developed to exchange and learn about participatory methods and techniques, strategies for community development and intersectoral projects (health, culture, education, religion, environment/agriculture, income generation, youth, gender).

4.4. Expected output 3: Capacity of provincial health authorities in planning and management of mental health activities on provincial and district level is enhanced

4.4.1. Learned lessons

A detailed view regarding the inclusion of the mental health in the Provincial Sub-Directorates was difficult during the evaluation due to time and travelling limitations. Provincial health staff has been integrated in the capacity building for doctors in the HN TPO training. In some provinces provincial health authorities were present at the opening and closing training sessions, in other provinces they participated at the training. A specific training for mental health planning, monitoring and management was not included in the project.
The teams of Nangarhar and the other provinces reported a good cooperation with their provincial health authorities. In general the provincial authorities appreciate the implementation of mental health and the mental health project as a whole. However it is not clear whether the sub-directorates are able to follow, monitor and evaluate the results of the project and quality of the implementation. The contact with the sub-directorate in Nangarhar pointed to weaknesses in the cooperation with the mental health project. The participation of provincial HN TPO teams and the Program Manager at provincial policy development meetings was considered insufficient. There was no regular joint planning and evaluation of the mental health activities in the province. A proper coordination between departments of provincial authorities namely the Primary Health Care (PHC) department and Provincial Health Director (PHD) is not regularly assured. HN TPO plans to involve both provincial health authorities when new developments concerning mental health are developed. The integrated mental health care supervision of HN TPO supervisors and provincial supervisors is practiced in some provinces while not yet in others.

4.4.2. Recommendations regarding the planning and management of mental health activities on provincial level

Recommendations to HN TPO, health authorities, EU

Particular attention has to be given in the future to strengthening the collaboration of the HN TPO mental health staff (national/provincial) and the provincial health authorities. Regular presence and active participation of a HN TPO representative in the provincial health boards should guarantee the integration of MH and PS in the provincial public health policy making processes and strategies. The HN TPO plan to involve both the Primary Health Care department and the Provincial Health Director when new mental health developments are at stake will also strengthen the relationship between the mental health HN TPO project and the provincial authorities and further consolidate the integration of mental health in the primary health facilities. Ideally a mental health officer should be appointed in the provincial directorates who can make the link with the activities and organizations involved in the MH care/capacity building in the province. Joint monitoring visits to health facilities and joint supervision have to be structurally planned.

Data and reports both concerning the capacity building and implementation of mental health in the province have to be discussed and lead to province-specific policies of the BPHS/EPHS. It is expected that such sustained collaboration will consolidate and develop mental health, but also psychosocial interventions and intersectoral community based projects.

As the sub-directorates will also play an important role regarding the EPHS and mental health - the establishment, policy and planning of a mental health department in provincial hospitals –the provincial authorities should be involved at an early stage concerning this development. In Jalalabad, such department has been created in 2008 in a joint effort of HN TPO and Provincial authorities.

In general, it is recommended that HN TPO and health authorities (provincial and national) learn lessons from the experiences since 4 years in Nangarhar province with regard to common tasks, management, planning of mental health provision of the different stakeholders (health authorities, BPHC, implementing agencies, donor) at the provincial level. These lessons will help to develop guidelines and practices to be used in other provinces.
4.5. Expected output 4: Mental health policy, planning and implementation capacity of the central Ministry of Health strengthened.

The evaluation of the activities and performance of the Mental Health Directorate at the MoPH is based on two visits to the MoPH. A first meeting with Dr. Mashal, Senior Advisor for the national EPI Program Health, MoPH, and the technical advisor Dr. Haroun. During a second visit on the final day of the evaluation period, the evaluator only met for a short time Dr. Alia, National Coordinator Mental Health, who returned from an international conference abroad. The objectives and planned activities described in the EU contract served as guide for the evaluator during these meetings.

