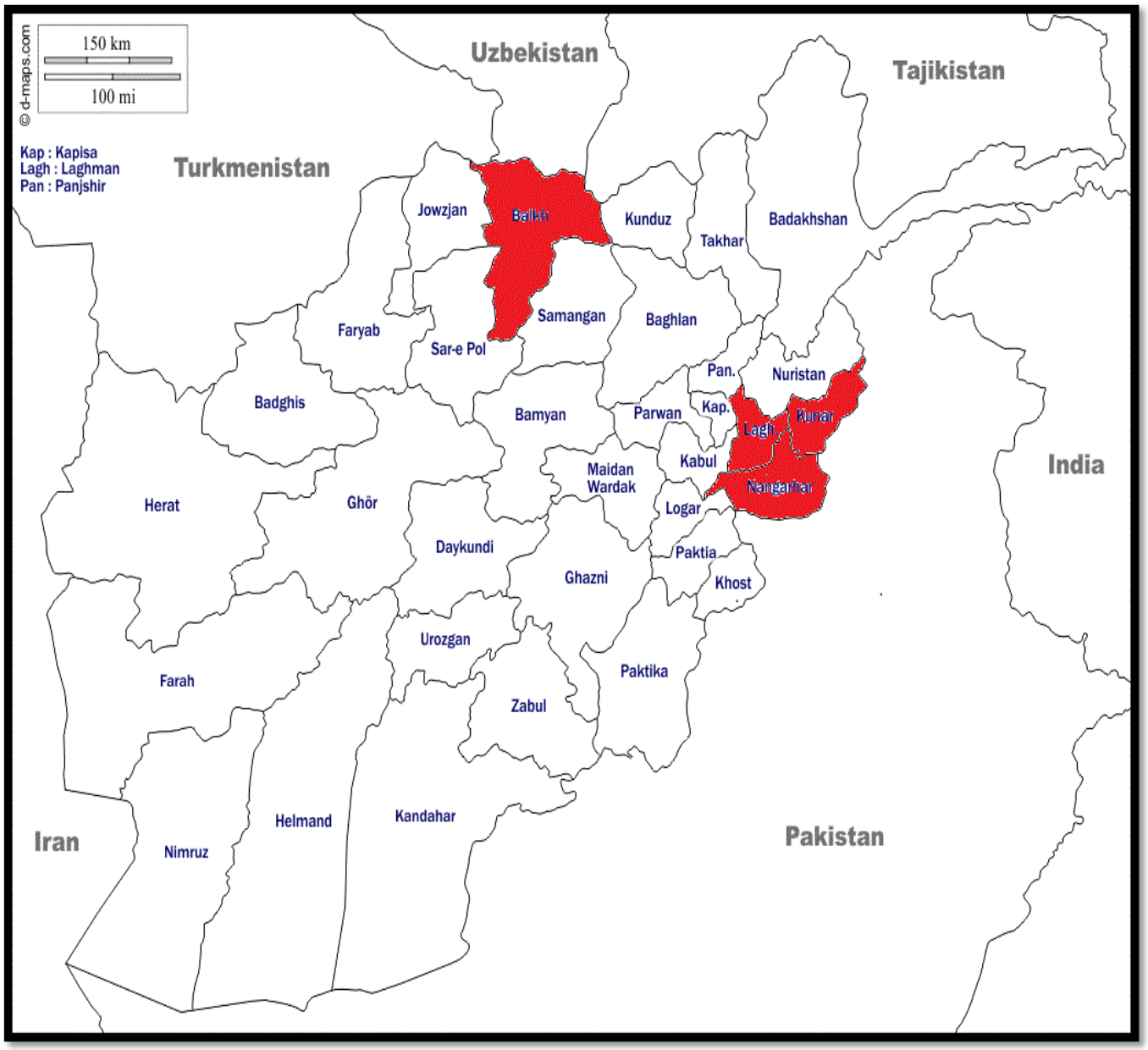
International Medical Corps

Afghanistan MHPSS Needs Assessment Report

May 2021
Balkh, Nangarhar, Laghman and Kunar provinces

AFGHANISTAN



ABBREVIATIONS

AADA	Agency for Assistance and Development of Afghanistan
BDN	Bakhtar Development Network
BPHS	Basic Packages of Health Service
CHC	Comprehensive Health Center
CHWs	Community Health Workers
DH	District Hospital
DoWA	Department of Women Affairs
ECHO	European Civil Protection and Humanitarian Aid Operations
EPHS	Essential Packages of Health Services
FGD	Focus Group Discussion
FPC	Family Protection Center
GAD	Generalized Anxiety Disorder
GBV	Gender-based Violence
HNTPO	Healthnet International and Transcultural Psychosocial Organization
IDPs	Internally Displaced Persons
KII	Key Informant Interview
MHPSS	Mental Health and Psychosocial Support
MoPH	Ministry of Public Health
OCD	Obsessive-Compulsive Disorder
ORCD	Organization for Research and Community Development
PFA	Psychological First Aid
PTSD	Posttraumatic Stress Disorder
SIDA	Swedish International Development Cooperation Agency
WGSS	Women and Girls' Safe Space

Table of Contents

Acknowledgements

International Medical Corps is thankful for the generous support of the USAID Bureau of Humanitarian Assistance, which funded this Rapid Mental Health and Psychosocial Support Needs Assessment. We thank the different international non-governmental organizations in Afghanistan that participated as key informants in this assessment. We particularly thank Dr. Bashir Ahamad Sarwari, Head of the Mental Health Department in Afghanistan's Ministry of Public Health for his unwavering support throughout the entire process, and Ms. Nadia Jabarkhail, Afghanistan MHPSS Working Group Coordinator, for data collection and desk review. We would also like to recognize the health agencies and organizations in the provinces that we targeted, for supporting the process of this assessment and data collection. We appreciate the efforts of the data collection team for reaching far and wide in remote areas. We acknowledge the support by the Field Site Managers, Ihsanualhai Ihasn, Dr. Ahmad Farid Arian, and the M&E team for their supervisory role in supporting ground teams. We also would like to thank the International Medical Corps Afghanistan MHPSS team, including Mahmuda Mahmuda and Roman Naseri.

For questions or to learn more about this assessment, kindly contact:
Claire Whitney
Senior Global Mental Health and Psychosocial Support Advisor
cwhitney@InternationalMedicalCorps.org

For questions or to learn more about International Medical Corps' work in Afghanistan, kindly contact:
Mark Ward
Country Director
mward@internationalmedicalcorps.org

Section 1: Executive Summary

1.1 Introduction

This assessment report by International Medical Corps examines the sources of psychosocial distress; the specific needs of women, girls, men and boys in relation to mental health and psychosocial support; traditional ways of coping; help-seeking behaviors; existing MHPSS services; critical gaps in services provided; and barriers to accessing support. We provide recommendations for all key actors and stakeholders, with the goal of improving the delivery of MHPSS services in Afghanistan—a country with one of the world's most prolonged and complex humanitarian emergencies.

