Child Mental Health, Psychosocial Well-Being and Resilience in Afghanistan: A Review and Future Directions

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Introduction

The impact of war on child and adolescent mental health is an issue that sits high on the global public health agenda, especially where it concerns young people living in low-income countries (Patel, Flisher, Hetrick, & McGorry, 2007) and conflict zones (Morris, van Ommeren, Belfer, Saxena, & Saraceno, 2007). One key debate in the literature on 'conflict and child health' focuses on the relative importance of exposure to different kinds of violence (Panter-Brick, Goodman, Tol, & Eggerman, 2011): are mental health outcomes primarily driven by war-related trauma, family-level violence and/or structural barriers taking the form of institutional, social and economic stressors? Of course, a protracted war exacerbates poverty, weakens social institutions, drives poor health and often increases social and economic inequalities. But such a macro-level view of the consequences of war does not necessarily help to understand the everyday experiences, emotional lives and social realities of children in conflict zones. It is essential for research to carefully assess the main drivers of child and adolescent mental health, in order to understand which cluster of childhood adversities has the greatest impact, to reach specific insights that have both local and global significance and to underscore which interventions might be most effective.

Another key debate in the public health and child development literature centres on the conceptual understandings of 'risk' and 'resilience'. Both risk and resilience matter to child well-being: it is necessary to assess both the vulnerabilities and the strengths of children, families and communities living with protracted conflict. However, research on mental health in humanitarian settings is still dominated by a paradigm narrowly focused on individual responses to potentially traumatic events: a broader understanding of resilience is only nascent (Panter-Brick, 2010). As argued by Layne, Waren, Watson, and Shalev (2007), the fields of developmental

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psychopathology and traumatic stress research have been dominated by studies investigating a 'shopping list' of risk and protective factors, with little understanding of the intervening variables that mediate or moderate pathways of influence. By contrast, resilience research is attentive to social contexts and developmental processes, beyond the study of individual attributes shaping worse-than- or better-than-expected health outcomes. Thus a key emphasis of resilience research is to contextualise developmental and social trajectories, identifying what critical changes need to be made in social, educational and material environments to turn individual trajectories towards more favourable health outcomes (Panter-Brick et al., 2011). Contexts and resource provision are of central importance to turning points fostering trajectories of resilience. This conceptual framework is particularly useful to bridge major gaps between scientific evidence and policy-making pertaining to war-affected children. For a state-of-the-art review of findings on ecological resilience relevant to children and adolescents exposed to political violence in low- and middle-income countries, see the chapter by Tol and colleagues in this volume (Tol et al., 2013).

This chapter reviews the literature on child mental health and psychosocial well-being in present-day Afghanistan. Use of these terms needs some clarification. 'Mental health problems' and 'mental disorders' are terms in the vocabulary of psychiatrists, psychologists, epidemiologists and policy-makers. However, many social scientists and humanitarian workers prefer to focus attention on 'psychosocial well-being'—referring to a 'dynamic relationship that exists between psychological and social processes, each continually influencing the other' (Williamson & Robinson, 2006). Thus psychosocial well-being refers not only to the subjective nature of one's experiences but also to the social nature of life stressors, behavioural responses and contributions made to the community (Strang & Ager, 2003). We follow here the consensus established in the humanitarian sector (IASC, 2007): the composite term 'mental health and psychosocial support' describes 'any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder'(Wessells & Van Ommeren, 2008). This approach entails a wide lens on child mental health that includes epidemiological and clinical data on 'problems' and 'disorders' as well as contextual data on economic, cultural and social structures that impact vulnerability and resilience in everyday lives.

This chapter thus provides a synthesis of child-focused research and intervention literature related to mental health and psychosocial well-being in Afghanistan. Our intent is to inform the research agenda and service provision strategies for Afghan children and adolescents. We also discuss a framework for developing initiatives to promote mental health and psychosocial well-being within this group, and make recommendations for future directions.

Afghan Childhood in Social Context

We begin this section with a brief historical background of the country, and then highlight contextual aspects of childhood in Afghanistan pertaining to socialisation, education and health.

A History of War, Poverty and Sharp Inequalities

Afghanistan has had a long history of invasion and war. Situated at the crossroads of the Middle East, the Asian steppes and the Indian subcontinent, this country has been a battleground of many great powers, from Alexander the Great to Genghis Khan, the Indian Mughals and the British Empire. Afghanistan became an independent entity when the legendary Ahmad Shah Durrani united the Pashtun tribes in 1747 and founded the Durrani dynasty. The monarchy was abolished in 1973, followed by a communist coup d'état in 1978 (Dupree, 1980). Since then, the country has been in a nearly constant state of turmoil with cycles of heavy violence and protracted armed conflict. The invasion of the Soviet Union in 1979 led to a 10-year-long *jihad*, or 'holy war', by opponents of the Afghan communist regime who identified themselves as *mujahedeen*. That

war generated an estimated one million deaths and six million refugees (Physicians for Human Rights, 1998). In 1992, 3 years after the withdrawal of Soviet forces, a loose alliance of several different *mujahedeen* groups succeeded in toppling the communist government. A struggle for political power between these groups then led to a 4-year civil war, often structured by ethnic and Islamic sectarian divisions and driven by the ambitions of rival warlords. During this period, large parts of the capital Kabul were destroyed, and most of its inhabitants were internally displaced or took refuge abroad. The rapid rise of the Taliban, a fundamentalist group originating from the southern parts of the country and mostly trained and educated in Pakistan, brought some stability (Rashid, 2001). Their interpretation of Islamic law imposed severe restrictions on all aspects of daily life (Rasekh, Bauer, Manos, & Iacopino, 1998). Violations of Taliban laws and decrees were met with harsh sentences: public beatings, imprisonment, torture and execution. Access to education for girls was severely restricted; women were not allowed to leave the house without male chaperone—a *mahram*.

In 2001, massive US bombings and a US-led invasion drove the Taliban out of power. The signing of the Bonn Agreement (December 2001) then created a framework for the country's reconstruction and the dissolution of factional armies led by 'warlords'. In recent years, however, the country has seen a violent resurgence of the Taliban, particularly in the Pashtun-dominated south and south-east, and frequent terrorist attacks on 'Western targets' which include government schools, foreign embassies, security personnel and aid organisations (Fergusson, 2010). Considerable external funding earmarked for reconstruction efforts has led not only to better access to health care and education but also to widening socio-economic inequalities and a growing discontent with the Afghan government (Donini, 2007). Even young urban elites readily identify security and governance issues as their top social concerns, along with family stressors that have the most lasting impact on physiological stress (Panter-Brick, Eggerman, Mojadidi, & McDade, 2008). The demographics of the country are certainly increasing frustrations related to lack of possibilities for education and employment—Afghanistan has a rapidly urbanising population estimated at 29.8 million, half of which (14.9 million) is under the age of 18 (UNICEF, 2011).

Childhood in Afghanistan

Afghan society is patriarchal (elder men are decision-makers), patrilineal (a child belongs to his father's family) and patrilocal (the girl moves to her husband's household at marriage). The core social and economic unit is the extended family, although its influence has to some extent been eroded by social changes linked to forced displacement and urbanisation. The home and family are private domains. Surrounding walls shield family life from public view, and walls of silence habitually shield family problems from outsiders. While family life is recognised as a nexus of care and protection, desperate poverty, poor family dynamics and loss of key family members can turn families into harsh and unloving environments for children (De Berry et al., 2003).

Afghan children usually have no 'adolescence' as conceptualised in the Western world, that is, no transitional life stage situated within peer groups before social adulthood. Traditionally, Afghan boys from the age of 10 to 12 years, or even younger, move directly into an adult world (Dupree, 1980), while girls are given in marriage around puberty. In contemporary Afghanistan, individuals older than 14 are considered adults rather than children (Loughry et al., 2005), and this is also the legal age of employment. Particularly in nonurban areas, children assume social responsibilities early and have limited time for play. Social life is rigorously gendered and often includes systematic exposure to violence. Some 30 years ago, Afghan street games were described as rough but including war games only rarely (Dupree, 1980; Van Oudenhoven, 1979); nowadays, according to personal communications from Afghan colleagues, street games include violent re-enactments of the war, and children's drawings readily show disturbing images of armed conflict, death and injury (De Berry et al., 2003; Save the Children USA, 2002).

A central concept in the socialisation of Afghan children is *tarbia*, a word found in both Arabic and Persian, commonly translated as 'training' or 'education' while also implying 'upbringing' or 'civility'. It includes both *adab* (politeness and good manners) as well as *akhlaq* (morality) (Karlsson & Mansory, 2007). One qualitative study involving both children and adults in Kabul concluded that *tarbia* was a term used to refer to children's manners and the quality of their relationships with others. Good *tarbia* entailed good manners and proper language, respect for elders, bodily cleanliness and hospitality. The concept is gender-specific: a girl must display modesty (lowering her gaze outside the home, not looking around or making eye contact with boys, keeping her head covered), but this is not expected of boys (De Berry et al., 2003). Among the main qualities Afghan girls are expected to acquire in the process of becoming a woman are 'acceptance, suffering and patience' (Billaud, 2012).

Education

At the end of the Taliban era, around 80 % of the schools had been destroyed. In 2002, the Afghan government launched a 'Back to School' campaign, which resulted in huge expansion in school attendance throughout the country from about 900,000 to nearly 6.4 million in 2008. The percentage of girl's primary school attendance has grown from almost 0 % in 2001 to over 37 % in 2007 (UNESCO, 2010a). The gender gap in education is narrowing, but girls still lag far behind boys in school enrolment, especially at the secondary level. In general, the education of girls is increasingly accepted; many Afghans now see it as a religious obligation within Islam (*farz*), though often on the condition that older girls are taught by female teachers (Karlsson & Mansory, 2007). The adult literacy rate is pegged at 28 %, with a strong gender inequality (43 % males, 13 % women; UNDP, 2007). There are still many challenges for programmes of state-sponsored education, related to both economic and political insecurity. In particular areas of the country, schools are increasingly regarded as justifiable targets by insurgents (UNESCO, 2010b).

Health Care

After the fall of the Taliban, Afghanistan had (and still has) some of the worst health indicators in the world. Life expectancy was estimated at 45 years for males and 44 years for females. The maternal mortality ratio (maternal deaths per 100,000 live births) is the second in the world, at 1400 (UNICEF, 2011). One in 11 women face a lifetime risk of death from causes related to pregnancy or childbirth. The under-five mortality rate is estimated at 199/1000, the second highest in the world; almost 40 % of the surviving under-five population are underweight.

Progress has been made over the past years, especially with respect to access to health care. The primary health care system offers a 'basic package of health services' (BPHS), developed to address the basic needs of the Afghan population (Waldman, Strong, & Wali, 2006). The BPHS is comprised of core health services, including maternal and newborn care, family planning, child health and immunisation, and management of communicable diseases such as tuberculosis, malaria and HIV. With backing from the Ministry of Health and non-governmental organisations (NGOs), and after some hesitation on the part of international donors, mental health and disability services were included in the BPHS in 2003, and their relative importance has grown in revised versions of the package (MOPH, 2009).

For health care in general, there has been a significant improvement in coverage of health care services. One study showed that in 2002 less than 40 % of the Afghan population had access to health services, but by 2007 this figure had risen to an estimated 82 %. The relatively quick recovery of health care structures is largely attributed to the close collaboration between government, donors and implementing NGOs (Arur et al., 2010; Sabri, Siddiqi, Ahmed, Kakar, & Perrot, 2007). A nationwide survey also found that the government BPHS had partially reached its goal of targeting the most vulnerable, including disabled people and members of female-headed and poorer households; these groups were indeed visiting health centres relatively more often than others. However, the study also

showed that such vulnerable groups still face considerable difficulties in using health facilities and that their out-of-pocket expenditures were higher than those of other population groups (Trani, Bakhshi, Noor, Lopez, & Mashkoor, 2010). The quality of health care provided to Afghan children aged less than 5 years has also improved (Edward et al., 2009). No data are available regarding the coverage of mental health services within the basic health care system although overall the access to basic mental health services has significantly improved (WHO, 2013).