4.5.1. Activities and learned lessons

- The MoPH has defined mental health as one of the priorities in the future development of the packages of the Health Service. The creation of a National Coordinator Mental Health within its organigram is an expression of this priority. The project has provided managerial, logistic support and capacity building opportunities to the mental health department and the National Coordinator.
- With the support of EC two technical advisors and of WHO one technical adviser have recently been appointed to advise the mental health department of MoPH on the development of policies and programs for mental health and psychosocial interventions.
- Currently the department is preparing a national mental health national policy, a mental health plan, standards and guidelines in collaboration with and as intermediate between the MoPH and other stakeholders (WHO, EU, HN TPO and other national and international NGO’s).
- The mental health department of MoPH has set up a national Task Force for mental health and organises conferences and workshops to elaborate policies, programs and guidelines with these stakeholders.
- The program manager mental health of HN TPO participates at the task force of the MoPH and other stakeholders. This technical assistance is appreciated by the national coordinator. This expertise from HN TPO is particularly welcome for MoPH as the learned lessons of the community-based and culturally sensitive model is relevant for Afghanistan and fits with the national health policy and approach.
- Currently models and initiatives by different stakeholders for setting up projects on counselling are debated. A crucial issue is how the psychosocial component can be implemented in the health system, what model to be used and developed into standards and curricula.
- Two national conferences were held in collaboration with HN TPO to disseminate the learned lessons, achievements and challenges of the current mental health implementation in the BPHS.
- The training manuals developed by HN TPO have been validated and further training material is developed with HNTPO and the MoPH.
- So far mental health department has not been able to develop an M&E program that has to be used to evaluate the current and future implementation of MH and PS projects.
- HN TPO and MoPH have agreed performance indicators for the Mental Health Directorate activities during the EU contract phase (e.g. number of MH taskforce meetings held, guidelines and manuals developed, national MH policy developed, supervision conducted to the provinces, etc.). The evaluation did not cover a detailed appreciation of the performance output according to these indicators due to lack of information and limited time of the meeting with the National Coordinator.
4.5.2. Recommendations regarding the Mental health policy, planning and implementation capacity of the central Ministry of Health

Recommendations to health authorities, HN TPO, EU and other donor agencies

- The logistic and managerial support from HN TPO is highly appreciated within the different levels of the MoPH and needs to be continued.
- The mental health Directorate in MoPH and HN TPO should consolidate their collaboration to develop the policy and guidelines in the mental health task force installed in the department, thematic conferences and other regular meetings. The topics of the provided expertise and consultancy cover the implementation of MH PS care in the public health system (BPHS and EPHS), the capacity building (training and supervision), the evaluation and analysis of the current experiences in the mental health field (mental health, psychosocial work, counselling by HN TPO or other NGO’s), the design of research questions, the development of a curriculum for psychiatrists.
- Contacts of the mental health Directorate of MoPH and HN TPO with other ministries which are operative in the different fields of community development (rural development, woman, religious and cultural, income generation) have to be initiated in order to develop and support intersectoral pilot projects.
- Structural solutions which address the reported gaps in the BPHS have to be prioritized and new developments can be experienced in pilot projects and evaluated from a public health perspective before final decision making.
- The model, objectives and design of psychosocial interventions, have to be thoroughly studied through the implementation and evaluation of pilot projects. It is important to develop these psychosocial interventions from a public health perspective with a particular attention for relevance, effectiveness, equity, coverage and accessibility. They have to take into account the learned lessons of current psychosocial projects of HN TPO and other NGO’s in the field.
- An M&E strategy and plan is urgently needed to monitor and assess the impact of current and future projects both at quantitative and qualitative level. Effectiveness studies for mental health and for psychosocial community-based interventions both at individual patient/beneficiary level and at the level of the community should be designed. The results of such studies can help the MoPH and major stakeholders to design and improve culturally sensitive and effective interventions. As mental health is only recently installed in Afghanistan, it is recommended to view the development of standards and guidelines in a developmental perspective.

Recommendations to health authorities, EU and other donor agencies

- The capacities of the mental health team should be strengthened by the MoPH in the future. Priority has to be given to management capacities involving leadership, planning and control, policy and strategy and acquisition of funding. The capacity building and tasks of the MoPH mental health team can be designed in a multi-year planning with clear priorities. As the budgets for national policy making are limited and the tasks of national policy and strategy building at MoPH level are huge, clear priorities will prevent a dispersion of resources.