1.2 Method

This assessment relies on both qualitative and quantitative data collection and analysis, including desk reviews, 4Ws MHPSS service mapping, focus group discussions (FGDs) and key informant interviews (KIIs). International Medical Corps conducted the MHPSS needs assessment from January 25 to February 11, 2021, in select villages of 27 districts of four provinces (Balkh, Nangarhar, Kunar and Laghman). We collected data from 38 KIIs and 279 participants in FGDs.

1.3 Results

The assessment revealed that stress, depression and anxiety are the most commonly reported mental health conditions in the community. COVID-19, poverty, unemployment, insecurity, war, fighting, economic problems, disunity, oppression, theft, bribe, addiction to narcotic drugs, violence and psychological problems are perceived as the main problems communities are facing.

According to the responses from the survey, in Balkh and Nangarhar provinces the communities' coping strategies for emotional distress or mental health conditions include receiving treatment from mullahs (religious leaders), keeping busy in studying, watching movies, engaging in sports, being supported by their families, walking outside, and getting encouraged and motivated by the community despite the presence of stigmatization. In Kunar, people deal with mental health problems by consulting with doctors, resting and engaging in activities such as cooking and spending time with children. In Laghman, people deal with such problems by staying home, resting, taking medication, sleeping and praying.

With regards to available MHPSS services, there are around 69 health facilities in all assessed provinces that are providing some form of MHPSS services, including 21 in Balkh, 11 in Kunar, 11 in Laghman and 26 in Nangahar. Among them, 53 facilities are providing basic psychosocial counseling and psychological first aid (PFA). Thirteen of these facilities have trained medical doctors providing pharmacological treatment and two of them have psychiatrists for specialized mental health services.

1.4 Recommendations

Key recommendations include the following.

- Increase MHPSS programing aimed at increasing mental health awareness and stigma reduction.
- Implement evidence-based, scalable psychological interventions to address depression, anxiety and stress.
- Advocate for developing specific and adapted approaches/interventions for children and persons with disabilities.
- Establish a strong referral pathway between specialized mental health hospitals and public health facilities.
- Train first responders on PFA and effective communication skills at the community level.
- Address the treatment gap by providing mental health care within general healthcare programs.

Section 2: Background and Context

Afghanistan is a landlocked mountainous country located within South Asia (some consider it part of the Middle East or Central Asia). The country is the 40th largest in the world in geographic size. Kabul, the capital, is the largest city in Afghanistan, located in Kabul Province.

Strategically located at the crossroads of major trade routes, Afghanistan has attracted a succession of invaders since the sixth century BCE. The Hindu Kush mountains, running northeast to southwest across the country, divide the nation into three major regions: 1) the Central Highlands, which account for roughly two thirds of the country's land area; 2) the Southwestern Plateau, which accounts for one-fourth of the land; and 3) the smaller Northern Plains area, which contains the country's most fertile soil[1].

The population of Afghanistan is around 37.5 million as of 2021, which includes roughly 3 million Afghan citizens living as refugees in both Pakistan and Iran. The nation is composed of a multi-ethnic and multilingual society, reflecting its location astride historic trade and invasion routes between central, southern and western Asia. Ethnic groups in the country include Pashtun, Tajik, Hazara, Uzbeks, Nuristanis, Aimaq, Turkmen, Baloch and several others that are less well-known. Afghanistan's official languages are Dari (also known as Afghan Persian) and Pashto. Approximately 46% of the population is under 15 years of age; 74% of all Afghans live in rural areas[2].

Islam is the official religion of Afghanistan and approximately 99.7% of the population is Muslim. There are some very small residual communities of other faiths, including Christians, Sikhs, Hindus and Baha'i. However, the numbers of minority Muslim and non-

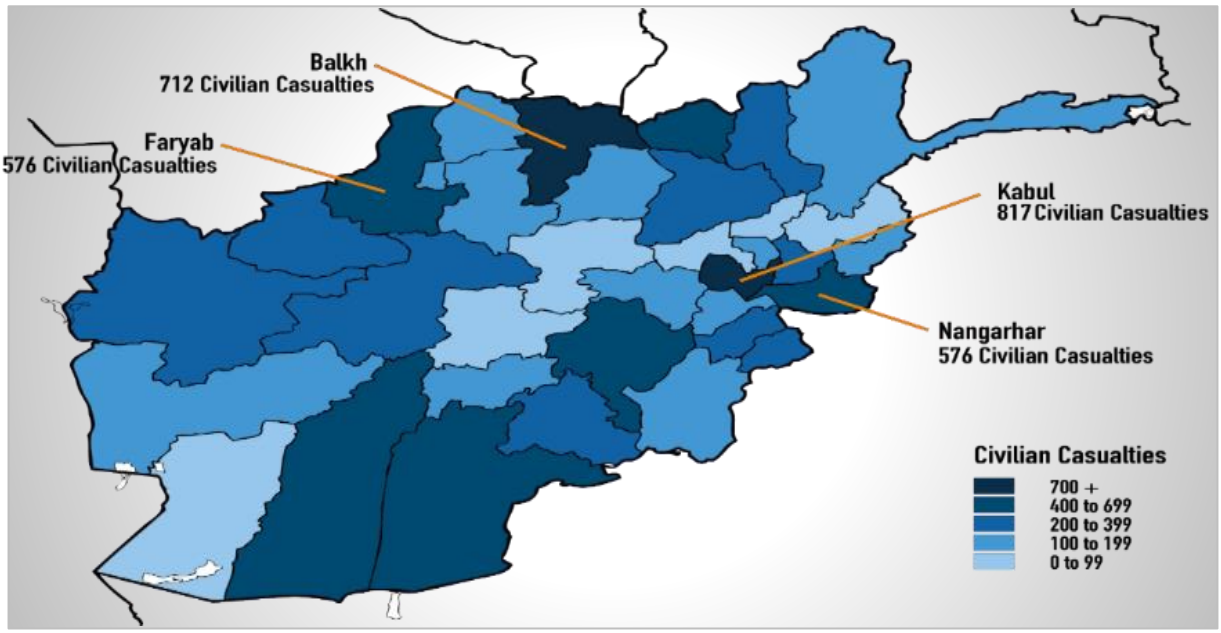
1 Geography of Afghanistan https://en.wikipedia.org/wiki/Geography_of_Afghanistan#cite_note-South_Asia-6

2 Demographics of Afghanistan: https://en.wikipedia.org/wiki/Demographics_of_Afghanistan / reference data 29 March 2021.

Muslim groups have significantly declined over the past decades as people have fled sectarian tensions and conflict[3].