Child and Adolescent Mental Health, Distress and Resilience

In this section, we review the existing literature on child and adolescent mental health (age ≤ 18 years) in Afghanistan. From May 2011 to August 2012, we conducted a comprehensive review of this literature, using online databases, PubMed and PsycINFO, with the following search terms: 'Afghan*' and 'child*' or 'adolescent' and 'mental' or 'psychosocial', in abstracts, titles or keywords and without a limit on date of publication. In addition, we searched available databases on Afghanistan, including published reports and unpublished studies presenting primary research data. We excluded literature unrelated to mental health or psychosocial support, and media reports or scientific publications focused solely on adults and/or Afghan refugees in high-income countries. We included, however, reports on Afghan child refugees in neighbouring countries such as Pakistan and Iran, given their cultural and socioeconomic similarity to Afghanistan. We found a total of 43 publications suitable for full text review, and subsequently excluded 23 for not meeting the inclusion criteria or for reporting on data sets already included and retained 20 for full discussion (Table 5.1). After presenting their main findings, we contextualise these studies by drawing upon a much larger body of scientific publications; reports by the Afghan government, international agencies and NGOs; and media reports.

Psychosocial Distress

Decades of war and conflict have had a significant impact on health and well-being across almost all domains of children's lives, due to exposure to violence, pervasive poverty, ongoing insecurity, strained family relations, disrupted networks of social support, curtailed education and poor health. A 1998 needs assessment and situation analysis for child protection agencies in five provinces found that security and safety-related problems were the most important threats to child well-being and that support for families and caregivers was required to provide an adequate livelihood for their children (Sellick, 1998). In 2003, UNICEF and Save the Children published a qualitative study on the well-being of children in Kabul 2 years after the fall of the Taliban: *The children of Kabul*, *Discussions with Afghan Families* (De Berry et al., 2003). While children reported many disturbing past experiences, they were most worried by and preoccupied with ongoing, day-to-day threats and pressing concerns, such as the risk of becoming disabled due to landmines, unexploded ordnance (UXO) and traffic accidents, economic hardship and poverty, and problems and tensions in the family. Participants stated that poverty was a major source of the latter: parents worried about feeding, clothing and providing care for children, which took its toll on relationships within the family and also put extra pressure on children themselves. The study also highlighted children's difficulties stemming from the loss of and/or separation from family members, due to both deaths and disappearances during years of conflict and as a result of protracted illnesses or traffic accidents.

> My father died, and then I lived with my uncle and he died also, and then I lived with another uncle but he also died, and then I lost all my protectors (Focus group discussion with boys; De Berry et al., 2003).

> The main impact of war on children has been that they grew very afraid, also during the war no one could give good 'tarbia' to their children (Focus group discussion with mothers; De Berry et al., 2003).

Such findings are echoed in an unpublished survey in four districts in northern Afghanistan which assessed the psychosocial and mental

Table 5.1 A review of literature on child and adolescent mental health and psychosocial well-being in Afghanistan

Authors	Study design	Objective	Setting	Study population	Main findings and conclusion
Catani, Schauer, and Neuner (2008)	Cross-sectional survey	Establish the extent of cumulative traumatic and stressful experiences related to war and family violence in schoolchildren in Kabul	Urban district in Kabul affected by war and violence in the past	287 children (ages 7–15) from two schools in Kabul, 2005	In addition to multiple exposure to war- or disaster-related traumatic events, children also indicated high levels of exposure to family violence
Catani et al. (2009)	As above, see Catani et al. (2008)	See Catani et al. (2008)	See Catani et al. (2008)	See Catani et al. (2008)	Boys reported higher overall amounts of traumatic events, specifically domestic violence. Boys have higher rate of PTSD (26.1 %) compared to girls (14.1 %). Average of 4.3 different types of violent incidents at home. Child labour was a common phenomenon and associated with an increased likelihood of experiencing family violence for girls
De Berry et al. (2003)	Explorative study using ethnographic methods (key informant interviews, focus group discussions)	Identify well-being goals for children, threats to psychosocial well-being and existing coping resources	Kabul	321 children (ages 7–13) 116 children (ages 13–18) 215 parents	Afghan families considered their children's emotional and social development important, and highlighted the central importance of *tarbia*—obedience, manners and correct conduct—in their upbringing. Child well-being was dependent on the availability of opportunities for personal and social development, their personal characteristics and the immediate situation around them. Children in Kabul drew on many resources to cope with challenges; some coping mechanisms were found to be comforting in the present but to have potentially negative long-term consequences
Eggerman and Panter-Brick (2010)	Thematic analysis of responses to open-ended questions from children and caregivers in a stratified randomised sample of schools (see Panter-Brick et al. 2009)	Analyse how constructs of hope and suffering frame the life experiences of schoolchildren and their caregivers in light of reported stressors and professed solutions	See Panter-Brick et al. (2009)	See Panter-Brick et al. (2009)	Adults were primarily concerned with overcoming economic difficulties, while children prioritised problems in their learning environments as well. Education was perceived as the key to social and economic improvement of the family. Respondents derived hope from a sense of moral and social order embodied in the expression of key cultural values: faith, family unity, service, effort, morals and honour. These values form the bedrock of resilience, drive social aspirations and underpin self-respect and dignity. However, respondents also reported strong feelings of entrapment caused by a combination of economic impediments, social expectations and cultural dictates which frustrated the realisation of personal and social aspirations

Gupta (1997)	Cross-sectional survey with self-report questionnaires	Identify psychopathology in children	Kabul during Taliban rule in 1996	Community sample ($n=310$) of children aged 8–18 years	72 % had experienced the death of a family member between 1992 and 1996. 41 % had lost one or more parents because of the conflict. Nearly half had seen many people killed in rocket and artillery attacks. Over 80 % of the children indicated that they were often so sad that they felt they could not cope with events and felt that life was not worth living
HealthNet TPO (2008b)	399 structured questionnaires; 22 focus group discussions; 40 key informant interviews; 12 case studies	Assessment of mental health and psychosocial well-being; coping and barriers to service provision	Four districts (Baghlan, Kapisa, Kunduz, Parwan)	School-age children, parents, teachers, community elders, traditional healers and health care staff	Moderate but omnipresent psychosocial problems, with 25 % of children indicated for some form of psychosocial support. Current stressors (poverty, social injustice, child marriages) reportedly cause most frequently reported problems (aggression, substance abuse, distress, disturbed peer relations, suicide attacks, family violence). Boys report more complaints than girls
HealthNet TPO (2008c)	Exploratory participatory assessment; individual interviews ($n=19$) and 5 group discussions ($n=49$)	Rapid assessment of perceived MHPS problems and local resources in the context of NGP programme design	Uruzgan Province in Southern Afghanistan	Local key informants (governmental leaders, formal and informal mental health care and psychosocial service providers)	Psychosocial concerns that were prioritised by participants included (a) domestic and family violence, (b) drug abuse, (c) general psychological symptoms, (d) poverty, (e) tribal conflicts and (e) malpractices in marriage customs. As child-specific psychosocial and mental problems respondents mentioned fear and anxiety, concentration problems, development problems and epilepsy
Hoodfar (2008)	Ethnographic research using participant observation, focus group discussions and key informant interviews	Map experiences, concerns, self-perceptions and coping strategies of Afghan youth in Iran	Urban areas in Iran (Mashhad, Tehran, Qom aged)	100 Afghan refugees (aged 12–18) in Iran (2001) 51 Afghan refugees (aged 12–18) in Iran (2002–2003)	Afghan girls and boys are not passive victims of circumstances but actively adopt strategies to deal with unwanted family dynamics (marriage, discrimination). Young Afghans seek to introduce fundamental changes into their families and communities often using the legitimate force of religion
Izutsu et al. (2005)	Cross-sectional study	Describe physical and mental health status of Afghan refugee children	Refugee camps in Pakistan in the early post-Taliban period	100 Afghan children aged 6–14	The majority of children showed signs of hopelessness, suicidal feelings and other mental health difficulties
Kassam and Nanji (2006)	Brief exploratory study using focus group discussions and key informant interviews	Explore mental health situation of Afghan refugees in Karachi	Afghan refugee camp in Karachi, Pakistan (1999)	61 participants (including adolescents)	Distress was communicated on a collective level. Mental illness was often equated with severe psychotic illness. Somatic symptoms were a common way of expressing distress. Social and community-based approaches that drew on natural coping strategies were recommended to improve mental health

(continued)

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Authors	Study design	Objective	Setting	Study population	Main findings and conclusion
Loughry et al. (2005)	Quasi-experimental design	Develop instruments for child psychosocial well-being Compare psychosocial with non-psychosocial intervention	7 villages in Northern Afghanistan	267 children (8–14 years), 145 adults	Developed a culturally grounded, quantitative scale for assessing Afghan child psychosocial well-being. Quantitative data showed the non-psychosocial intervention had better outcomes for child well-being than the psychosocial intervention
Omidian and Papadopoulos (2003)	Questionnaires; interviews with teachers, students and parents; classroom observations	Compare impact in the classroom environment for teachers who received psychosocial training vs. those who did not	4 schools for Afghan refugees in Peshawar, Pakistan, November 2002	4 schools. Sample size of people interviewed is not mentioned	The attitudes of teachers who received psychosocial training had changed substantially. By helping teachers to better understand their own emotions and that of their students, they became better teachers. Their way of teaching was more relaxed, they exhibited patience, were more friendly and helpful and felt able to find out about the students' problems and to help resolve many of them
Panter-Brick et al. (2009)	Stratified random sample; interviews with children, caregivers and teachers	Evaluate mental health, suffering and trauma exposure among Afghan schoolchildren and their caregivers; assess multiple outcomes and triangulation across child, parent and teacher reports	24 schools in three provinces (Kabul, Bamyan, Mazar-e-Sharif), 2006–2007	1,011 male/female 11–16-year-old schoolchildren, 1,011 caregivers, 358 classroom teachers	Children's *most* distressing lifetime trauma included accidents, painful medical treatment and domestic and community-level violence, not just war-related events. Mental health outcomes were strongly associated with number of lifetime traumatic events and with caregivers' mental health status. Emotional problems were more prevalent than behavioural disorders. The research highlights the value of school-based initiatives to raise awareness of mental health, and to address wider issues of everyday suffering and resilience
Panter-Brick et al. (2011)	Longitudinal study; gender-balanced, stratified random sample, with follow-up 1 year after baseline, after Panter-Brick et al. (2009); interviews with children and caregivers	Examine 1-year mental health trajectories for multiple outcomes; assess the relative impact of risk and protective factors using individual, family and area-level variables	9 schools (Kabul)	234 male/female 11–16-year-old schoolchildren (64 % of baseline sample) and their caregivers	With the exception of post-traumatic stress symptoms, mental health outcomes improved in the absence of a targeted intervention. Family-level events such as traumatic beatings, stressful conflict and violence worsened mental health outcomes; improvements in family life and relationships had protective effects. Post-traumatic stress symptoms remained dependent on lifetime trauma exposure; by contrast, other mental health problems associated with intervening-year family-level violence rather than war-related violence

Raj, Gomez, and Silverman (2011)	Open-ended interviews ($N=102$)	Identify Afghan perspectives on the causes of and potential solutions to child and forced marriage	Religious leaders, police, teachers, Afghan staff of non-governmental organisations and government officials	Three major towns (Kabul, Jalalabad and Mazar-e-Sharif)	Informants reported recognition of the poor social and health consequences of child and forced marriage for mothers and infants. Recommended solutions centred on child marriage prevention; most informants felt little could be done for married girls
Sellick (1998)	Semi-structured interviews with convenience samples of children supplemented by focus group discussions with parents and adults working with children	Needs assessment and situation analysis for child protection agencies on the effects of conflict on children in Afghanistan	Urban and rural locations in five provinces (Kabul, Herat, Mazar-e-Sharif, Jalalabad, Kandahar)	500 children (aged 6–18) in five provinces	Security and safety-related problems were the most important threats to Afghan child well-being. Support to families and caregivers is required to provide an adequate livelihood for children. Agency assistance needs to be guided by local vulnerability analyses, with special attention to disability and gender
Slugget (2003)	Key informant interviews with senior staff	Situation analysis related to child sexual abuse in Afghanistan	Afghanistan (Kabul)	Senior staff in UN, NGOs	Cases of child sexual abuse are not made public, especially in the case of girls due to the high value placed on their virginity. There is strong social stigma directed at abused children, and such abuse brings shame upon their families
Smith (2008)	319 semi-structured interviews, 56 focus group discussions	Identify and understand stress factors and individual and societal attitudes regarding violence on children within the family	Urban and rural sites in four provinces (Kabul, Nangarhar, Bamyan and Herat), 2006–2007	More than 200 adult men and women from 61 different families	To some extent, domestic violence against children is an accepted way of disciplining children, although there is social disapproval regarding the use of violence; child abuse is seen as a problem, and mainly attributed to the inability of adults to control their anger
Trani and Bakhshi (2006)	Nationwide population-based survey with probability proportional to size sampling	Evaluate the prevalence of disability and access to public services for persons with disability	175 clusters in all 34 provinces	People of all ages in 5,250 selected households	2.7 % of all Afghans fulfilled the (strict) criteria for disability; among those aged 0–9 years, the figure was 1.4 %, rising to 2.4 % for the 10–19 age group. Over 20 % of Afghans share a household with a person who has a disability. Prevalence of severe learning disability was 0.26 % and of epilepsy/seizures 0.51 %. People with disabilities had higher levels of mental distress
Wessells and Kostelny (2002)	Semi-structured interviews and focus group discussions	Identify key risks and issues of child protection/ well-being; identify vulnerable groups	Northern Afghanistan in early post-Taliban period	200 children and 120 adults	Key issues affecting child well-being were landmines; protection and support for the most vulnerable; disarmament, demobilisation and reintegration (DDR); informal education; gender discrimination; and drug abuse. Vulnerable groups included ex-child soldiers; children who had been internally displaced, orphaned or separated from their families; children with disabilities; working children; and victims of sexual exploitation

health problems of 399 school-age children, and the perceptions of parents, teachers and other community stakeholders regarding them (HealthNet, 2008b). Gender discrimination and social injustice, unmet basic needs and poverty, continued insecurity and violence, and marriage-related issues were reported as causing children's psychosocial and mental health problems. While war and conflict-related traumatic events were commonly mentioned as a cause of psychosocial and mental health difficulties, structural socio-economic problems and recurrent stressors (maltreatment of children by adults, domestic violence and traffic accidents) were also seen as contributing to much of the perceived distress of children.