Recommendations to health authorities, EU, agencies/donors

- Implementation of activities that support or inform health authorities should be outsourced to and implemented by the organisations that can provide technical assistance and organise the activities as HN TPO has been offering. To reach this aim, it is recommended that MoPH
clarifies the roles, tasks and boundaries of the mental health Directorate of MoPH, of the different stakeholders/technical advising bodies, their collaboration and the Task force. For that purpose a clear management structure and planned management approach is necessary both for the mental health Directorate as well as for the Task Force and stakeholders/agencies. It will also help the mental health Directorate of MoPH to implement in a focused way its role of global policy and strategy making body, setting guidelines and M&E procedures as well as for the Task force to enhance the conducting, programming and effectiveness of its meetings.

- The relationship between the national and provincial level of the health authorities are clearly defined by their different roles in the health system: national: global policy, strategy, guidelines and M&E adapted to the afghan health system; provincial: management of the mental health program in the province. It is recommended to design adequate and regular communication channels with respect of their respective tasks in the system. Through this link, provincial sub-directorates will be enabled to take up their role in a sustainable manner with regard to mental health activities in the provinces.

- The financial and logical support to the mental health department is dependent on project financing as it was the case for this EC project. The HN TPO project has been extremely important to settle mental health at implementation and at policy level. Mental health is now defined as a priority and given full attention in a recent national conference. It is recommended to integrate in the future planning of the MoPH more structural financial solutions in order to consolidate the acquired capacities.

- Recently the afghan government has decided to provide free care in all the facilities of the health system and the BPHS/EPHS. The evaluator has learned from all the visits to the facilities that since august the number of patients has increased suddenly with 50% in the months following this decision while their budgets remained at the same level. Doctors in facilities often have the impression that part of the persons come to health facilities without serious complaints but for more social reasons. Considering the fact that the health system is nearly totally dependent on external funding it is recommended that MoPH in its strategic position pays attention to the sustainability of the health system in place and the mental health part in it. It is also important to be aware about the impact of this financial national policy on the performance of health facilities and health providers, the quality of care and the patient satisfaction and on adequate strategies to cope with the consequences of the policy.

**4.6. Expected output 5: The implemented mental health and psychosocial policies and are monitored, evaluated and researched.**

**4.6.1. Project management at central and provincial level**

Since the HN TPO mental health program has been extended to the national level and has included 7 provinces in this project, it has become clear that the organizational structure, management, monitoring and evaluation has not yet been well consolidated in a coherent and effective manner. The different formats are used to report the registered data in the provinces and to collect them in reports for funding agencies. A comprehensive and systematic model that provides the possibility to evaluate and analyze the output of the mental health services and capacity building is not yet in place. Mental health components are integrated in the provincial and national HIS.

**4.6.2. Monitoring and Evaluation**

The expatriate psychiatric and psychosocial HN TPO consultants have evaluated the project during the funding period. Their advice has been taken into account. A more regular follow-
up and technical assistance regarding the M&E and the program development will strengthen the quality of the capacity building, the implementation in the BPHS and the capacities of the managerial and technical staff (trainers-supervisors). In search of additional intervention models field studies and research on community-based interventions is needed. These studies should also involve population categories that deserve urgent attention namely child and adolescent mental health care.

4.6.3. Recommendations

Recommendations to HN TPO, EU

- HN TPO needs to establish an organizational structure able to face the actual challenges and complexity of community-based MH PSS.
It is recommended that the PM develops his management capacities. This concerns in particular the capacity to develop leadership, represent the MH program and to communicate about developments/policies/strategies with the Country manager, with the environment and external stakeholders (health authorities, funding agencies, NGO’s,). Also the capacity, to lead, support and stimulate his team should be strengthened.
- Instead of having one deputy project coordinator for mental health and one for psychosocial interventions, a more effective organizational set-up could be to appoint one deputy for planning, management, M&E and reporting of the integrated MH and PSS activities in the BPHS/EPHS at national and provincial level and a second deputy for the development, planning, and implementation of the training programs, supervision and capacity building both for MH and PSS at national and provincial level. This set up may be more functional for the double task/mission of the organization (service delivery and capacity building/technical expertise). It may also better guarantee the integration of both psychiatric and psychosocial components both in the implementation part and the capacity building of a community based public health approach.
- A transparent human resource policy, in particular for the technical staff of trainers-supervisors, should fit with the development of the HN TPO program and offer more possibilities for the experienced members to be upgraded in terms of capacities and responsibility within the organization.
- An M&E plan has to be designed that provides accurate information for monitoring and evaluating (parts of) the program. Such plan should enable the management in HN TPO and in the National and Provincial health authorities to reorient and remediate weaknesses in the program.