Decades of conflict, prolonged population displacement, civil unrest, armed group activity and recurring natural disasters contribute to humanitarian needs in Afghanistan. Between November 2020 and March 2021, corresponding to the lean season, around 13.2 million people (42% of the total population) are likely to experience high levels of acute food insecurity (IPC Phase 3 or above), out of which an estimated 8.9 million people will likely be in Crisis (IPC Phase 3) and nearly 4.3 million people will likely be in Emergency (IPC Phase 4). In the first quarter of 2021, conflict displaced approximately 80,950 people, and 6,657 people were affected by natural disasters, according to the UN[4]. Furthermore, the World Health Organization (WHO) estimated that up to 3 million people were deprived of essential health services in 2020 because of the closure of health facilities by parties to the conflict, often in the most vulnerable, conflicted-affected locations. The loss of healthcare workers and damaged medical infrastructure will have long-lasting consequences on the healthcare system.

Afghanistan remains among the deadliest places to be a civilian, with the United Nations documenting in 2020 more than 3,000 civilian deaths because of armed conflict, for the seventh consecutive year, including a shocking 13% increase in the number of women killed[5].



3 Religion: https://culturalatlas.sbs.com.au/afghan-culture / Reference Date: 29 March 2021.

4 https://reliefweb.int/report/afghanistan/afghanistan-weekly-humanitarian-update-12-18-april-2021

5 UNAMA: Afghanistan protection of civilians in armed conflict annual report 2020, page # 4: https://unama.unmissions.org/sites/default/files/afghanistan_protection_of_civilians_report_2020.pdf

2.1 Mental Health and Psychosocial Support System in Afghanistan

The first national mental health survey, conducted in 16 provinces under eight zones in Afghanistan, was done in 2018. The objective of this survey was to help the Ministry of Public Health (MoPH) obtain comprehensive data about mental disorders. This survey revealed that 47.7% people were experiencing psychosocial stress and distress, with 24.3% of them badly affected and their work and life quality impaired by mental disorders. According to the prevalence of common mental disorders, the survey shows that 36.5% of people had mild to moderate depression; among them, 13.4% had major depressive disorder.

Another survey, conducted in 16 provinces, showed that 7.25% of people experienced suicidal thoughts during their lifetime, while 2.5% experienced these thoughts for 12 months. In addition, 4.0% had made a suicide plan during their lifetime, while 3.4% had attempted suicide. Prevalence of these thoughts were high in the southern zone, compared to the other zones. Reported suicidal thoughts were lower than reported by populations other countries; however, suicidal attempts were higher[6].

Results from the Afghanistan National Drug Use Survey 2015 suggest that between 2.5 and 2.9 million Afghans (11% of the population) use drugs, and 1.9 and 2.3 million (about 7% of the population) use opiates. Approximately 1 million use cannabis, about half the rate of opioid users[7].

After pursuing integration of mental health in its general healthcare system in 2005, Afghanistan developed its first national mental health strategy for the period 2011–2015. Its second strategy, developed for 2019–2023, was developed after evaluation and follow up of the first mental health strategy.

The MoPH's policy on mental health is to have most of the work on mental health done with and within the community. The ministry recognizes the important progress that has occurred in meeting mental health needs through pilot program and other work (Health policy 2017–2021)[6].

According to MoPH information, there are 130 psychiatrists working in different public and private health centers in the country, with 129 basic counselors, 103 advanced psychosocial counselors and 53 trained medical doctors providing pharmacological interventions.

- In 2019, almost all health facilities that provided basic packages of health service (BPHS) and essential packages of health service (EPHS) also were providing some form of MHPSS services, through 19,000 health posts and 38,000 community health workers (CHWs) providing awareness-raising, referral and identification of mental health cases.
- 198 mobile teams and 807 sub-centers were providing basic interventions, such as PFA and basic psychosocial counselling.
- 830 primary health clinics were providing basic counseling and pharmacological treatment of mental disorders.

6 National Mental Health Symposium Report (March 2019), Page # 9-10, Presentation # 4

7 Afghanistan National Drug Use Survey 2015. https://www.issup.net/knowledge-share/publications/2016-10/afghanistan-national-drug-use-survey-2015

- 430 comprehensive health centers were providing advanced counseling, with pharmacological management of mental disorders, by trained medical officers.
- 83 district hospitals were providing bio-psychosocial treatment of mental disorders.
- 27 provincial hospitals were providing medical and psychosocial treatment, with short-stay hospitalization.
- Five regional mental health wards were providing inpatient (320 beds) and outpatient specialized services for people, and referral from BPHS and EPHS, including residency program for psychiatrists.
- Five community mental health and psychosocial projects provided prevention and promotion for mental disorders and mental health[8].

2.2 Challenges to Providing Appropriate MHPSS

Prolonged conflict and political instability in Afghanistan have led to a high burden of mental health disorders among the country's citizens. About 2 million Afghans—or one in every 15 people—suffer from mental health issues, according to the World Health Organization (WHO). Treating this growing public health problem is especially challenging as there are just 16 psychiatrists and 8 psychologists available for every 100,000 citizens in the country[9].

The lack of trained psychiatrists, psychiatric nurses, psychologists, and social workers presents a serious challenge for mental healthcare service delivery. Nationwide, only 320 hospital beds in the public and private sector are available for people suffering from mental health problems[10].

In 2018, a national mental health survey indicated the following gaps in mental health care:

- a lack of mental health training (this was identified as the most challenging barrier toward integration of mental health into the BPHS and EPHS);
- a shortage of essential psychotropic medications, a lack of knowledge by medical staff about psychotropic drug administration and an absence of pharmacotherapy training in most public health facilities; and
- a lack of space for mental health access (mentioned as the primary challenge by 12% of the resources, including 17% of the CHCs).

Most of the facilities also declared having referred patients to specialized psychiatric hospitals, but said the opposite does not happen.

Section 3: Methods and Data Sources

3.1 Methods

A desk review of the background and current relevant documents included:

1. The Afghanistan geographical, demographic and religious backgrounds
2. Afghanistan IPC Acute Food Insecurity Analysis: August 2020–March 2021

8 Mental Health Strategy 2019- 2023. Page 5.

9 https://www.aku.edu/news/Pages/News_Details.aspx?nid=NEWS-001613

10 WHO- Mental and disability health/ http://www.emro.who.int/afg/programmes/mental-health.html Reference date 27 March 2021.

3. USAID: Food Assistance Fact Sheet Afghanistan, updated September 30, 2019
4. UNAMA: Annual Report on Protection of Civilians, 2020
5. OCHA: Population Movements in Afghanistan, January 2021
6. USAID: Food Assistance Fact Sheet, Afghanistan, updated September 30, 2019
7. Afghanistan National Mental Health Survey, 2018
8. National Mental Health Symposium Report, March 2019
9. Afghanistan National Drug Use Survey, 2015
10. Afghanistan MoPH Mental Health Strategy, 2019–2023
11. WHO: Mental Health Atlas, 2017

The methodology for this assessment included an MHPSS service mapping, 28 FGDs and 38 KIIs across four provinces and 27 districts in Afghanistan during the first quarter of 2021. Within each of the pre-determined districts, two informants were identified for KIIs and one FGD was conducted. The team marked the targeted influential people, community elders and field health staff for KIIs, and communities and local beneficiaries for FGDs.