More recently, a systematic survey of mental health, lifetime trauma exposures, daily stressors and social resilience was conducted with a random sample of 1,011 children and 1,011 caregivers in three areas of the country (Kabul, Mazar-e-Sharif and Bamyan; Panter-Brick et al., 2009). The qualitative component of the study featured a content analysis of responses elicited, in face-to-face interviews conducted in Dari and Pashto, regarding the main problems faced in daily life and the solutions envisaged. For both male and female caregivers, economic stressors were identified as the most significant day-to-day problem, while for 11–16-year-old boys and girls, stressors pertaining to education were the most significant. Afghan adults and children alike underscored the overriding importance of economic insecurity as 'the root of all man's misery', using the Dari expression *iqtisad kharab* ('broken economy') to label a state of socio-economic 'entrapment' (Eggerman & Panter-Brick, 2010).

Poverty led to overcrowding in the home, strained social relationships and domestic conflict. Economically frustrated men become 'ill natured' (*bad khalqi*), an expression denoting difficult, abusive or morally reprehensible behaviour. Violent behaviour at home was often attributed to *takleef asabi* ('a mental problem'). For example, one young girl expressed the linkages between economic frustrations, poor mental health and domestic violence as follows:

> My father's salary is not enough for us, he has takleef asabi and he beats us. If he finds a decent job then maybe he will calm down (Interview with a 16-year-old girl; Eggerman & Panter-Brick, 2010).

Coping and Resilience

For Afghan families, resilience to adversity is the cornerstone of survival and well-being, signifying emotional, social and economic fortitude in the face of war, displacement, social conflict, severe illness and crippling debt. As De Berry et al. (2003) showed, the emotional and social development of children is a paramount social and cultural issue. Among the most important prerequisites for child well-being were morality, respect, faith, positive feelings, good relationships and correct behaviour, as well as physical health—all values which would help one to cope with challenging life circumstances. Children saw that families adopted coping strategies that were effective in the short term but problematic in the long term: hiding the truth, overprotection, use of physical punishment, violence and taking revenge (De Berry et al.). Building on a similar understanding of emic representations of emotional and social priorities, Loughry et al. (2005) constructed a quantitative measure of children's well-being, consisting of several subscales to assess feelings, social relations and coping strategies, for use in NGO project evaluations of psychosocial interventions.

Six cultural values fundamental to upbringing, psychosocial well-being and fortitude were identified in Eggerman and Panter-Brick's larger-scale interdisciplinary study (2010):

1. Faith in Islam (*iman*) plays a fundamental role in framing life experiences in Afghanistan; it is a source of strength, perseverance and hope in the face of hardship and uncertainty, at both the individual and family levels. Faith helps individuals make sense of what happens to them; this can be articulated in expressions of resignation—an acceptance that all life proceeds from the will of God, and is ultimately beyond the control of the individual.
2. Family unity and harmony (*wahdat* and *ittifaq*). Afghan households and families attribute great importance to peaceful resolution of disputes within the primary reference group, and adherence of all members to consensus decisions.
3. Service (*khidmat*). A critical value in the Afghan cultural system is the ability to make useful contributions to the well-being of

others, to 'serve' parents, family, community and country. Failure to 'serve' can be a source of shame, and viewed as a sign of weakness in character.

4. Perseverance and effort (*koshesh*). In order to achieve a goal, one needs to be persistent. Children often stated that they could improve their lives through 'hard work and *koshesh*'.
5. Morals (*akhlaq*). This refers to cultural codes governing appropriate and morally correct behaviour, deference to parents and community elders, modesty in dress and comportment and good manners in day-to-day relationships.
6. Social prominence, respectability and honour (*izzat*). By fulfilling their parent's ambitions for them, by working hard, demonstrating good morals and serving others, children hope to achieve respect and social recognition.

These six cultural values underpin the sense of resilience in Afghan culture. They provide a moral framework to order experiences of suffering, as well as hope and the promise of a better life (Eggerman & Panter-Brick, 2010). Hope and resilience were closely connected:

> The only way to make life better is to be hopeful… If a person has hope, then he or she can work and acquire knowledge to make their life better (Interview with an Afghan mother; Eggerman & Panter-Brick, 2010, p.76).

This sense of hope centred on accessing the resources needed to create social and economic opportunities for one's family. Children went to school in the hope of advancing the economic situation of their household—and also bore the burden of such expectations. In this context, 'hope' was the bedrock of resilience as well as the crux of social suffering.

Indeed, there can be no simplistic understanding of promoting 'culture' as resilience or using 'hope' as a simple index of well-being. Efforts to adhere to cultural values often contributed to feelings of entrapment, for instance, when men married several wives to demonstrate their social standing, or when school attendance was interrupted so that boys could 'serve' the household economy, or to allow girls to be married off into another family. While faith is clearly central to resilience in Afghanistan (Kanji, Drummond, & Cameron, 2007), religious beliefs can themselves be a source of suffering, and may encourage inactivity or even paralysis in dealing with adversity (Wessells & Strang, 2006). Feelings of entrapment led to considerable personal distress and social tensions, potentially reaching the point of violence and attempted suicide. Eggerman and Panter-Brick (2010) identified three forms of entrapment:

1. Poverty, overcrowding and other harsh socio-economic realities prevent people from demonstrating cultural values and meeting social obligations, individually or collectively.
2. Individual ambitions clash with expectations inherent in the values of morality, 'service' and 'family unity'.
3. Cultural dictates, particularly those surrounding marriage decisions and the social position of women in family and society, are themselves a cause of direct suffering.

Mental Health Disorders in Children

Rigorous data on the prevalence of child and adolescent mental health disorders in Afghanistan are scarce. The first large-scale epidemiological survey of common mental health problems was published in 2009: as mentioned above, this was a multi-stage random sample of 1,011 school-based children to assess adversity, experiences of trauma and life stressors, and resilience. Importantly, it included a multi-informant assessment (child, caregiver and teacher) of emotional/behavioural psychiatric difficulties and prosocial strengths, based upon *both* symptoms and impact on social life (across four domains of home, classroom, leisure and peer activities). It also included assessment of depression and post-traumatic symptoms, based on international instruments, and featured a combination of international and locally constructed scales (Miller, Omidian, et al., 2006) to assess caregivers' mental health (Panter-Brick et al., 2009). The instruments were validated, with Dari and Pashto translations copyrighted (http://www.sdqinfo.org). The survey showed that one out of five schoolchildren (22.2 %) met the criteria for probable psychiatric disorder, with girls two-and-a-half times more likely to have disorders than boys. Children who had suffered five or more traumatic events were

two-and-a-half times more likely to have a psychiatric disorder, as well as three times more likely to report symptoms of post-traumatic stress, than those who had experienced four or less. The study showed that caregiver mental health was correlated with the well-being of the children under their care: there was a 10 % increase in the likelihood of child psychiatric disorder for each and every symptom of psychological distress reported by caregivers.

A follow-up survey was undertaken in Kabul—but not in other areas of the country, due to logistical and security problems. This represents the first longitudinal survey of family-level mental health in Afghanistan, with follow-up data on 115 boys, 119 girls and 234 caregivers. The research aimed to test the extent to which individual-level, family-level and community-level exposures to adversity predicted a 1-year change in mental health outcomes such as psychiatric difficulties, depression and post-traumatic stress. It examined which aspects of violence and poverty were the most critical predictors of changes in child and adult mental health status, and conversely, which aspects of the family and community environment were the best predictors of mental health recovery (Panter-Brick et al., 2011).

The weight of the evidence indicates that even in a context of militarised violence, cumulative 'everyday' socio-economic stressors are critical determinants of mental health and well-being: these daily stressors impose a major burden on family relationships, triggering domestic violence, and were identified in this research as the main predictor of 1-year changes in mental health burden. Yet over the 1-year follow-up period, child and adult mental health outcomes improved for the cohort as a whole, for all measures except post-traumatic stress symptoms. This improvement occurred in the absence of a dedicated mental health intervention, or even better political and economic security. The follow-up pertained to Afghan families who had kept their near-adolescent children in school: in the context of Afghanistan, this was a significant expression of hope for socio-economic advancement and resilience to social and economic challenges—and continued school attendance was demonstrably associated with unexpected mental health improvements, for both children and caregivers in the study cohort.

Previous studies have generated a great deal of valuable contextual data on the extent of war-related deaths affecting children during the early years of Taliban control (Gupta, 1997), emotional despair and suicidal feelings in refugee camps (Izutsu et al., 2005), and the burden and war-related and domestic violence (Catani et al., 2009). However, these studies did not triangulate data from multiple informants, used nonvalidated questionnaires, and specifically looked for links between direct exposure to war-related violence and psychopathology. In a context where studies in conflict zones are increasingly common, several authors have warned that prevalence rates derived from trauma-focused psychiatric epidemiology are of limited value to community-based organisations working to promote mental health and psychosocial well-being (Bolton & Betancourt, 2004; Miller, Kulkarni, & Kushner, 2006; Rodin & van Ommeren, 2009; Ventevogel, 2005). Furthermore, recent evidence from conflict zones, including Afghanistan, has shown that in the genesis of mental health problems and psychosocial distress, war-related trauma does not necessarily outweigh the 'structural' daily stressors associated with the struggle to make a living. Even traumatic experiences, from the perspectives of children, are not solely contingent on war-related violence but are related to family-level and community-level violence—such as punitive beatings; disputes between relatives or neighbours; criminal acts, including robberies and stabbings; or physical harassment by local hooligans and/or police (Panter-Brick et al., 2009). Social stressors in the family-level environment are also demonstrably associated with biomarkers of stress such as immune competence and blood pressure, over and above other social and political factors reported as 'top stressors' in Kabul (Panter-Brick et al., 2008).

Self-Inflicted Injury and Suicide

Women and girls in Afghanistan have limited ways to 'protest' when they disagree with

decisions made about them, particularly in choosing a marriage partner or in controlling use of their time and labour. They may present with health problems at local clinics or hospitals simply because visits to health centres are often one of the few acceptable ways to leave the house, and because being ill draws attention to the seriousness of their malaise. In addition, Afghan teenage girls may seek resolve in self-injury, such as beating themselves severely when they are highly stressed (Mann, 2006; Omidian & Miller, 2006).