5. Effectiveness, efficiency and sustainability of the project

The project was effective. It has achieved its objectives as stated in the original objectives and logical framework matrixes, and in several parts of it far beyond the expected output. The local structures and health facilities as well as the population has benefited to a maximal degree. Both training staff and trained care providers in the health system and in the communities are able to implement care for mentally ill persons. The project has provided the possibility to learn and identify components of the design that need improvement. These concern mainly referral mechanisms and the link between health facility interventions and community psychosocial work. The quality of the services and effectiveness of the interventions need more detailed follow-up. The management was effective to implement the program. In some provinces supervision in health facilities and communities in rural areas is now very difficult due to the impossibility of secure travelling. It is however remarkable that the project has been able to reach such remarkable results in this difficult context.
The project was efficient. The financial resources were used properly. Some parts of the project were delayed due to difficulties of co-financing the projects in the 5 provinces. The plan to realize this program in 7 provinces was very ambitious given the available resources. The necessity to apply the project in all 7 provinces in due time and make reports for a high number of co-funding agencies put a huge stress on the organisation, its management and training staff. Some aspects like regular monitoring of the whole project, follow-up of psychosocial work in the communities and development of the training staff as senior trainers have suffered from this situation.

The project is not yet fully sustainable. The integration of mental health in the health facilities is an essential asset regarding sustainability. But refresher courses and prolonged supervision is necessary to consolidate these competences. The psychosocial community-based services are not yet sustainable. Based on the past experience, the BPHS and HN TPO have to develop in collaboration with MoPH a model and small-scale projects in order to achieve more sustainability of this essential part of the program.

The financial sustainability is a matter of high concern both for the BPHS and mental health as a whole but also for the continuity and consolidation of HN TPO as resource centre in Afghanistan.

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ANNEX 1.

Terms of Reference

Project title: Mental Health Program - Nangarhar Province Afghanistan
Mission: External Evaluation
Time: September 2008

Introduction and Background:
Country Background:
Afghanistan has emerged from decades of armed conflicts and initiated a process of reconstruction. In 2003, a new constitution was adopted, with the National Assembly inaugurated in 2005. Post-conflict Afghanistan is suffering from structural problems typical for transition periods, which include an ample process of political, economic and social reorientation. The country belongs to the group of “least developed countries” (6th poorest country in the world), with more than 50% of the population living below the poverty line (in rural areas: three quarters). The national unemployment rate is estimated at 40%, and the country’s economy is partly based on illegal products (drugs) for which substitutes with sufficient added value have yet to be found. As a result of the long war periods, reliable statistical data are hard to obtain, so that policy making often has an insecure basis. The estimated population of 23 million has been increased by some two millions of refugees repatriated, a process which has not yet culminated. In addition, internally displaced persons need support for resettlement, including the provision of basic housing, clean water, employment, health and education services. Per capita GDP is estimated at 800 USD. Though economic recovery is taking root, the country may be dependent on foreign aid support for many years to come. Life expectancy at birth is low (43 years), the annual population growth rate is over 4 percent, and there are rural-urban biases in most fields of population statistics, with an additional bias on women. Chronic malnutrition translates into low weight (almost 40%) and stunting in over 50% of Afghan children. Diarrhoea and ARI belong to the most important causes of infant mortality. Some of Afghanistan’s health indicators outdo any statistics of countries of the wider area, with an under-five mortality rates of 230/1.000 live births, and a maternal mortality rate of 1.600/100.000. The total fertility rate of 6.8 represents the highest in the whole of Asia. There are enormous morbidity gaps between rural and urban areas. Immunization coverage and general quality of care are reduced in rural areas by a series of factors, especially the lack of accessible health care facilities and appropriate staff. The Basic Package of Health Services (BPHS) is one of the strategies to increase equity in the health sector and to make strong interventions in areas that will have the highest impact on an improved public health. BPHS is a primary care based health system, introduced as health policy in 2003 and revised in 2005.