The FGD sessions had 279 participants of different groups, including 102 women, 97 men, 59 girls and 58 boys. Each FGD included an average of 10 participants. FGDs were conducted separately for males and females and with different age groups, participation in FGDs was open and voluntary for all groups and individuals, and written consent was collected from all groups after they were informed, in advance of the assessment, about its overall objectives.

The KIIs targeted affected community elders, religious leaders and other influential community members and health-services providers at districts and provincial levels.

The survey team consisted of 28 people, including 16 male and 12 female enumerators in all four provinces, with overall technical support provided to them by International Medical Corps' M&E Coordinator and mental health technical teams (including the MHPSS Project Manager and the MHPSS Coordinator) and project site managers in all relevant provinces.

The enumerators were trained for one day in both regions on different topics related to the assessment, including assessment tools, methodologies and how to conduct KIIs. FGDs with beneficiaries and stakeholders considered all the ethical issues of a survey.

3.2 Tools for Data Collection

The assessment tools used were adapted from the WHO/UNHCR MHPSS Assessment Toolkit and included the International Medical Corps MHPSS Basic Rapid Assessment tools as well as other participatory tools. The methodological approach was in line with global best practices, including the Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings.

Section 4: Results of the Assessment

4.1 Common Problems and Stressors

During FGDs respondents pointed out that poverty, unemployment, insecurity, war, fighting, economic problems, disunity, violent behavior, oppression, relationship problems, theft,

bribery, child abuse, addiction to narcotic drugs and violence are the main difficulties that the people are facing in their communities. Less than half of the male participants also stated that lack of agriculture, electricity and shelter are also the problems that need to be addressed in all four provinces. In Laghman, some women also reported lack of separate schools or madrasa for girls while in Kunar some women participants also reported about domestic violence and sexual harassment, insecurity, and lack of shelters as major problems for them. Other common problems reported from Key Informant interviews are described in the table below. All of them were mentioning increased suffering during pandemic period.

Common Problems and Stressors in the Two Regions Reported in KIIs	
Men	**North:** 80% of male participants reported that poverty, unemployment, insecurity, addiction to drugs, family conflicts, psychological problems, discrimination, conflict, lack of clean drinking water, and migration and displacements as their main problems. **20%** of male participants stated that disrespectful cultures, forced marriage, child abuse, police misconduct, illiteracy, corruption and lawbreaking are main/common problems. **East:** In *Nangahar*, 77% of the respondents reported poverty, economic problem, unemployment, insecurity, natural disaster, violence, child abuse, using narcotic drugs, mental/psychological, health problem, disunity and lack of education; **23%** of them stated that bad traditions, lack of awareness, migration, COVID-19, inappropriate competition, malnutrition are their main problems. In *Kunar*, 66% of male participants mentioned unemployment, domestic violence, insecurity, family conflicts, war, psychological problems and financial problems. 34% of the male participants mentioned legal problems, exchange marriage, displacement, grief and poverty. In *Laghman,* 50% of males mentioned war, financial problems, lack of education/unawareness, violence and gender-based violence are common problems, while 50% male mentioned using narcotics, harmful culture, lack of drinking water, disease, family conflict and migration/displacement as main/common problems.
Women	**North:** 50% of female participants reported poverty, gender-based violence, unemployment, family conflicts, lack of awareness, forced marriages, lack of quality education and insecurity as issues. 35% of females in KIIs responded that addiction, discrimination, lack of drinking water, lack of access to transportation, violating the law, and lack of awareness of and lack of psychosocial centres as issues. 15% of females also mentioned that addiction, environmental problems, lack of access to health facilities, shelter, lack of female teachers, and child and maternal mortality are the main problems.

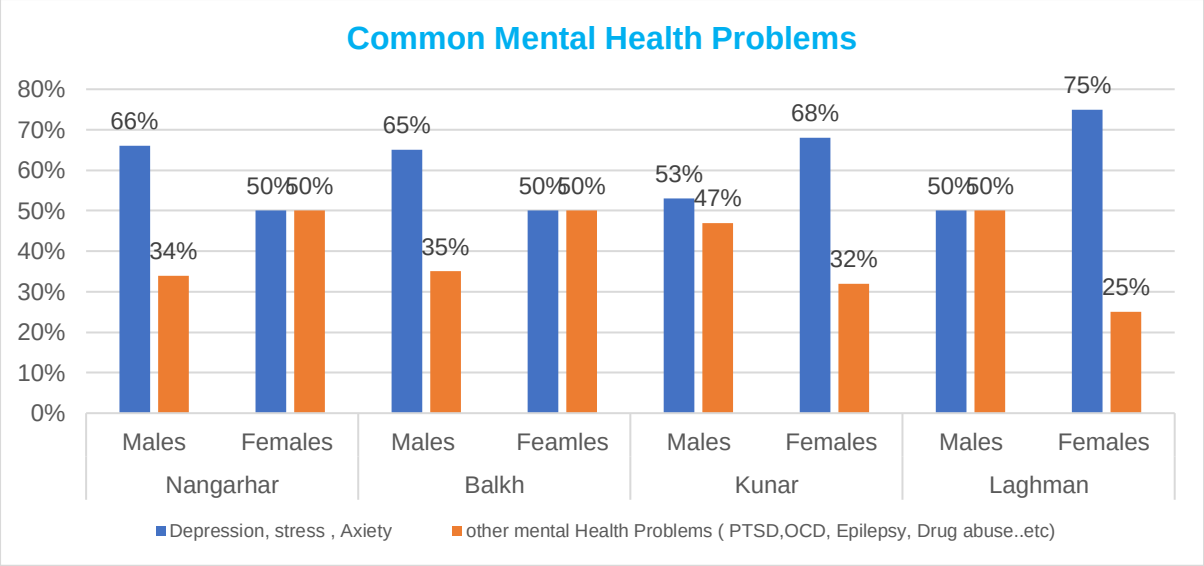
	East: In *Nangarhar*, 66% of female participants reported that economic problems, lack of shelter, violence, psychological problems, cultural problems, insecurity, illiteracy, lack of water, displacement, child abuse and unemployment are common in their society. 17% of the interviewed women responded that lack of education, COVID-19, access to food and poverty are issues. 17% further mentioned protection issues, family conflict, drug abuse, are their main problem. In *Kunar*, 42% of them mentioned migration, displacement, family conflict, lack of shelter, war, drought and disability, while 58% reported insecurity, health problem (including mental health), illiteracy, unemployment, financial problems and poverty, and domestic violence. In *Laghaman*, 70% reported insecurity, psychological/health problems, economic problems/poverty, unemployment, domestic violence, and violence as common problems; 30% responded that migration, displacement, child labour, harmful traditions and lack of hygiene are common problems for them.
Children	**Both Regions:** Children cited insecurity, poverty, robbery, lack of attention from the government, less access to shelter, lack of health services, unemployment, lack of amusement parks, lack of education facilities and the pandemic as issues, Illiteracy, unavailability of professional teachers, lack of protection or support of families and government, lack of drinking water are also cited as common problem in the communities; almost all the same problems also have been reported by children in the east, in addition to financial problems, electricity problems, vehicle and transportation problems, injustice, disunity, bribes, mental health and psychological problems, peace and conflict issues, narcotics, family conflicts, explosions, deaths and physical illness.
People with disabilities	**Both Regions:** Violence, forced marriages, disabilities, violation of rights, lack of education facilities for disabled, lack of shelters for the people living with disability, harmful traditions and lack of safe drinking water in their communities.