In extreme cases, women and girls may go as far as attempting suicide, often by burning themselves or by taking poison. A study carried out by the international NGO Medica Mondiale documented cases based on medical records at central hospitals in Kabul, Wardak and Herat provinces; this study found that girls as young as 12 years old had committed self-immolation, while girls aged 16–19 were particularly at risk. Forced child marriage and abuse from in-laws were among the most frequent reasons given to explain self-immolation, which often occurred after girls spoke out against the violence to which they were subjected or sought help in alleviating the violence (Medica Mondiale, 2007; Raj, Gomez, & Silverman, 2008). The high number of suicidal attempts among young Afghan women may be indicative of the difficulties they face in attempting to reconcile a 'modern' feminine identity with 'traditional' Afghan roles (Billaud, 2013). The United Nations news network IRIN quotes an 18-year-old girl receiving treatment for her burn injuries in a hospital in the capital, Kabul, four months after she was married against her will:

> I did not know how to end the misery of torture and daily beatings I got from my cruel husband. So I poured petrol on myself and set myself ablaze. I did not like him [the husband] even at the beginning… but there was no solution because I was married by my father. (IRIN, 2006)

There are no comprehensive statistics on the number of suicides in Afghanistan. However, anecdotal reports suggest the problem is significant (Tang, 2006), and there has been a concerted effort by the Afghanistan Independent Human Rights Commission (AIHRC) and other advocacy groups to address the problem (AIHRC, 2006a).

Drug Use

Afghanistan is the world's largest producer of opium and heroin, and the origin of more than 90 % of the heroin consumed in Europe and other countries. According to surveys by the United Nations Office of Drugs and Crime, Afghanistan is home to nearly one million problem drug users, roughly 8 % of the population between 15 and 64 years old (UNODC, 2009). An estimated 60,000 children are heroin users—approximately 0.7 % of the total Afghan child population (UNODC, 2005). Around 50 % of drug users in the north and south of the country are reported as giving opiates to their children (UNODC, 2009). Afghan folk traditions include the use of raw opium to alleviate common physical complaints, e.g. to suppress children's coughs and allow them to sleep. It is likely that the abundance of psychological stressors in overcrowded urban settings and among displaced populations with limited or no resources and social support networks fuels opiate use among those who previously only considered opiate use for medicinal or social purposes. These processes may disproportionately affect youth in urban settings (Todd, Macdonald, et al., 2012; Todd, Nasir, et al., 2012). In the Western town of Herat alone, there are some 2,000 drug-addicted children. One of them, 17-year-old Mohammad Zarif, told how he became addicted to opium while cutting poppy plants in nearby Farah province:

> I'm not happy that I'm an addict. But I can't stop - there is no treatment for me. There is no real employment, either, and I do anything I have to in order to get food and drugs. (Behnam & Afzali, 2006)

Vulnerable Subpopulations

Gender-Specific Risk Factors

The system of *purdah* separates the male domain from the closely regulated female domain. It is an important part of men's honour to protect a woman from outside influences. This protection results in a narrowly defined code of conduct and

far-reaching restrictions on female movements. Many men consider seclusion of women the only way to protect them. During Taliban rule the extreme isolation of women, in particular those in the cities who were confined to small apartments that they could hardly leave, led to considerable mental distress (Dupree, 2004; Rasekh et al., 1998). However, this '*purdah*-related depressive state' is not only related to Taliban rule but engrained in Afghan society (De Jong, 1999). The position of women and girls is subject to rapid and sometimes dramatic change. Many women and girls who have lived in refugee camps in Iran or Pakistan have seen the relatively higher degree of participation of women in society, and have often had the opportunity to pursue an education (Hoodfar, 2008). The work of many NGOs and the new government to bolster the rights of women and girls has had a clear impact, but is also cause of considerable tension within families and communities. Attempts to explicitly link the position of women and issues such as domestic violence to mental health and the promotion of women's rights may in fact exacerbate the problem of domestic violence, since men will often simply not accept *purdah*-related stress as a possible source of female problems (Van de Put, 2002).

Interestingly, in the above-mentioned study of children in four northern provinces of Afghanistan (HealthNet, 2008b), boys reported higher levels of problems on most indicators (functional impairment, resources and coping, psychological difficulties, conduct problems, hyperactivity and peer problems). No significant differences were found for post-traumatic stress and depressive symptoms. The counter-intuitive finding that boys report more problems than girls may be explained by a greater exposure of boys to contextual stressors—they enjoy more freedom of action, are more mobile and are more likely to be employed in work environments that may expose them to abuse. It may also be that they are more willing to express complaints in a research context. We should therefore be careful not to underestimate the problems that boys face, particularly in rural areas.

Girls in Early or Forced Marriages

By custom, marriage occurs at a young age, although among educated people, the wedding is often postponed until the completion of school. The legal minimum age for marriage is 16 years; however, the Afghan Ministry of Women's Affairs reports that an estimated 57 % of girls are married before the age of 16, with a mean age of marriage of 17.8 years for women and 25.3 years for men (MOWA, 2008). Several thousand girls in Afghanistan are married as early as 10 years of age. Forced marriage was estimated to be the norm rather than the exception, reportedly accounting for between 60 and 80 % of marriages (Afghanistan Human Development Report, 2007). In a survey among 102 Afghan NGO workers, government officials, religious leaders, police officers and teachers, most acknowledged the detrimental social and health outcomes of these practices for mothers and infants, and advocated for child marriage prevention; however, the consensus was that little could be done to assist girls who were already married (Raj et al., 2011).

In a study carried out in Kabul, many young girls raised serious concerns about early marriage, saying that they were not prepared for pregnancy (Slugget, 2003). An 18-year-old mother of four, who was married at age 13 to a 59-year-old man as his third wife stated:

> My husband is too old; he cannot work and cannot bring anything like brush or anything for us. My husband's first wife died last year in child birth, the other wife is not well. So now, at 18, I take care of all these children, four of mine and five of theirs. (FIFC, 2004)

After marriage a girl will usually move to the husband's family. An important and often conflict-ridden relationship is that of the newly married woman and her mother-in-law. Sometimes two families exchange girls, with each marrying a son from the other family, in order to avoid dowry costs or the division of inheritable property, particularly land holdings. The decision to exchange girls between two families is often made when the children are still young, sometimes even immediately after birth; thus, in most cases, the

girl has no influence on the arrangement. Such *badal* marriages may strengthen the ties between families, and in this respect they provide support and protection. However, they also increase the vulnerability of the women involved; for instance, if a husband mistreats his wife, her relatives may take revenge on his sister, who was married into the other family and lives in their household.

In Pashtun custom, violent crimes (such as murder) can at times be settled peacefully through a decision by the tribal *jirga* (council) that a girl from the perpetrator's family or clan be given in marriage to someone from the victims' family (Medica Mondiale, 2007). The girls who are involved in these practices (known as *baad*) often suffer maltreatment and abuse, which they have no means to resist. The prevalence of these exchanges has not been quantified, nor are they permitted under Afghan state law. Nevertheless, a recent report on 'traditional' justice mechanisms acknowledged the continued existence of the practice while characterising it as 'an exception—not a norm' and pointing out that its acceptance as a vehicle for the settlement of disputes varied between areas of the country, being altogether prohibited by some groups (Afghanistan Human Development Report, 2007).

Child Labour

The law on labour in Afghanistan stipulates 14 years as the minimum legal age at which children can be employed; employment of children aged 13 as apprentices is also permitted. The most recent available report on working children from the AIHRC showed that in fact a considerable number of children under the age of 13 were employed or required to work by their families, often for long hours, and at the expense of attaining an education (AIHRC, 2006b). A subsequent AIHRC study of children aged 5–18 in predominantly rural areas found that just over half were working (AIHRC, 2007a).

Child labour is also common among children who are able to attend school. In their 2006–2007 study of 11–16-year-old children attending randomly selected schools in Kabul, Bamyan and Mazar-e-Sharif, Panter-Brick et al. (2009) found that two in ten were working outside school hours in low-wage or unpaid occupations. Paid work included peddling low-value goods (e.g. glasses of water, plastic bags, toilet paper) on the street, weaving carpets and working as apprentices (for car mechanics or tailors) for less than $1 US a week; unpaid work included tending market stalls and working in family-run shops, restaurants and other enterprises. Catani et al. (2008) found that—in two schools in Kabul—39 % of schoolchildren aged 7–12 (49 % of the boys vs. 29 % of the girls) reported daily work. On average, children who were compelled to contribute to the family's income generation worked 6.7 h/day (SD = 3.01) with a range of 1–13 h/day.

Child labour is often linked to family poverty. For children who do not attend school, child labour is likely to be more prevalent, particularly in rural, farming areas, where children are often called upon to participate in farm labour, or in larger cities, where children may work on the streets to contribute to family income (UNICEF, 2005). Forms of child labour amounting to indentured slavery can be found in carpet-weaving workshops, brick factories and car repair establishments (Dupree, 2004).

Child Soldiers

A rapid assessment by UNICEF in 2003 found an estimated total of 8,000 combatants under the age of 18 in Afghanistan. A programme for Disarmament, Demobilisation and Reintegration (DDR) was set up for child soldiers, and in 2007 more than 5,000 former child soldiers participated (Coalition to Stop the Use of Child Soldiers, 2008). The programme worked with NGO partners who developed community programmes to provide education, life skills and vocational training, and psychosocial support (Wessells, 2006). In some areas, demobilised child soldiers have returned home, but have faced problems reintegrating in the absence of vocational training and psychosocial support (HRW, 2004). Some critics of this programme have argued that child soldiers do not appear to have more psychological prob-

lems than children who have not been associated with armed militia and recommend that the DDR programme for children should be combined with the programme for adults (Chobrok, 2005).

Children with Disabilities

Children with Physical Disabilities. The high level of malnutrition, birth complications, accidents and untreated medical conditions in Afghanistan gives rise to high numbers of disabled children. According to the most recent, carefully conducted survey by Handicap International (2005), there are an estimated 196,000 school-aged children with disabilities in Afghanistan; less than one in four of them attend school. Children with disabilities have traditionally been seen as less worthy of social investment, which leads to exclusion of disabled children from services (Turmusani, 2004). Disabled children and adults also show more signs of mental distress than others (Bakhshi, Trani, & Noor, 2006). Increasing access to education in Afghanistan over the last decade has not significantly reduced the marginalisation of children with disabilities (Trani, Bakhshi, & Nandipati, 2012).

According to the United Nations Mine Action Centre for Afghanistan (UNMACA), Afghanistan has one of the highest landmine casualty figures in the world. About 70,000 Afghans have either been killed or disabled by landmines in the past two decades. Children are especially vulnerable to injury from these weapons, often in the course of performing everyday chores such as gathering wood, tending livestock and collecting water for their families. While overall annual figures for new mine victims are decreasing, the number of victims under 18 years is increasing (ICBL, 2007). In addition, UXO is easily mistaken by children for a toy or an interesting object to investigate. In a study in Kabul in 1995, roughly 85 % of all UXO victims were children (Save the Children USA, 2003).

There is no systematic research on the mental or psychosocial consequences of injuries due to landmines or UXO on children in Afghanistan. The effects are assumed to be profound as illustrated in this quote from a report by Save the Children on the subject:

> I feel miserable. I can't play football with my friends anymore or help my mother bring up water from the well. Why has this happened to me? I am so disappointed with my life. I don't understand why this has happened. (10-year-old Ali; he lost one leg while the other was severely injured.)

Children with Intellectual Disabilities. A nationwide epidemiological survey on disability found a point prevalence of 0.11 % for learning disabilities (Trani & Bakhshi, 2006). The case identification was through self-report by family members, who were asked if there was a member in the household who had delayed/slower speaking ability or delayed walking/mobility development compared to other members of the family, or who demonstrated behaviour that did not correspond to their given age. In neighbouring Pakistan using a less restricted definition, the prevalence of mental retardation was found to be considerably higher than in industrialised countries: nearly one in 50 children had severe mental retardation and one in 15 mild mental retardation (Durkin, Hasan, & Hasan, 1998). Many of the risk factors for mental retardation in the Pakistan study are present in Afghanistan: perinatal difficulties, consanguineous marriages, high rates of neonatal infections, postnatal brain infections (cerebral malaria), malnourishment of pregnant women and young children, and head trauma. The difficult living conditions faced by many Afghan families, including poor nutrition, hygiene and health care, lead to many developmental problems in children. Excessive numbers of infants are born with congenital abnormalities, which are probably the result of maternal malnutrition during early foetal development. Developmental milestones are significantly delayed for many Afghan children (Miller, Timouri, Wijnker, & Schaller, 1994; Prasad, 2006).

Violence Against Children

Domestic Violence Against Children. In Afghanistan violence in families is widespread, and beating children is, in general, not consid-

ered immoral when it is not excessive. The Afghan Independent Human Rights Commission (AIHRC) has drawn attention to the high level of domestic violence reported by children in both rural and urban areas. In one study, over half of the children interviewed by AIHRC reported experiencing physical violence at home; the report authors also point out that as many children were worried about answering the question, rates of domestic violence are likely to be underreported (AIHRC, 2007b). In her study of children in two schools in poor neighbourhoods in Kabul, Catani et al. (2008) found that while 39 % of respondents had directly experienced war-related events, 10 % reported having suffered at least one injury due to maltreatment at home. Children had experienced an average of 4.3 different types of domestic violence, with most children reporting three or more event types. Predictors of domestic violence included a history of experiencing war trauma, family size, engagement in child labour and poverty.