Policy background:
Since the end of the Taliban Regime in Afghanistan, the country has made considerable progress in many areas of development. The health sector is one of these areas, and health sector rehabilitation has given rise to a health system which, at least in theory, provides a minimum standard of care to all Afghans; The revised Basic Package of Health Services (BPHS) – 2005 provides standards for a four tier primary health care system and the Essential Package of Hospital Services (EPHS) provides the framework for the hospital system. The BPHS has a pyramidal structure with services provision at four different referral levels; community level health post (HP) staffed with volunteer community health workers (CHW), Basic Health Centres (BHC) staffed by one doctor and midwife, Comprehensive Health
Centres (CHC’s) staffed by two doctors, nurses, and laboratory staff and the District Hospitals (DH) providing a range of hospital services. These facilities are also part of the "Essential Package of Hospital Services" (EPHS), a package with focus on services delivery for provincial and regional hospitals. Financial support of these packages is made mainly by European Commission, World Bank, and USAID.

Organisational Background:
HealthNet-TPO (formerly HealthNet International) has been operational in Afghanistan and Afghan Refugee camps in Pakistan since 1992. The focus of the organisations global activities is on providing health care structural redevelopment in the transitional stage from complex emergency to development aid. HealthNet TPO’s operations in Afghanistan have three major components; Mental Health, Primary Health Care (the Health Care Support Programme) and the Malaria and Leishmaniasis Control Programme (MLCP).

The Health Care Support Programme is located in Nangarhar province and has its main office in Jalalabad city. As from 1995, HealthNet TPO has supported the implementation of basic health services in Nangarhar Province. The cornerstone of the project has been the establishment of a cost-effective cluster health management structure and the expansion of basic health services in the 20 districts out of total 21 districts of the Nangarhar province through one EC funding contract till May 2009.

2. The EC funded Mental Health Program background

Mental Health activities started in 2002 in Afghanistan in a pilot project linked to the HCSP program.

The overall goal of the programmes is to contribute to improvement of mental health services in Afghanistan. During the 23 years of conflict in Afghanistan much of the health care infrastructure has been destroyed and the war has had a negative impact on the mental health situation of the population. Presently hardly any mental health services are available in Afghanistan.

The project purpose is to develop, implement and evaluate a model for cost-effective, culturally appropriate, community based, and sustainable mental health services for the rural areas of Afghanistan.

The proposal comprises of activities at several layers of the health care system: the national level, the provincial level, the basic health care level, and the community level. These levels are reflected in the following specific objectives:

- A mental health component is introduced in the basic health care system of two provinces of Afghanistan
- A model for culturally appropriate community based psychosocial services in Afghanistan is developed and implemented
- Capacity of provincial health authorities in planning and management of mental health activities on provincial and district level in two target provinces is enhanced
- Mental health policy, planning, and implementation capacity of the central Ministry of Health strengthened.
- The implemented mental health and psychosocial activities are monitored, evaluated and researched.

3. Objectives of the evaluation
The external evaluation at the end of the project is a contractual requirement. The purpose of this evaluation is to provide the European Commission with an independent assessment of the relevance, appropriateness, achievements and sustainability of the programme activities carried out during the funding duration:

The achievements in relation to original objectives of the project as stated in the Contract, Logical Frame Work and Revised Work Plan;
The consequences for national mental health policy for universal coverage of population with basic mental health services if HN-TPO assistance ends and recommendations to further sustain efforts to improve basic mental health services in Nangarhar province and the country

4. Scope of the work

The work will include but not necessarily be limited to the following tasks:

Effectiveness:
Did the programme achieve its objectives – as stated in the original objectives and logical framework matrixes of the programme?
Has capacity building of local structures and organisations taken part as part of the intervention – and if so what have been the results and effects?
Has the HealthNet TPO Provincial Core Teams, the technical and management capacity to implement Mental Health Care in an effective and qualitative way.
To which extent have extraneous factors affected the outcomes of the programme?