4.2 Specific Mental Health Issues

During FGDs, participants were asked to focus on and talk about common mental health problems. All men and women in FGDs reported stress, depression and anxiety as the most common issues of mental health in their communities, while both males and females in FGDs also talked about using narcotic drugs, epilepsy, psychosis, PTSD, personality disorder, excessive anger, OCD, GAD, ADHD and loss of concentration as issues. The table below shows other specific mental health problems and issues reported by participants.

Mental Health Issues/Problems	
Most Common Issues	
Men	*Balkh*: using narcotic drugs, major depression, anxiety, PTSD. *Nangahar*: stress, depression, anxiety, using narcotic drugs, epilepsy, psychosis. *Laghman*: depression, stress, anxiety, PTSD, OCD, conversion disorder. *Kunar*: depression, OCD, stress, epilepsy, anxiety, using narcotics, insomnia, mania.
Women	*Balkh*: sadness and worries, ADHD, puerperal psychosis, phobias, aggressive behavior and anger, low self-esteem, depressed mood and suicidal thoughts, lack of insight, major depression, poverty, anxiety, PTSD. *Nangahar*: stress, depression, anxiety. *Laghman*: depression, stress, anxiety, sadness, suicide. *Kunar*: stress, depression, anxiety.
Children	*Balkh*: depression, stress, PTSD, GAD, ADHD. *Nangahar*: psychosis, excessive anger, sleep talking, getting angry easily, insomnia, talking to oneself, getting addicted to narcotics, distress, epilepsy, paranoia, intellectual disabilities, self-harm, stress, depression, anxiety, OCD, PTSD.
People with disability	*Balkh*: Depression, stress, PTSD, GAD, sleeping disorders. *Nangahar*: stress, depression, anxiety, PTSD.
Less common issues	
Men	*Balkh*: Stress, sleeping disorders, GAD, grief, loss. *Nangahar*: getting angry, medically unexplained somatoform symptoms, insomnia, obsession, phobia, talking during sleep, self-harm, PTSD. *Laghman*: sadness, suicide, human trafficking, getting addicted to alcohol or narcotics. *Kunar*: OCD, depression
Women	*Balkh*: Anger and lack of concentration, personality disorders. *Nangahar*: trauma, sadness, using narcotics. *Laghman*: nil. *Kunar*: trauma, OCD, PTSD, psychosis.
Children	N/A
People with disability	N/A

In KIIs from most provinces, both males and females participants also reported depression, stress and anxiety as the three most common issues of mental health, while almost half the people surveyed also reported other mental health problems as common. The chart below shows the percentage of people who talked about mental health issues:



4.3 Hierarchy of Common Mental Health Problems in Communities

Community members were further asked to rank specific mental health problems. The table below shows perceptions in how important mental health problems are in the community.

Most Important Mental Health Problems for the Communities			
Province	**High**	**Medium**	**Low**
Balkh	Depression and child abuse	Stress, PTSD, GAD, poverty	Use of narcotics, sleeping disorders, anxiety
Nangahar	Depression, trauma, neglect of women's rights, lack of mental health services, distress, anxiety and anger	OCD, stress, phobia, use of narcotics, anger	Epilepsy
Kunar	Depression, fear and anxiety, sadness, distress, lack of education for women	Mental weakness, laziness, psychological problems, anxiety, stress, OCD, trauma	Discrimination, obsession, use of narcotics, harmful traditional practices
Laghman	Depression	Stress, anger	Anxiety, insecurity, harmful traditional practices

During KIIs with stakeholders: The Department of Women Affairs (DoWA) of Balkh and Nangarhar had a similar perception that depression, suicide, violence and anxiety are the most important mental health problems that need attention. This was not different from other

stakeholders such as the Family Protection Center (FPC) in charge, who—in addition to the issues stated above—say that epilepsy, OCD and other somatic disorders are the most serious issues.

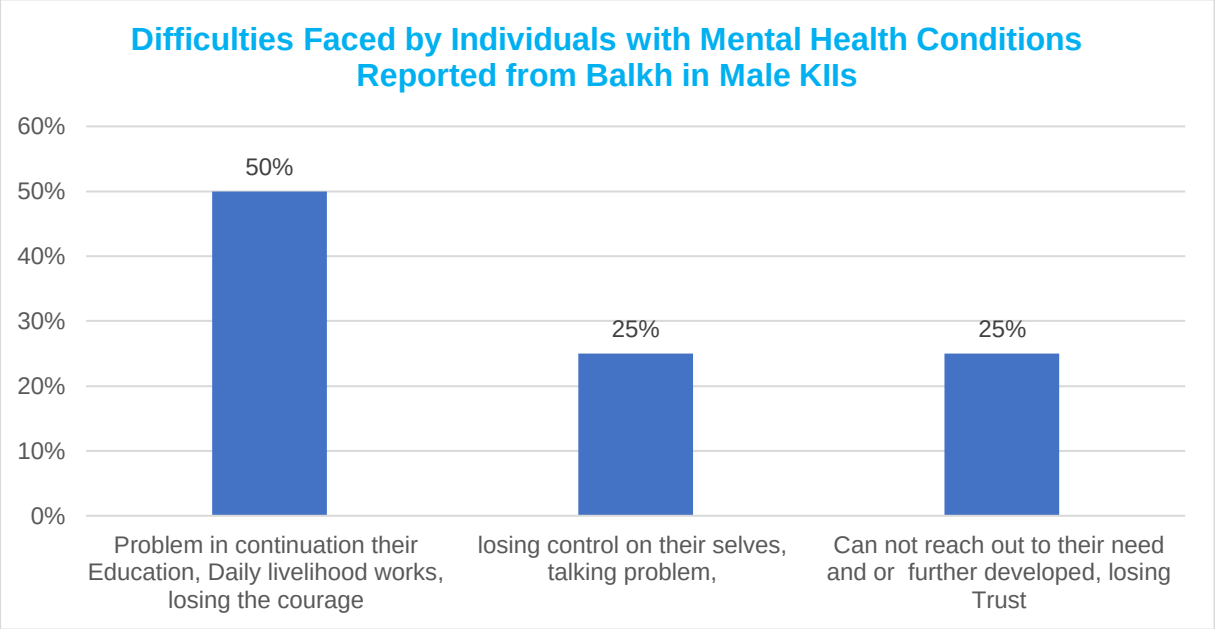
4.4 Mental Disorders and Psychosocial Challenges in Persons with Disabilities