Smith (2008) interviewed Afghan adults about their views on and experience of violence against children in the home, and found that they identified two distinct categories: violence used as a means of disciplining children and violence resulting from adult anger, stress or frustration. In the communities where the research was carried out, violence towards children by family members is accepted and widely practised. Much violence directed at children relates to how the adult is feeling, with adults under stress venting their anger on their children. Many people would be keen to adopt nonviolent means for disciplining their children but do not know how:

> Beating children also is not good. When I had my first daughter I beat her a lot when she was very small but now I know that we should not beat children because they do not understand. So parents should not beat their children. But when my husband fights with me and I'm angry I beat my children. And when I'm tired from doing housework I beat my children very hard if they do not listen to me. Once I had washed the clothes and it was three thirty and I was very tired. My husband had been doing construction work at home. When I finished the clothes and without giving me any break to drink tea, he asked me to cook food for dinner. I said ok after having some tea I will cook. But he didn't listen to me and asked me to cook food now. I became angry and did not say anything to him. At the same time my son came to me and I asked him to wash his face, I told him to take water and wash his face but he didn't listen to me and asked me to do it. I was angry with my husband, but I couldn't say anything to him so I took a big stone and I threw it at my son and shouted to him, do what I am telling. I am not your servant. Unfortunately, the stone broke one of his teeth and his mouth was bleeding. (Mother of a six-year-old son; Smith, 2008: 51)

Women in the large-scale study by Eggerman and Panter-Brick (2010) recounted similar experiences of becoming violent due to frustration with their circumstances:

> My husband is a driver, but he doesn't own the car he drives, so he has to give a large part of what he earns to the owner. We have to share a house with four other families, we live in the separate rooms of the house and it's difficult. My mind gets weaker and weaker, and I get upset and beat the kids. Yesterday I beat my daughter, then I felt bad about it and slapped myself on the face. (Woman, aged 28; Eggerman & Panter-Brick, 2010:75)

Prospective data, from a baseline and follow-up study, have most clearly shown the impact of domestic violence on child mental health: while cross-sectional data only point to associations between variables, longitudinal data can assess the relative causal impact of different types of violence and socio-economic stressors. In their follow-up study, Panter-Brick and colleagues concluded that violence inside the family was the most critical predictor of mental health trajectories, even in the context of exposure to extraordinary levels of collective violence (Panter-Brick et al., 2011; Panter-Brick & Eggerman, 2012). The quality of past-year family relationships was key to changes in depression and other psychiatric difficulties: domestic violence (reported as stressful), severe beatings (reported as trauma) and family conflict predicted worse outcomes, while family 'harmony and unity' (Dari: *ittifaq* and *wahdat*)—a sense of family cohesion and connectedness—predicted better outcomes. By contrast, exposure to militarised violence had no discernable impact on mental health changes over the period of study. Thus family environments

may outweigh collective violence in predicting psychiatric burden, including depressive symptoms (but not post-traumatic stress, for which lifetime trauma exposure trumped all other risk and protective factors). Family relationships are also central to developmental resilience, as evidenced by better-than-expected prospective mental health outcomes.

Sexual Violence Against Children. In Afghanistan it is very difficult to find information on sexual abuse of children. Most information is from press reports or anecdotal accounts as no official statistics are available (IRIN, 2007, 2008). Sexual abuse against a child is considered an offence against the honour of the family and not specifically a crime against the child itself (Slugget, 2003). Among Afghans, child abuse is thought to affect boys more frequently than girls, as the latter are supposed to be protected within the safety of their homes; abuse of girls is therefore a particularly 'taboo' subject, and hidden within the family.

Worldwide, marriages involving underaged girls show higher rates of mother and child mortality, due to problems during labour, miscarriages or unsafe abortions, and also higher risk for infertility in the mother and disability for their infants (WHO, 2009). Medical reports in Afghanistan suggest that reproductive health problems of young women constitute a health burden, with case reports of girls as young as 12 years presenting with vaginal and anal bleeding resulting from early consummation of marriage (WCRWC, 2002).

In Afghanistan, the unavailability of female sexual partners for men outside of marriage seems to provoke the use of young boys as sexual partners. In a cross-sectional sample of 4,750 men (ages 18–35) in the recruitment process for the Afghan National Army, 18.3 % reported having had sexual relations with boys. Very few of them (2.6 %) reported ever using condoms in such contacts (Todd, Macdonald, et al., 2012; Todd, Nasir, et al., 2012). Traditionally, the 'keeping' of handsome boys is a marker of status and prestige for men. The practice visibly continues today, with militia commanders and other important leaders accompanied by teenage 'tea boys,' and truck drivers by a young assistant referred to as a 'wife'. Khan (2009) reports the story of a boy whose father died when he was 5 years old, and whose mother remarried and sent him to live with his grandmother; the latter asked him to collect wood to sell in order to contribute to her household income:

> Some people were giving me money and started to sexually use me. I was happy with that because it was the easiest way to have money for my grandmother. Now it is my business, even if it is shameful. If there is another alternative, I will stop it. (Schoolboy in Kabul; cited in Khan, 2009)

Severe sexual violations against boys are thought to be most common in south and southeast of the country (FICF, 2004) but are also well known in the north. There is also evidence of young male adolescents being systematically exploited and sexually abused by tribal leaders, militia commanders or other powerful men, as part of a practice known as *bacha bazi* [lit. 'playing with boys']. Often poor and orphaned, these boys are bought by older men to dance at parties, and are sexually abused by them afterwards; such gatherings also serve as marketplaces, with good-looking boys being traded by their 'owners' for money. In 2008 the US Department of State Bureau of Democracy, Human Rights, and Labor concluded that 'child abuse was endemic throughout the country, ranging from general neglect, physical abuse, abandonment, and confinement to work in order to pay off family debts,' and that 'sexual abuse of children remained pervasive' (USDS, 2008).

Children in Detention

The majority of children in detention are male (75 %), and a significant number are in custody for minor offences or are illegally detained (AIHRC, 2008). Children face jail for 'moral' offences, such as sodomy or adultery for boys, and running away from an oppressive home life for girls. For adults in the prison system, torture is reported as routine procedure, particularly to gain a confession. Conditions in government jails are poor, and there is a lack of adequate legal representation for children, as well as a history of corruption in the judicial process. Moreover, children—particularly boys—are likely to experience violence when arrested (AIHRC).

Services to Assist Afghan Children and Youth

Psychosocial well-being of children can be affected by traumatic events and by daily stressors. Traumatic stressors may include war-related events, but also family conflict and community-level violence not directly related to war (Panter-Brick et al., 2009). Daily stressors consist of social and economic hardships in everyday life, related to physical ill health, malnutrition, crowding, unemployment, low wages, illiteracy and gender-based discrimination including domestic violence, social isolation and barriers to equitable access to health, educational and vocational resources (Arntson, 2001; De Berry et al., 2003; Miller, Omidian, Rasmussen, Yaqubi, & Daudzai, 2008; Omidian & Miller, 2006). Thus, the call from public health advocates for a population-based, youth-focused model, which explicitly integrates mental health with other health and welfare initiatives in low- and middle-income countries (Patel et al., 2007), is highly relevant for Afghanistan.

Successful mental health and psychosocial support programming in Afghanistan has to take into account the complex political, socio-economic and cultural situation of the country. It is hard to build sustainable systems of care, and in Afghanistan this requires taking community variation into account in the design, implementation and evaluation of programme initiatives. It requires collaboration with organisations and groups at community and district level, and with formal structures such as ministries and programmes at national and provincial level. Interventions have to address huge gaps between national-level policies and local priorities in the lives of ordinary people. Community relations with the outside world and regional political elites are often mediated through personal relationships with powerful decision-making 'key figures' at the national level. Until these higher-level elites are willing to allow transformation of existing power relations, it will be difficult to change social systems where change is required to meet the goals of quality and equity in access to basic services, and the effectiveness ability of programmes will be limited. Given this situation, a step-by-step approach and a willingness to work with existing community-based and governmental structures is required. Effort must be put into the creation of networks and the nurturing of collective action to improve the lives of Afghan children and their families.

Several organisations provide services for Afghan children; however, existing initiatives are fragmented, and many extant programmes are in the embryonic stage at best. Such efforts are often initiated and run by international NGOs and reach relatively small numbers of targeted groups; they may not be firmly rooted in Afghan social structures and may not prove to be sustainable. International consensus documents such as the IASC guidelines on mental health and psychosocial support in emergency settings (IASC, 2007) recommend that services must be connected within a multi-layered support system, in order to cater for a range of people affected in different ways who may require different kinds of mental health and psychosocial support (Fig. 5.1). We will provide an overview of existing initiatives in terms of this framework of interrelated services.

A small percentage of people experience intolerable suffering and have significant difficulties in daily function; they would need access to clinical, psychological, psychiatric or other highly specialised supports. A majority of people manage to cope with difficulties and distress through access to local, non-formal support systems bolstered by the re-establishment of adequate security, governance and services that meet basic survival needs. In between these extremes are people affected by disruptions in key family and community support networks, who will benefit from efforts such as tracking down missing family members and effecting a reunification, communal healing ceremonies, formal and non-formal education, livelihood activities and the strengthening of hope and social capital (Jordans, Tol, Komproe & de Jong, 2009; Jordans, Tol, et al., 2010; Wessells & Van Ommeren, 2008).

Layer 1: Basic Services and Security

The most important interventions to improve mental health and psychosocial well-being for

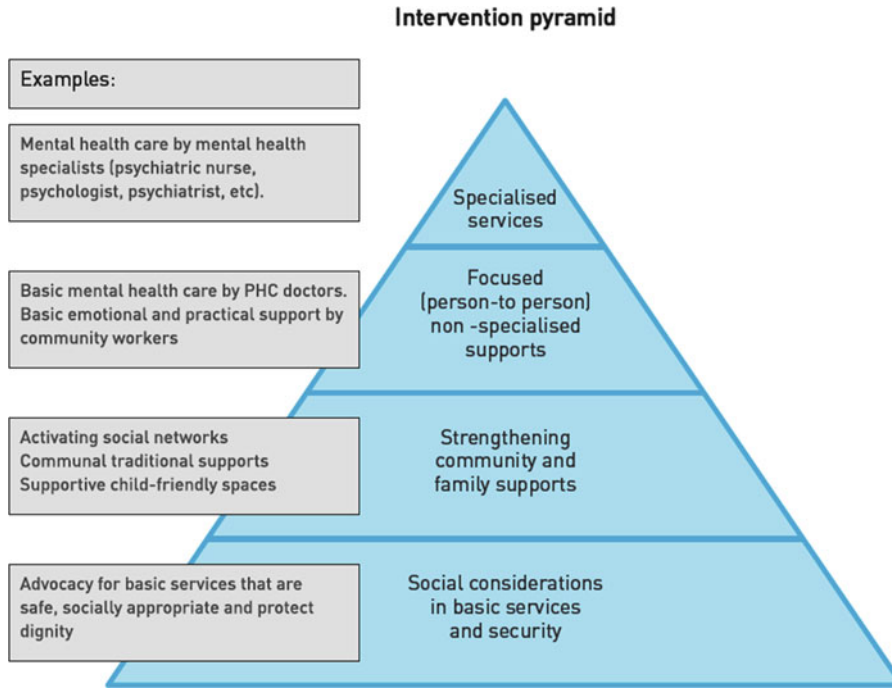

Fig. 5.1 Intervention pyramid for mental health and psychosocial support (IASC Reference Group MHPSS, 2010)

Afghan children and youth have apparently nothing to do with psychosocial support and mental health care. The best guarantee for improved mental health status is the normalisation of living circumstances and the alleviation of severe problems resulting from poverty and insecure livelihoods. Programmes to promote income generation and reduce children's workloads will have direct beneficial effects on children and their families. The development of infrastructure, health and educational services are important elements of the reconstruction of Afghanistan, as well as initiatives that bring together youth, local communities and stakeholders to increase general child safety, as exemplified by demining and road safety campaigns (De Berry, 2008).