Efficiency:
Were the financial resources and other inputs used properly to achieve the intended results?

Sustainability:
To what extent can interventions be said to be sustainable in the long term, particularly if ongoing financial support is not available?

Co-ordination:
To what extent has the mental health participated in coordination of activities with MoPH and other partners?

5. Methodological Aspects

The consultant will initially review relevant internal, external and background documentation (reports, contracts, copies of previous evaluations, project and programme documentation including financial details, and policy documents) in order to compile existing information to facilitate the evaluation. The documents will be made available to the consultant in advance so that he/she can have thorough and systematic insight into the programme. The consultant will have scope for influencing and detailing the methodology, but it should include the following:
A desk review of the relevant project documents (as above)
Observation of the process of site activities by selecting sample activities implemented by the mental health.
Initial interviews with key senior staff based in Jalalabad.
Visits to project sites to interview key field managers and staff and to observe the activities undertaken during the project period.
Interviews and meetings with beneficiaries in various locations.
Meetings with EC, other stakeholders implementing similar/other projects, both at national policy level as well as in the field.

6. Expertise required

In order to fulfil this assignment, the mission will comprise one consultant. The evaluation is to be carried by a person with advanced knowledge and experience in fields related to the ToR such as: health policy, mental health and psychosocial wellbeing, PHC and project development. The evaluation will focus on the objectives of the projects. The consultant should have experience of similar evaluations, and an understanding of the kind of work or project involved, and preferably should be acquainted with the cultural and political considerations relevant to Afghanistan. The consultant should ideally have a strong knowledge of management and organisational performance, as well as technical background.

Profile of consultants:

The consultant must a qualification in a field directly related to the ToR and a minimum of 5 years’ experience in the implementation and evaluation of development projects, especially mental health and psychosocial wellbeing, PHC and health systems development in developing countries. Also familiarity with the EC Project Cycle Management and Logical Framework Approach, cost benefit and impact analysis will be an advantage. Fluency in English is necessary.

7. Expected outputs

The information produced at the end of the evaluation will be distributed in the form of an evaluation reports (the main expected output of the evaluation) to all parties involved in the project funding and implementation, namely the European Commission and the Afghan Government.

An exit workshop involving the consultant, key HealthNet TPO staff members, MOPH representatives and the EC Representation Office to Afghanistan in Kabul to summarise impressions and solicit comments on the key findings.

Reporting

Preparation of an initial draft reports and sharing it with both the EC and Health Net TPO.

The suggested structure for the final reports will include executive summary, outline of process and methodology, list of interviews and meetings held and documents consulted, key findings and analysis of these findings, lessons to be learned, and practical recommendations. However, this structure can be modified by the consultant should they judge it advisable.

A draft reports (an electronic version) will be provided to HealthNet TPO not more than 15 days after the consultant ends the field programme.

15 days are required to review first drafts, and comments (by EC and HealthNet TPO) will be forwarded to the consultant within 15 days after receiving first draft. The final report considering comments by the concerned parties, will be provided plus one electronic copy within 15 days of receiving the comments on the draft report.
ANNEX 2:

The list of key persons in HN offices/teams, EC, national and provincial authorities, BPHS met during the field visit