Interviews about common mental health problems among people with disabilities yielded to the following perceived information:

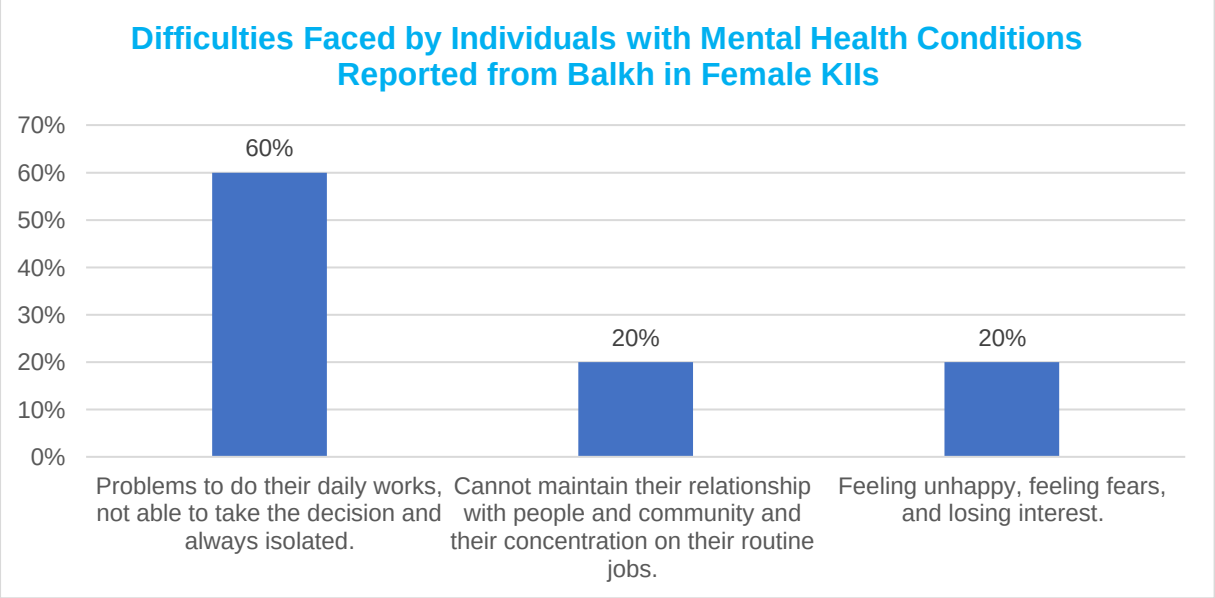
Province		Perception
Balkh	**Male**	Violent behaviors, less appetite, excessive desire to sleep, lack of interest, low self-esteem, isolation, withdrawal
	Female	Hopelessness, frustration, lack of interest, low self-esteem, isolation, suicidal ideation
Nangahar	**Male**	Lack of motivation, medically unexplained somatoform symptoms, lack of concentration, sleeplessness, increased use of narcotics, isolation
	Female	Impaired functioning, communication and relationship problems, lack of progress, loss of self-confidence, inability to take care of children, memory problems, anger, sleep issues
Kunar	**Male**	Financial problems, lack of religious faith, work and responsibility challenges, poor health-seeking behaviors, ineffective parenting skills, low efficacy in different tasks, sadness, guilt, sleeplessness, anger, intense fear, poor impulse control, addiction, change in personality
	Female	Poor problem-solving skills, impaired functioning, poor self-care, feeling under pressure, living in fear and worry, concentration problems, communication problems, shame, guilt, addiction
Laghman	**Male**	Difficulty in living normal lives, unemployment, feeing like a burden to other people, anger, insomnia
	Female	Inability to live a satisfying life, relationship and communication problems, anxiety, low self-confidence

During FGDs with children and adults with disabilities across the provinces, similar challenges—including the inability to complete education, low self-esteem, loss of memory and concentration, and lack of appetite—were reported. Participants also said that feelings of neglect and working under difficult situations led them to acquire hypertension. People living with disabilities also said they avoid gatherings due to feelings of guilt and embarrassment. Participants in Nangarhar cited a unique issue: an inability to be innovative in facing daily challenges.

During KIIs with stakeholders showed similar experiences to those experienced by those in FGDs, in all provinces. The charts below show the percentage of common psychosocial problems that are experienced: Men report low self-confidence, sense of helplessness and low academic achievement at 50% higher than lacking self-control at 25%.

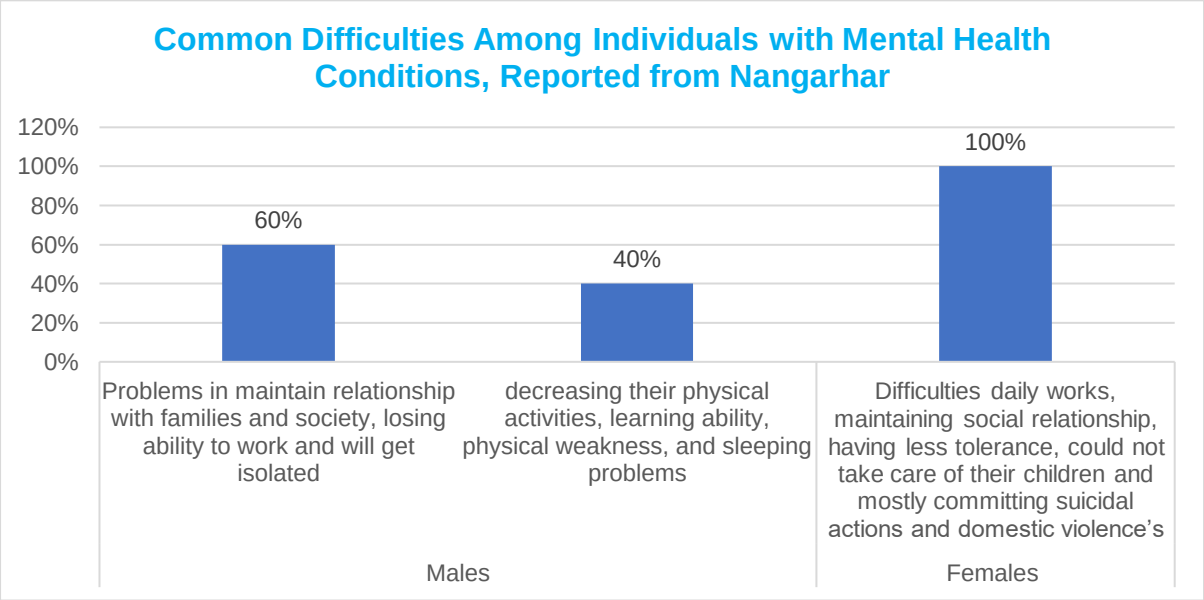


Females reported a higher percentage of indecisiveness and feelings of isolation (60%). However, they reported minimal feelings of unhappiness and losing interest (20%).