Example: *Building water wells improves psychosocial well-being*

An important impediment to healthy psychosocial development is ongoing violence and political instability. The continued violence between anti-government insurgents and pro-government forces, including foreign military troops, prevents a normalisation of life for many Afghans. In particular, attacks by Taliban on schools catering for girls and other public services for women increase the sense of insecurity among the population. Loughry et al. (2005) present a salient illustration of the importance of providing basic needs to improve psychosocial well-being. Using a quasi-experimental design, the project compared the effects after 9–14 months of a 'psychosocial' intervention, consisting of child-centred spaces and activities facilitated by Child Well-Being Committees (described below in layer 2) with an intervention to improve basic services: a water sanitation programme consisting of the construction of wells using a participatory process. A questionnaire-based measure indicated that the water intervention had greater impact on children's well-being than the psychosocial intervention.

Layer 2: Community and Family-Level Support

The second layer represents services to enable people to maintain good mental health and psychosocial well-being by accessing key community and family support (Van Mierlo, 2012). In the Afghan context, appropriate activities for children and youth might consist of promoting alternative disciplining techniques and providing child-rearing support. Examples include awareness-raising workshops for parents, teachers or local religious leaders, involving adolescents in meaningful activities to prevent substance abuse, training community members to better provide psychosocial support, and discouraging child abuse and maltreatment, social exclusion, gender discrimination and domestic violence. Further options include the activation of social networks through youth clubs or the development of recreational spaces to provide opportunities for sharing experiences and mutual learning. A similar approach is the promotion of 'child-centred spaces', places where children who have often lived with war all their lives can resocialise through play and education in the norms and values of peaceful Afghan society (Snider & Triplehorn, 2003). We give two examples of interventions offering community-level and family support undertaken in Afghanistan:

Example: *Child Well-Being Committees*, *giving children a voice in decision-making*

Since 2002, three major international NGOs (Child Fund Afghanistan, Save the Children USA and International Rescue Committee) formed the Consortium for the Psychosocial Care and Protection of Children, with the objective to 'improve, in a sustainable manner, the psychosocial well-being and development opportunities of Afghan children, enabling primary and secondary stakeholders to cope better with the effects of a poverty-stricken, protracted conflict environment through participatory, community-based programming' (USAID/DCOF, 2007). The backbone of this approach is the establishment of Child Well-Being Committees, consisting of a mixed group of children, adolescents and adults that aim to mobilise, monitor and guide child protection efforts. The committees address a variety of issues relevant to children such as health and hygiene, child protection, parenting skills and monitoring the protection of vulnerable children in the community. During evaluations in 2005, children felt safer, went to school more often, made friends with children from other ethnic groups and—according to their parents—exhibited better behaviour (Loughry et al., 2005). A 2006 follow-up revealed significant changes in children's self-reported behaviours: negative behaviours such as fighting with and hitting other children declined. In remote Faryab province, girls reported a dramatic increase in their ability to speak up in a group. This finding was corroborated by reports from community members, one of whom described the children as follows:

> *They are aware of their rights. They know things in the right ways. They are able to prepare songs and poems and [know] how to gather information about the problems in the community. The change is positive. Children share information with other children and attempt to have the other children involved in the activities. Children will know what to do when they are adults, how to resolve problems and to allow children to participate* (Women's Community Committee Member; USAID/DCOF, 2007).

Example: *Promotion of physical education and play in schools and communities*

The NGO 'War Child Holland' implemented psychosocial activities in schools and in communities throughout Herat and Kabul (Ventevogel, van Huuksloot & Kortmann, 2005). A component of this programme was getting non-school-attending working children back to school. Communities are encouraged to develop children's clubs as a means through which issues affecting children could be identified, explored and addressed through subsequent advocacy campaigns. The programme used community-relevant indicators related to social change, such as increased opportunities to meet peers and escape from isolating and monotonous home-based activities, improved balance between work-related responsibilities and leisure activities, less violent games (which often trigger

memories of conflict), more positive interactions between children, the understanding and acceptance by adults of children's right to play, and the importance of play for child development and well-being. A 2006 evaluation of the school- and community-based work found that there has been an increase in parent's support for children's play and learning. Girls in particular had received increased support from adults to play and attend school; many girls had not been permitted to play before. The attendance of girls and working children in learning activities was seen as a clear expression of increased support, as some of these required a small fee from parents for participation. As one mother stated:

> *I have five daughters and they are all involved in the NGO activities. They are in different courses and they are learning things like tailoring and English. We have an activity now. We did not have any when we were in Iran, because they looked down on us because we are Afghans. Now I am happy that my daughters can learn things that I could not. We want to open first aid and beauty classes. We are also learning table tennis* (Woman in Herat Province; report by War Child Holland, 2007).

Layer 3: Focused Nonspecialised Supports

The third layer consists of focused support for people who require individual, family or group interventions by trained and supervised workers who are not necessarily specialists in mental health and psychosocial support. Interventions within this layer can include a system of caseworkers who provide psychosocial support to families and individuals. In Afghanistan, HealthNet TPO has developed community-based psychosocial work using para-professional psychosocial workers as the backbone of the service (HealthNet, 2008a). Structured psychosocial group interventions for children and youth with symptoms of moderate distress have not been documented for Afghanistan, but there is some evidence for its effectiveness in other settings (Bolton et al., 2007; Jordans, Komproe, et al., 2010; Jordans, Tol, et al., 2010; Tol et al., 2008). Organising such services requires a long-term commitment by skilled helpers to ensure appropriate follow-up support, ongoing training and supervision. Omidian and Lawrence (2007) describe how they use 'focusing' self-therapy—a therapeutic technique of 'bringing attention to the body in a gentle, accepting way and becoming aware of felt sensations, leading to insight, physical release and positive life change'—which connects well with the rich Afghan heritage of Islamic Sufi philosophy and Farsi poetry.

Example: *Helping school teachers to provide psychosocial support*

In Afghanistan many teachers have no notion of teaching beyond academic instruction and lack the necessary skills to promote the social and emotional development of children. Organisations such as Save the Children USA and UNICEF have made an effort to integrate training on psychosocial support into the primary school teacher curriculum. With approval of the Afghan Ministry of Education, a training module was developed on how teachers could offer psychosocial support and take measures to protect children. The module aimed to help teachers integrate traditional Afghan coping strategies for promoting emotional well-being into their work. The Ministry of Education prepared and distributed the training package to all primary school teachers in Afghanistan (De Berry, 2004). Similar approaches have been taken to train teacher in psychosocial wellness models and to enable them to provide improved psychosocial support to children in the classroom (Omidian, 2012; Omidian & Papadopoulos, 2003).

Layer 4: Specialised Services

The pyramid's top layer represents specialised interventions required for a small percentage of people with severe psychological complaints or mental disorders. Appropriate interventions include services to treat substance abuse in adolescents, and the identification and treatment of severely depressed children. Afghanistan does not have specialised services for child psychiatry or child psychology (Ventevogel, Nassery, Azimi, & Faiz, 2006; Rahimi & Azimi, 2012).

Institutional mental health services hardly exist, with just one national mental health hospital and four psychiatric wards in general hospitals. The proportion of child and adolescent users of these mental health services is low (WHO-AIMS, 2006). Given the extreme scarcity of Afghan mental health professionals and limited financial resources, the establishment of specialised mental health services for children in the country still has a long way to go.

The World Health Organization advocates the inclusion of mental health services within existing primary health care services (WHO, 2008). This entails training health care workers to identify mental, neurological and substance use disorders, installing a system of clinical supervision and regular medication supply, and promoting awareness-raising activities in communities. In Afghanistan this approach has been developed by NGOs such as HealthNet TPO in eastern Afghanistan and the International Assistance Mission (IAM) in the western provinces around Herat (Ventevogel et al., 2012; Ventevogel, Faiz, & van Mierlo, 2011; Ventevogel & Kortmann, 2004).

Afghan NGOs such as Windows for Life (WFL), Humanitarian Organization Supporting Afghans (HOSA) and Medica Mondiale provide psychosocial services through psychosocial counsellors who have had intensive training in a variety of counselling techniques and are extensively supervised. These services are not specifically geared towards children and adolescents. A recent randomised control trial among Afghan women ($n=61$), diagnosed with poor mental health symptoms by local physicians, compared the impact of routine medical treatment (treatment as usual) with psychosocial counselling (for 5–8 sessions) following a purposively developed protocol. At 3-month follow-up, the patients who had received psychosocial counselling showed a drastic decrease in symptoms of depression and anxiety and an enhancement of coping strategies, while no such improvements were seen in the control group (Ayoughi, Missmahl, Weierstahl, & Elbert, 2012).We may conclude that adding psychosocial services into the basic health care services of Afghanistan has proven to be both feasible and effective. Yet there is still a long road ahead, despite the impressive progress made to date with regard to the provision of mental health services in Afghanistan (WHO, 2013). One specific priority is tailoring mental health and social services to the needs of children and adolescents.

Conclusions

This chapter has provided a focused study of research and intervention efforts related to child mental health and well-being in Afghanistan. We reviewed the structural adversities that challenge Afghan children and adolescents, in terms of war, displacement, poverty, widening inequalities, social expectations and restricted opportunities for education and health care. We reviewed the evidence base for psychosocial distress and mental health disorders, emphasising the importance of family dynamics and the capacity for resilience. A fundamental take-home lesson from Afghanistan is that the family is a central institution shaping child health and well-being—in terms of both everyday distress and everyday resilience. Six fundamental cultural values—faith (*iman*), family unity and harmony (*wahdat* and *ittifaq*), service (*khidmat*), perseverance and effort (*koshesh*), morals (*akhlaq*), and respectability and honour (*izzat*)—underpin the sense of resilience in Afghan culture. These key values provide a moral framework to make sense of suffering, regulate social behaviour, maintain a sense of hope and human dignity, and give a sense of coherence to past experiences and future aspirations.

A second key point is that family relationships and cultural values are themselves a driver of poor mental health, where war, poverty and discrimination steal away the wherewithal to realise economic and social milestones. Family relationships become marred by conflict, while ambitions to adhere to cultural values are frustrated by dire poverty or powerlessness—this drives ordinary people into a sense of entrapment, especially with regard to cultural dictates governing reproductive and economic decisions. Such drivers of psychological distress and social entrapment are especially relevant for children who are forcibly married, children in forced labour, children with physical or intellectual disabilities, children who face domestic or sexual violence, and children

using illicit drugs or resorting to self-injury. 'Everyday stressors', rooted in poverty and violence, generate lasting psychological distress in children and adolescents, over and above the more dramatic forms of trauma associated with the brutality of war.

The implication of such research findings is that structural injustices in Afghanistan (including gender and ethnic discrimination, lack of stable employment opportunities and exposure to violence) need to be addressed through a multilevel system of interventions that cuts across sectors of health, education, employment and social work. Indeed, with respect to child mental health, policy-makers, researchers and practitioners have begun to move well beyond a primary consideration of the acute negative impacts of war-related violence. Efforts to design integrated, effective and equitable access to basic health, social and economic services are still fragmented, but there is a sense that real progress has been made to date, and that formal evaluation of concrete initiatives will provide an important next step towards the consolidation of basic service provision. Because education is often perceived as the gateway to social and economic success, and because Afghans often express hope in the future in terms of social prominence and economic milestones, initiatives to improve the quality of education are crucially important. Other interventions have focused on livelihoods and community governance, such as building wells and establishing child-centred spaces. Yet other programmes have been concerned with fostering community-based psychosocial support, including training psychosocial workers or group interventions based on therapeutic techniques such as focusing. This is a rich tapestry of interventions but one that needs better integration in existing systems in such a way that sources of resiliency are strengthened rather than undermined.

The best way forward is to answer to the simple logic of a pyramid structure with interconnected layers of interventions: the bottom layer of the pyramid encompasses initiatives for equitable access to broad-based services such as health care, education and shelter. The middle layers of the pyramid focus on activities aimed to strengthen coping and resilience in families and local communities, and initiatives that enable community-based health workers and teachers to assist children who present psychosocial problems that cannot be handled with simple family or community support. Specialised *clinical* interventions, constituting the very top of the pyramid, target children and adolescents with severely disabling mental disorders and substance use disorders, who cannot be adequately supported within other layers of the service system.