<table>
<thead>
<tr>
<th>Name</th>
<th>Denomination</th>
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<tbody>
<tr>
<td>Dr. A. Majeed Siddiqi</td>
<td>Head of mission / Country manager HN-TPO for Afghanistan and Pakistan</td>
</tr>
<tr>
<td>Dr. M. Taufq Mashal</td>
<td>Senior Advisor for national EPI Program Health System Strengthening Project/GAVI Ministry of Public Health</td>
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<tr>
<td>Dr. Alia</td>
<td>National Coordinator Mental Health, MoPH</td>
</tr>
<tr>
<td>Dr. Haroun</td>
<td>Technical advisor Mental health Department, MoPH</td>
</tr>
<tr>
<td>Dr. Ajmal Pardis</td>
<td>Provincial Health Director, Sub-directorate Nangarhar province.</td>
</tr>
<tr>
<td>Dr. Khalid</td>
<td>M &amp; E officer HealthNet TPO country office Kabul</td>
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<tr>
<td>Dr. M. Tahir Ghaznavi</td>
<td>Project Officer – Health &amp; Social Protection Delegation European Commission to Afghanistan Kabul</td>
</tr>
<tr>
<td>Dr. M. Naseem</td>
<td>Program Manager HCSP Jalalabad and Kabul office HN-TPO</td>
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<tr>
<td>Dr. Hafiz Faiz</td>
<td>Program manager, Mental Health Program HN TPO</td>
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<tr>
<td>Dr. A. Khalid Humayuni</td>
<td>Deputy Program Coordinator, Mental Health, Program HN TPO Afghanistan</td>
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<tr>
<td>Dr. E. A. Khalil</td>
<td>Senior Administrator HN TPO Afghanistan</td>
</tr>
<tr>
<td>Dr. F. van der Vorst</td>
<td>Program Manager GF program HN TPO, Afghanistan</td>
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<tr>
<td>Dr. A. Qami Alimi</td>
<td>Team leader Project Kapisa province</td>
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<tr>
<td>Dr. Z. Sharifi</td>
<td>Mental health supervisor, core team Nangarhar province.</td>
</tr>
<tr>
<td>Mr. Akmal Noorani</td>
<td>Psychosocial supervisor, core team Nangarhar province.</td>
</tr>
<tr>
<td>Ms. Shama</td>
<td>Psychosocial team leader, core team Nangarhar province.</td>
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<tr>
<td>Ms. Farishta</td>
<td>Psychosocial officer, core team Nangarhar province.</td>
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<tr>
<td>Mr. Raz Mohammad</td>
<td>Psychosocial officer, core team Nangarhar province.</td>
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<tr>
<td>Dr. Zalmay</td>
<td>Team leader supervisor Mental health, core team Nangarhar province.</td>
</tr>
<tr>
<td>Dr. M. Nasir Sharifi</td>
<td>Mental health supervisor, Laghman province.</td>
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<tr>
<td>Dr. A. Rawan</td>
<td>Team leader Kunar province.</td>
</tr>
<tr>
<td>Dr. Nisar Alizai</td>
<td>Team leader Khost province.</td>
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</table>
ANNEX 3 : Documents Consulted

The list of documents consulted for the external evaluation of the Project ‘Integrating mental health into the primary health care system of Afghanistan. EC: ASIE/2004/097-608 (AF68)


- Proposal HN TPO Project ‘Integrating mental health into the primary health care system of Afghanistan. EC: ASIE/2004/097-608 (AF68)

- No cost extension for integrating mental health into primary health care system. EC: ASIE/2004/097-608 (AF68)

- Project reports AF68EC, Dr. Hafizullah, Program Manager (2005-2007)
  - Annual report apr 2005-march 2006
  - Annual report april 2006-april 2007
  - Operational report april 2007-october 2007
  - Report march 2007 – December 2007 (Cordaid)
  - Final report February 2007-april 2008 (Embassy Netherlands)
  - Kapisa mental health project 18 months activity report, Nov. 2006- April 2008
  - Training of trainers evaluation report, 5 provinces, Dr. Zalmay
  - Internal evaluation report draft Nangarhar & Kapisa (M&E unit - march 2008)
  - Internal monitoring report draft Nangarhar (M&E unit October 2008)

- HN TPO Financial consolidated report AF68 project 08.14.08

- HN TPO Consultancy reports Mental Health Mission Project, B. van Mierlo
  2006, November 30th-December 8th Jalalabad, Afghanistan,
  2007, May 26 - June 3rd Jalalabad, Afghanistan,
  2007, October 19th – October 29th, Mansehra, Pakistan
  2008, April 28th – May 9th Kabul, Afghanistan

- HN TPO Consultancy reports Mental Health Mission Project, Dr. F. Kortmann
  2007, February 24th – March 5th
  2007, September 26th – October 4th

- Report of a survey on Impact of psychosocial services in Nangarhar province (September 2007), B. van Mierlo, PH & R department, HN TPO Amsterdam

- Training manuals
  - Handout for psychosocial workers
  - Handout for Community Health workers
  - Handout for doctors
  - Handout for nurses and midwives