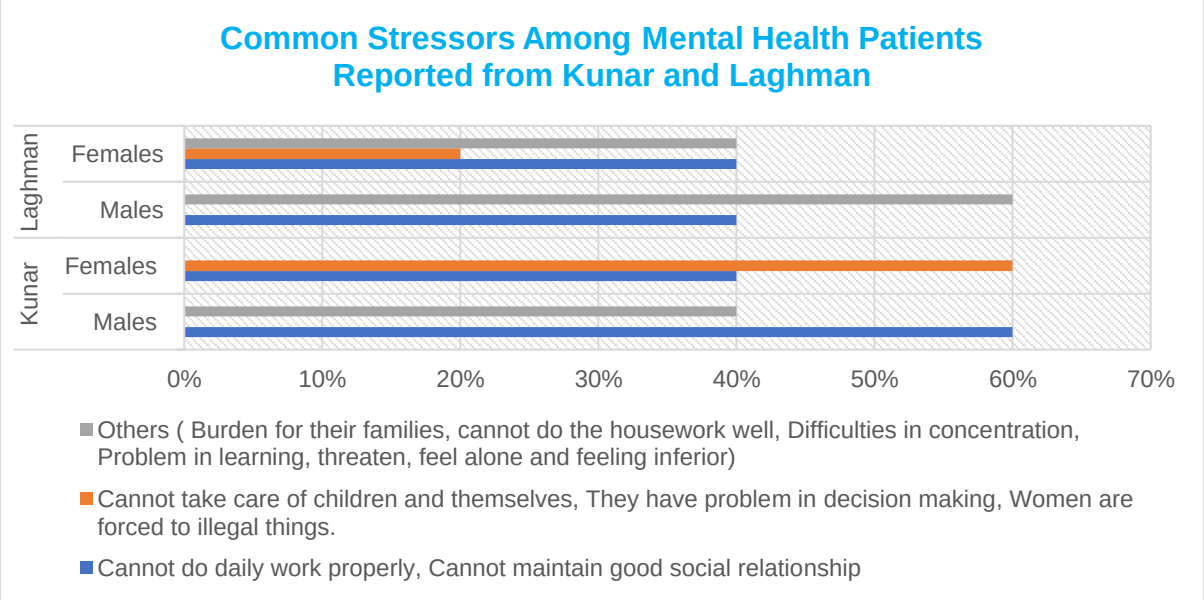


In Nangarhar, the KII participants cited similar concerns. The chart below shows a comparison of the perception of challenges between males and females. Men reported being more confident of being in control of most aspects of their lives (60%) than women, who feel

less confident that they are in control (100% were challenged by relationships, domestic violence, etc.).



During KIIs in Kunar and in Laghman, males and females reported that people with mental health problems could face different challenges and issues if they are not treated in a timely manner.



4.5 Addressing Mental Health in the Communities

During FGDs in Balkh, people were mainly asked to talk about how they address mental health difficulties at the community level.

Province		Perception
Balkh	Male	*Most:* studying, watching movies, sports, getting encouraged and motivated by others in the community, walking outside. *Some:* accepting reality, talking to mullahs (religious leaders) for some religious beliefs and treatment purposes. *Less:* using narcotics, traditional medication or treatment.
	Female	Most women cited visiting shrines, receiving religious treatment (by talking to mullahs), doing Nazir (distributing foods or money to relatives and poor people). A smaller number cited receiving support from their families. Some women also mentioned that coping with the situation depends on each individual's perception, ability and understanding level.
Nangahar	Male	Treatment from mullahs, visiting doctors. A small number of people stated that they are using sleeping pills or narcotics; some talked of relying on religious faith.
	Female	Most cited talking to mullahs, going to the shrine and going to the doctor. Less than half of them cited more sleeping, medications, beating themselves or their children, praying and reciting from the Quran. Some of them cited fighting with family members, beating children, smoking, using narcotics, social works with other people or keeping themselves busy at home.
Kunar	Male	Most cited consulting with the doctor and taking medicine, resting, keeping busy with activities. A minority cited going to the shrine or talking with religious leaders. Some said that no one can help these people and community cannot do anything for them; a few people also said that the community may hide these affected people, as they are not considered good. Some others said that people do provide assistance to them.
	Female	The majority cited visiting doctors and taking drugs, or said they self-medicate by using sleeping pills. Less than half said that they recite from the Quran and pray to cope with their problems. Some said that they work on keeping a good relationship with families and sharing problem with them. They also mentioned weeping and using narcotics, A few said they don't do anything, but keep silent.
Laghman	Male	Staying at home, resting, taking medication, sleeping, praying, sometimes fighting.
	Female	Resting, keeping themselves busy, praying. Believe that community and family should maintain good relationships with affected people.

FGDs with specific groups (children and people with disabilities) reveal almost the same as above. Girls in Balkh reported that telling some interesting jokes to each other and playing