We believe it is essential to view services provision within such a broad perspective to ensure that culturally relevant interventions to improve mental health and psychosocial well-being encompass efforts to build resilience, rather than just focus on at-risk groups of children. Building resilience in Afghanistan entails strengthening families and communities, addressing the main factors which weaken helpful social ties: poor governance, economic and political insecurity, severe overcrowding, recurrent domestic violence and unequal opportunities for education and advancement. We therefore call for broad community-oriented approaches to address issues of mental health and psychosocial well-being, giving specific attention to the physical needs and social aspirations of children and adolescents. To be successful, such initiatives are best embedded in a multi-sectoral approach that addresses larger issues pertaining to poverty reduction, environmental safety, quality health and education, family dynamics and stability of governance, livelihoods and social structures—a matter of securing a stable future and dignity at the most crucial social level, that of the family.

Summary Points

- The study of psychosocial distress in children and adolescents in Afghanistan needs to consider the critical importance of 'everyday' adversity rooted in poverty and domestic violence and not merely focus on the direct effects of military violence.
- The bedrock of resilience is hope, underpinned by cultural values which provide a moral

framework to cope with life adversity; however, the pursuit of these cultural values may foster a sense of entrapment.
- Family is the most important context for child well-being, distress and resilience. Children in especially difficult circumstances confront early marriage, forced labour, curtailed education, domestic or sexual violence, disabilities, self-injury and illicit drugs.
- To build upon concrete but still-fragmented efforts to improve child mental health in Afghanistan, interventions need to address the structural drivers of psychosocial distress, address the impact of family-level violence as well as military conflict, assist families and communities to cope with psychosocial problems and integrate specialised mental health interventions within general health care, social and educational service provision.

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References

Afghanistan Human Development Report. (2007). *Bridging modernity and tradition—Rule of law and the search for justice*. Kabul: Centre for Policy and Human Development.

AIHRC. (2006a). *Evaluation report on the general situation of women in Afghanistan*. Kabul: Afghanistan Independent Human Rights Commission. Retrieved from http://www.aihrc.org.af/Evaluation_Rep_Gen_Sit_Wom.htm. Accessed 16 January 2009.

AIHRC. (2006b). *An overview on situation of child labour in Afghanistan*. Kabul: Afghanistan Independent Human Rights Commission. Retrieved from http://www.aihrc.org.af/reports_eng.htm. Accessed 16 January 2009.

AIHRC. (2007a). *The general situation of children in Afghanistan*. Kabul: Afghanistan Independent Human Rights Commission. Retrieved from http://www.aihrc.org.af/reports_eng.htm. Accessed 16 January 2009.

AIHRC. (2007b). *Economic & social Rights in Afghanistan II*. Kabul: Afghanistan Independent Human Rights Commission. Retrieved from http://www.aihrc.org.af/reports_eng.htm. Accessed 16 January 2009.

AIHRC. (2008). *Justice for children. The situation of children in conflict with the law in Afghanistan*. Kabul: Afghanistan Independent Human Rights Commission.

Arntson, L. (2001). *Review of psychosocial support activities in the former soviet embassy compound IDP camp*. Kabul: Save the Children.

Arur, A., Peters, D., Hansen, P., Mashkoor, M. A., Steinhardt, L. C., & Burnham, G. (2010). Contracting for health and curative care use in Afghanistan between 2004 and 2005. *Health Policy and Planning, 25*, 135–144.

Ayoughi, S., Missmahl, I., Weierstahl, R., & Elbert, T. (2012). Provision of Mental Health Care Services in Resource-Poor Settings: A randomised trial comparing counselling with routine medical treatment in North Afghanistan. *BMC Psychiatry, 12*, 14.

Bakhshi, P., Trani, J. F., & Noor, A. A. (2006). *Towards wellbeing for Afghans with disability: The health Challenge: National Disability Survey Afghanistan 2005*. Lyon/Kabul: Handicap International.

Behnam, S., & Afzali, S. (2006). *Afghan Drug Boom Fuels Child Addiction Rates*. Institute for War and Peace Reporting (IWPR). Retrieved from http://www.iwpr.net. http://iwpr.net/?p=arr&s=f&o=325631&apc_state=heniarr2006. Accessed 2 January 2008.

Billaud, J. (2012). Suicidal performances: voicing discontent in a girls' dormitory in Kabul. *Cult Med Psychiatry, 36*(2), 264–285.

Bolton, P., & Betancourt, T. S. (2004). Mental health in postwar Afghanistan. *Journal of the American Medical Association, 292*, 626–628.

Bolton, P., Bass, J., Betancourt, T., Speelman, L., Onyango, G., Clougherty, K. F., et al. (2007). Interventions for depression symptoms among adolescent survivors of war and displacement in Northern Uganda. *Journal of the American Medical Association, 298*, 519–527.

Catani, C., Schauer, E., & Neuner, F. (2008). Beyond individual war trauma: Domestic violence against children in Afghanistan and Sri Lanka. *Journal of Marital and Family Therapy, 34*, 165–176.

Catani, C., Schauer, E., Elbert, T., Missmahl, I., Bette, J.-P., & Neuner, F. (2009). War trauma, child labor, and family violence: Life adversities and PTSD in a sample of school children in Kabul. *Journal of Traumatic Stress, 22*, 163–171.

Chobrok, V. (2005). *Demobilizing and reintegrating Afghanistan's young soldiers* (Rep. No. Report 42). Bonn, Germany: BICC.

Coalition to Stop the Use of Child Soldiers. (2008). *Child Soldiers Global Report 2008*. London: Coalition to Stop the Use of Child Soldiers.

De Berry, J., Fazili, A., Farhad, S., Nasiry, F., Hashemi, S., & Hakimi, M. (2003). *The children of Kabul: Discussions with Afghan families*. Kabul: Save the Children USA and UNICEF.

De Berry, J. (2004). Community psychosocial support in Afghanistan. *Intervention, 2*, 143–151.

De Berry, J. (2008). The challenges of programming with youth in Afghanistan. In J. Hart (Ed.), *Years of conflict: Adolescence, political violence and displacement* (pp. 209–229). New York: Berghahn.

De Jong, E. (1999). *Mental health assessment, Ghurian and Zendah Jan districts, Herat province, Afghanistan*. Brussels, Belgium: Médecins Sans Frontières.

Donini, A. (2007). Local perceptions of assistance to afghanistan. *International Peacekeeping, 14*(1), 158–172.

Dupree, L. (1980). *Afghanistan*. Princeton, NJ: Princeton University Press.

Dupree, N. H. (2004). The family during crisis in Afghanistan. *Journal of Comparative Family Studies, 35*, 311–331.

Durkin, M. S., Hasan, Z. M., & Hasan, K. Z. (1998). Prevalence and correlates of mental retardation among children in Karachi, Pakistan. *American Journal of Epidemiology, 147*, 281–288.

Edward, A., Dwivedi, V., Mustafa, L., Hansen, P. M., Peters, D. H., & Burnham, G. (2009). Trends in the quality of health care for children aged less than 5 years in Afghanistan, 2004-2006. *Bulletin of the World Health Organization, 87*, 940–949.

Eggerman, M., & Panter-Brick, C. (2010). Suffering, hope, and entrapment: Resilience and cultural values in Afghanistan. *Social Science & Medicine, 71*, 71–83.

Fergusson, J. (2010). *Taliban*. London: Bantam Press.

FIFC. (2004). *Human security and livelihoods of rural Afghans, 2002–2003*. Boston: Feinstein International Famine Center Youth and Community Program Tufts University.

Gupta, L. (1997). *Psychosocial assessment of children exposed to war related violence in Kabul*. Kabul: UNICEF.

HealthNet TPO. (2008a). *Rehabilitation through Psychosocial care: Consolidation and further development of the psychosocial program in Afghanistan*. Amsterdam: HealthNet TPO.

HealthNet TPO. (2008b). *Psychosocial and Mental Health Assessment of Children in Afghanistan, July to September 2008*. Kabul: Amsterdam: HealthNet TPO Afghanistan.

HealthNet TPO. (2008c). *Psychosocial and Mental Health Needs Assessment in Uruzgan, Afghanistan*. Kabul, unpublished report submitted to the Dutch Consortium for Uruzgan II (DCU-II). Amsterdam: HealthNet TPO.

Hoodfar, H. (2008). The long road home: Adolescent Afghan refugees in Iran contemplate 'return'. In J. Hart (Ed.), *Years of conflict. Adolescence, political violence and displacement* (pp. 165–187). New York: Berghahn.

HRW. (2004). *Afghanistan: Child soldier use. Briefing for the 4th UN Security Council open debate on children and armed conflict*. New York: Human Rights Watch.

IASC. (2007). *IASC guidelines on mental health and psychosocial support in emergency settings*. Geneva: Inter-Agency Standing Committee.

IASC Reference Group MHPSS. (2010). *Mental health and psychosocial support in humanitarian emergencies: What should humanitarian health actors know?* Geneva: Inter-Agency Standing Committee Reference Group for Mental Health and Psychosocial Support in Emergency Settings.

ICBL. (2007). *Factsheet Afghanistan*. International Campaign to Ban Landmines. Retrieved from http://www.icbl.org/lm/2007/afghanistan. Accessed 27 December 2007.

IRIN. (2006). *Desperate women choose suicide*. Reuters AlertNet, November 29, 2006.

IRIN. (2007). *War, poverty and ignorance fuel sexual abuse of children*. (Kandahar) 6 June, 2007.

IRIN. (2008). *Little support for victims of child sexual abuse*. (Kabul) 16 June, 2008.

Izutsu, T., Tsutsumi, A., Sato, T., Naqibullah, Z., Wakai, S., & Kurita, H. (2005). Nutritional and mental health status of Afghan refugee children in Peshawar: A descriptive study. *Asia-Pacific Journal of Public Health, 17*, 93–98.

Jordans, M. J. D., Tol, W. A., Komproe, I. H., & de Jong, J. T. V. M. (2009). Systematic review of evidence and treatment approaches: Psychosocial and mental health care for children in war. *Child and Adolescent Mental Health, 14*, 2–14.

Jordans, M. J., Tol, W. A., Komproe, I. H., Susanty, D., Vallipuram, A., Ntamatumba, P., et al. (2010). Development of a multi-layered psychosocial care system for children in areas of political violence. *International Journal of Mental Health Systems, 16*(4), 15.

Jordans, M. J. D., Komproe, I. H., Tol, W. A., Kohrt, B., Luitel, N., Macy, R. D. M., et al. (2010). Evaluation of a classroom-based psychosocial intervention in conflict-affected Nepal: A cluster randomized controlled trial. *Journal of Child Psychology and Psychiatry, 51*, 818–826.

Kanji, Z., Drummond, J., & Cameron, B. (2007). Resilience in Afghan children and their families: A review. *Paediatric Nursing, 19*, 30–33.

Karlsson, P., & Mansory, A. (2007). *An Afghan dilemma: Education, gender and globalisation in an Islamic context. Studies in International and Comparative Education 72*. Stockholm: Institute of International Education at Stockholm University.

Kassam, A., & Nanji, A. (2006). Mental health of Afghan refugees in Pakistan: A qualitative rapid reconnaissance field study. *Intervention, 4*, 58–66.

Khan, S. (2009). *Rapid assessment of male vulnerabilities to HIV and sexual exploitation in Afghanistan. Final Report*. London: Naz Foundation International.

Layne, C., Waren, J., Watson, P., & Shalev, A. (2007). Risk, vulnerability, resistance, and resilience: Towards an integrative conceptualization of posttraumatic adaptation. In M. Friedman, T. Keane, & P. Resick (Eds.), *Handbook of PTSD* (pp. 497–520). London: Guilford Press.

Loughry, M., Macmullin, C., Eyber, C., Ababe, B., Ager, A., Kostelny, K., et al. (2005). *Assessing Afghan Children's psychosocial well-being. A multimodal study of intervention outcomes*. (Unpublished report) CCF, Oxford University, Queen Margaret University. http://www.forcedmigration.org.

Mann, C. (2006). Les shahidé du monde traditionnel: le suicide des jeunes filles afghanes. *Recueil Alexandries, Collections Esquisses*. Retrieved from http://www.reseau-terra.eu/article439.html. Accessed 2 August 2012.

Medica Mondiale. (2007). *Dying to be heard: Self-immolation of women in Afghanistan. Findings of a research project*. Kabul: Medical Mondiale.

Miller, K. E., Kulkarni, M., & Kushner, H. (2006). Beyond trauma-focused psychiatric epidemiology: Bridging research and practice with war-affected populations. *The American Journal of Orthopsychiatry, 76*, 409–422.

Miller, K. E., Omidian, P., Quraishy, A. S., Quraishy, N., Nasiry, M. N., Nasiry, S., et al. (2006). The Afghan symptom checklist: A culturally grounded approach to mental health assessment in a conflict zone. *The American Journal of Orthopsychiatry, 76*, 423–433.

Miller, K. E., Omidian, P., Rasmussen, A., Yaqubi, A., & Daudzai, H. (2008). Daily stressors, war experiences, and mental health in Afghanistan. *Transcultural Psychiatry, 45*, 611–638.

Miller, L. C., Timouri, M., Wijnker, J., & Schaller, J. G. (1994). Afghan refugee children and mothers. *Archives of Pediatrics & Adolescent Medicine, 148*, 704–708.

Morris, J., van Ommeren, M., Belfer, M., Saxena, S., & Saraceno, B. (2007). Children and the Sphere standards on mental and social aspects of health. *Disasters, 31*, 71–90.

MOPH. (2009). *Basic package of health services 2009/1388*. Kabul: Ministry of Public Health.

MOWA. (2008). *Women and men in Afghanistan: Baseline statistics on gender*. Kabul: Ministry of Women's Affairs.

Omidian, P. (2012). Developing culturally relevant psychosocial training for Afghan teachers. *Intervention, 10*(3), 237–248.

Omidian, P., & Lawrence, N. J. (2007). A community based approach to focusing: The Islam and Focusing Project of Afghanistan. *Folio, Journal for Focusing and Experiential Therapy, 20*, 152–164.

Omidian, P., & Miller, K. (2006). Addressing the psychosocial needs of women in Afghanistan. *Critical Half, 4*, 17–22.

Omidian, P., & Papadopoulos, N. (2003). *Addressing Afghan children's psychosocial needs in the classroom: A case study of a training for trainers*. Peshawar, Pakistan: International Rescue Committee.

Panter-Brick, C., Eggerman, M., Mojadidi, A., & McDade, T. W. (2008). Social stressors, mental health, and physiological stress in an urban elite of young Afghans in Kabul. *American Journal of Human Biology, 20*, 627–641.

Panter-Brick, C., Eggerman, M., Gonzalez, V., & Safdar, S. (2009). Ongoing violence, suffering and mental health: A school-based survey in Afghanistan. *Lancet, 374*, 807–816.

Panter-Brick, C. (2010). Conflict, violence, and health: Setting a new interdisciplinary agenda. *Social Science & Medicine, 70*, 1–6.

Panter-Brick, C., Goodman, A., Tol, W., & Eggerman, M. (2011). Mental health and childhood adversities: A longitudinal study in Kabul Mental health and childhood adversities: A longitudinal study in Kabul, Afghanistan. *Journal of the American Academy of Child and Adolescent Psychiatry, 50*, 349–363.

Panter-Brick, C., & Eggerman, M. (2012). Understanding culture and resilience: The production of hope. In M. Ungar (Ed.), *The social ecology of resilience* (pp. 369–386). New York: Springer.

Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Mental health of young people: A global public-health challenge. *Lancet, 369*, 1302–1313.

Physicians for Human Rights. (1998). *The Taliban's war on women: A health and human rights crisis in Afghanistan*. Cambridge, MA: Physicians for Human Rights.

Prasad, A. N. (2006). Disease profile of children in Kabul: The unmet need for health care. *Journal of Epidemiology and Community Health, 60*, 20–23.

Rahimi, Y. A., & Azimi, S. (2012). War and the crisis of mental health in Afghanistan. *International Psychiatry, 9*(3), 55–57.

Raj, A., Gomez, C., & Silverman, J. G. (2008). Driven to a fiery death: The tragedy of self-immolation in Afghanistan. *The New England Journal of Medicine, 358*, 2201–2203.

Raj, A., Gomez, C. S., & Silverman, J. G. (2011). Multisectorial Afghan perspectives on girl child marriage: Foundations for change do exist in Afghanistan. *Violence Against Women, 2011*, March 29. doi:10.1177/1077801211403288.

Rasekh, Z., Bauer, H. M., Manos, M. M., & Iacopino, V. (1998). Women's health and human rights in Afghanistan. *Journal of the American Medical Association, 280*, 449–455.

Rashid, A. (2001). *Taliban: The story of the Afghan Warlords*. London: Pan Books.

Rodin, D., & van Ommeren, M. (2009). Explaining enormous variations in rates of disorder in trauma-focused psychiatric epidemiology after major emergencies. *International Journal of Epidemiology, 38*, 1045–1048.

Sabri, B., Siddiqi, S., Ahmed, A. M., Kakar, F. K., & Perrot, J. (2007). Towards sustainable delivery of health services in Afghanistan: Options for the future. *World Health Bulletin, 85*, 712–718.

Save the Children USA. (2002). *Afghanistan: Children in crisis*. Westport: Save the Children USA.

Save the Children USA. (2003). *Children and landmines*. Westport: Save the Children USA.

Sellick, P. (1998). *The impact of conflict on Afghan children*. Kabul: UNICEF/Save the Children.

Slugget, C. (2003). *Mapping of psychosocial support for girls and boys affected by child sexual abuse in four*

countries in south and central Asia. Dhaka, Bangladesh: Save the Children.

Smith, D. (2008). *Love, fear and discipline: Everyday violence toward children in Afghan families*. Kabul: Afghanistan Research & Evaluation Unit (AREU). Available at http://www.areu.org.af.

Snider, L., & Triplehorn, C. (2003). *Assessment of CCF's emergency entry program into Afghanistan: Its impact on child well-being and protection*. Richmond: Christian Children Fund.

Strang, A. B., & Ager, A. (2003). Psychosocial interventions: Some key issues facing practitioners. *Intervention, 1*, 2–12.

Tang, A. (2006). *Afghan women commit suicide by fire*. Reuters News Agency, November 18, 2006.

Todd, C. S., Macdonald, D., Khoshnood, K., Mansoor, G. F., Eggerman, M., & Panter-Brick, C. (2012). Opiate use, treatment, and harm reduction in Afghanistan: Recent changes and future directions. *The International Journal on Drug Policy, 23*(5), 341–345.

Todd, C. S., Nasir, A., Mansoor, G. F., Sahibzada, S. M., Jagodzinski, L. L., Salimi, F., et al. (2012). Cross-sectional assessment of prevalence and correlates of blood-borne and sexually-transmitted infections among Afghan National Army recruits. *BMC Infectious Diseases, 12*, 196.

Tol, W. A., Jordans, M. J. D., Kohrt, B. A., Betancourt, T. S., & Komproe, I. H. (2013). Promoting Mental Health and Psychosocial Wellbeing in Children Affected by Political Violence. Part I: Current Evidence for an Ecological Resilience Approach. In C. Fernando & M. Ferrari (Eds.), *Handbook of Resilience in Children of War* (pp. xxx-xxx). New York: Springer.

Tol, W. A., Komproe, I. H., Susanty, D., Jordans, M. J. D., Macy, R. D. M., & De Jong, J. T. V. M. (2008). Children and communal violence in Indonesia: Cluster Randomized Trial of a psychosocial school-based intervention. *Journal of the American Medical Association, 300*, 655–662.

Trani, J. F., & Bakhshi, P. (2006). *Understanding the challenge ahead: National disability survey in Afghanistan 2005*. Lyon, France: Handicap International.

Trani, J. F., Bakhshi, P., Noor, A. A., Lopez, D., & Mashkoor, A. (2010). Poverty, vulnerability, and provision of healthcare in Afghanistan. *Social Science & Medicine, 70*, 1745–1755.

Trani, J. G., Bakhshi, P., & Nandipati, A. (2012). 'Delivering' education; maintaining inequality. The case of children with disabilities in Afghanistan. *Cambridge Journal of Education, 42*, 345–365.

Turmusani, M. (2004). *Applying the minority perspective to disability in Afghanistan*. Disability World 26. http://www.disabilityworld.org.

UNDP. (2007). *Human Development Report 2007/2008*. New York: United National Development Programme.

UNESCO. (2010a). *Country programming Afghanistan 2010–2011*. Kabul: United Nations Educational, Scientific and Cultural Organization.

UNESCO. (2010b). *Education under attack*. Paris: United Nations Educational, Scientific and Cultural Organization.

UNICEF. (2005). *Investing in the children of the Islamic world*. New York: UNICEF.

UNICEF. (2011). *The state of the world's children 2011*. New York: UNICEF.

UNODC. (2005). *Afghanistan drug use survey, 2005*. Kabul: United Nations Office for Drug Control & the Ministry of Counter Narcotics of the Government of Afghanistan.

UNODC. (2009). *Afghanistan's drug use survey 2009*. Kabul: United Nations Office for Drug Control.

USAID/DCOF. (2007). *Internal evaluation integrated consortium report*. Kabul: NGO consortium for the psychosocial care and protection of children (Child Fund Afghanistan, Save the Children USA, International Rescue Committee).

USDS. (2008). *Afghanistan Country Report on human rights practices*. Washington: US Department of State—Bureau of Democracy, Human Rights, and Labor.

Van Mierlo, B. (2012). Community Systems Strengthening in Afghanistan: A way to reduce domestic violence and to reinforce women's agency. *Intervention, 10*, 134–145.

Van de Put, W. (2002). Addressing mental health in Afghanistan. *Lancet, 360*(Suppl), s41–s42.

Van Oudenhoven, N. (1979). *Common Afghan street games*. Lisse, The Netherlands: Swets & Zeitlinger.

Ventevogel, P. (2005). Psychiatric epidemiological studies in Afghanistan: a critical review and future directions. *Journal of the Pakistan Psychiatric Society, 2*(1), 9–12.

Ventevogel, P., & Kortmann, F. (2004). Developing basic mental health modules for health care workers in Afghanistan. *Intervention, 2*, 43–54.

Ventevogel, P., van Huuksloot, M., & Kortmann, F. (2006). Mental health in the aftermath of a complex emergency: the case of Afghanistan. In J. O. Prewitt Diaz, R. Srinivasa Murthy, & R. Lakshminarayana (Eds.), Advances in Psychological and Social Support after Disasters. New Delhi, India: Voluntary Health Association of India Press, 83–93.

Ventevogel, P., Nassery, R., Azimi, S., & Faiz, H. (2006). Psychiatry in Afghanistan, country profile. *International Psychiatry, 3*, 36–38.

Ventevogel, P., Faiz, H., & van Mierlo, B. (2011). Mental health in basic health care: Experiences from Nangarhar Province. In J. F. Trani (Ed.), *Development efforts in Afghanistan: Is there a will and a way? The case of disability and vulnerability*. Paris: l'Harmattan.

Ventevogel, P., van de Put, W., Faiz, H., van Mierlo, M., Siddiqi, M., & Komproe, I. H. (2012). Improving access to mental health care and psychosocial support in a fragile convict setting: A case study from Afghanistan. *PLoSMedicine, 9*(5), e1001225.

Waldman, R., Strong, L., & Wali, A. (2006). *Afghanistan's health system since 2001: Condition improved, prognosis cautiously optimistic*. Kabul: Afghanistan Research and Evaluation Unit.

WCRWC. (2002). *Fending for themselves. Afghan refugee children and adolescents working in urban Pakistan*. New York: Women's Commission for Refugee Women and Children.

Wessells, M. (2006). *Child soldiers. From violence to protection*. Cambridge: Harvard University Press.

Wessells, M., & Kostelny, K. (2002). *After the Taliban: A child-focused assessment in the northern Afghan provinces of Kunduz, Takhar, and Badakshan*. Kabul: CCF International/Child Fund Afghanistan.

Wessells, M., & Strang, A. (2006). Religion as a resource and risk. The double-edged sword for children in situations of armed conflict. In N. Boothby, A. Strang, & M. Wessells (Eds.), *A world turned upside down. Social ecological approaches to children in war zones* (pp. 199–222). Bloomfield: Kumarian.

Wessells, M., & Van Ommeren, M. (2008). Developing inter-agency guidelines on mental health and psychosocial support in emergency settings. *Intervention, 6*, 199–218.

WHO. (2008). *Mental Health Gap Action Programme: Scaling up care for mental, neurological and substance use disorders*. Geneva: World Health Organization.

WHO. (2009). *Mental health aspects of women's reproductive health; a global review of the literature*. Geneva: World Health Organization and United Nations Population Fund.

WHO. (2013). *Building back better*: *Sustainable mental health care after disaster*. Geneva: World Health Organization.

WHO-AIMS. (2006). *Report on mental health system in Afghanistan*. Kabul: WHO and Ministry of Public Health.

Williamson, J., & Robinson, M. (2006). Psychosocial interventions, or integrated programming for well-being? *Intervention, 4*, 4–25.