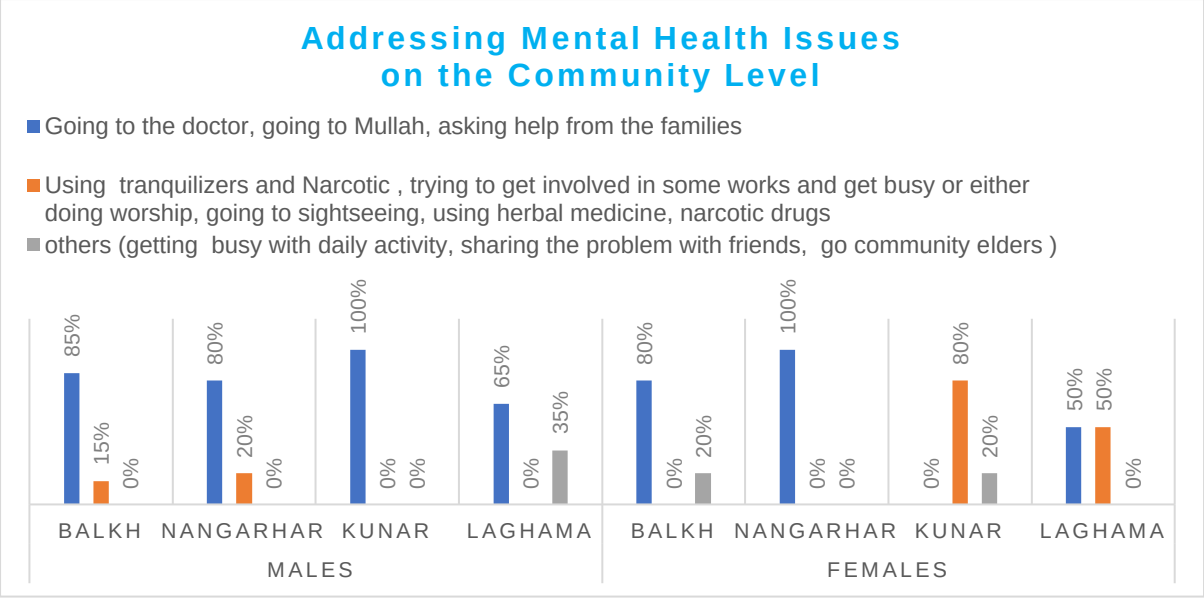
with other children sometimes help resolve problems. Boys said that engaging with the community and educational tools help them. Boys in Nangarhar said that it is helpful when people with mental health problems share their issues with others. They also said that sightseeing and going to the doctor in their communities is helpful. In Kunar, girls said that people with mental health issues visit the doctors, use narcotics and/or keep silent as ways of coping. People with disabilities in Blakh added that talking about emotions, studying, keeping busy, listening to music, drawing, watching movies and walking are common activities that people use to cope. In Nangarhar, males reported that they take some tranquilizers, that the community does not help them and said that no one can help in this regard. Female participants said that they take medication, recite from the Quran and/or do nothing.

The KIIs with key stakeholders also reported a lack of awareness and knowledge in regards of mental health problems, lack of facilities and services.

In *Balkh*, participants added that family members are supporting them, and that sometimes they seek support from psychosocial counselors, and community and religious leaders. Sometimes community members provide some financial support for treatment. Participants noted that the ways people cope with mental health issues is different among affected people and communities: some people get addicted, some people harm themselves, but most visit mullahs while others visit shrines or doctors.

In *Nangarhar*, in addition to the aforementioned ways of addressing mental health problems, the participants mentioned that people with mental health problems believe in religious leaders and traditional healers. Some people go to the doctor, rest, engage in business and sightsee. If they know there are resources, people ask for support and visit doctors, pray, exercise, recite from the Quran. Some added that families are not supporting them, and said they use tranquilizers to improve their sleep, take advantage of religious resources and/or go to the doctor.

Moreover, KIIs with community participants found almost similar things and gaps in the targeted communities. Participants in all provinces talked about talking to mullahs, going to the doctor, asking for help from families and/or using tranquilizers. The below chart shows the percentage of different methods adopted to address the mental health issue in communities, disaggregated by males, females and province.



4.6 Services Availability

According to the Mental Health Atlas 2017, Afghanistan was identified as being among low-income countries. Mental health services availability and uptake shows that the median number of mental health beds per 100,000 population ranges below 7 in low- and lower middle-income countries, compared with more than 50 in higher-income countries. Equally large disparities exist for outpatient services, child and adolescent services, and social support. Globally, the median number of mental health beds for children and adolescents is less than 1 per 100,000 population. It is as low as below 0.2 in low- and lower middle-income countries, compared with more than 1.5 in higher-income countries[11].

Mental health has been accepted as one of the MoPH's priorities. Mental health is a component of basic packages of health services (BPHS) in Afghanistan, through which people receive psychosocial and mental health services all over the country at the community level. It became part of BPHS in 2003 and gained recognition as a public health issue in 2008[12].

The assessment revealed that 69 health facilities in the assessed provinces are providing basic MHPSS services at the non-specialized level. There is a huge gap in specialized services. Psychiatrists, psychiatric nurses or physicians trained in the WHO's Mental Health Gap Action Programme (mhGAP) are not available to respond in critical clinical cases.

11 Mental Health Atlas 2017: http://apps.who.int/iris/bitstream/handle/10665/272735/9789241514019-eng.pdf?ua=1

12 National Mental health Survey and Assessment of Mental Health Services, 2018. Page# 21.

The table below further presents the number and location of health facilities in each province.

Province	Facility Type	Implementer	Total
Balkh	Comprehensive Health Center (CHC)	BDN	15 health facilities providing basic counseling and PFA only.
	District Hospital (H3)	BDN	Five general medical doctors are trained and providing medication for mental health.
	Provincial Hospital	MoPH	One professional mental health specialist providing comprehensive mental health services.
Kunar	Comprehensive Health Center (CHC)	HNTPO/ORCD	Nine, eight of which have basic counseling and PFA.
	District Hospital (H3)	HNTPO/ORCD	Two with medication on mental health.
Laghman	Comprehensive Health Center (CHC)	HN-TPO	Eight, all of which are providing basic counseling and PFA.
	Provincial Hospital	MoPH	One professional in mental health and providing comprehensive mental health services.
	District Hospital (H3)	HN-TPO	Two medical doctors are trained and providing medication for mental health.
Nangarhar	Comprehensive Health Center (CHC)	AADA/HNTPO	22, all of which have basic counseling and PFA.
	District Hospital (H3)	AADA/HNTPO	Four medical doctors are trained and providing medication for mental health.
Grand Total **54 CHC available; 53 of them providing basic counseling and PFA.** **13 DH are available; all of them have medical doctors trained and providing medication for mental health.** **2 PH are available; both of them have professions on mental health and providing the comprehensive mental health services.**			**69**

Gaps in Services Availability

- There is a large diversity in access to MHPSS services across regions, which hampers equitable access to care, especially in rural and dangerous areas.
- Depression and anxiety affect the Afghan population as per the findings of this assessment, but most communities do not seek treatment.
- The availability of medications is not adequate: according to the MoPH, a substantial percentage of health facilities lack essential drugs due to challenges in medication procurement.
- There is a gap in service accessibility by the most vulnerable in the community, who reportedly seek services mainly from public facilities. Satisfaction rates among service users at public health facilities is much lower than those of service users at private health facilities. Half of the specialized care is provided by private health facilities, and 80% of the cost of medicine is covered by the family.
- Mental health training plans are partially completed: 65% of the PHC has at least one member trained in basic counselling and 71% of the CHCs do not have a full-time position that requires advanced psychosocial training. In addition, only 25% of community health workers have basic mental health training. It is noteworthy that around 40% of health facility staff identify capacity building as a major challenge. Moreover, training on psychotropic medications is lacking in most health facilities.
- Lack of space is mentioned as the main challenge to mental health access by 12% of the facilities and by 17% of the comprehensive clinics.
- Referrals to specialized psychiatric hospitals seem to take place, but the reverse does not happen, as community health centers do not receive “counter-referrals” from the specialized hospitals, which results in uncoordinated discharge[13].

4.7 Barriers and Solutions Related to Accessing Mental Health Services Identified

4.7.1 Barriers to Accessing Mental Health Services

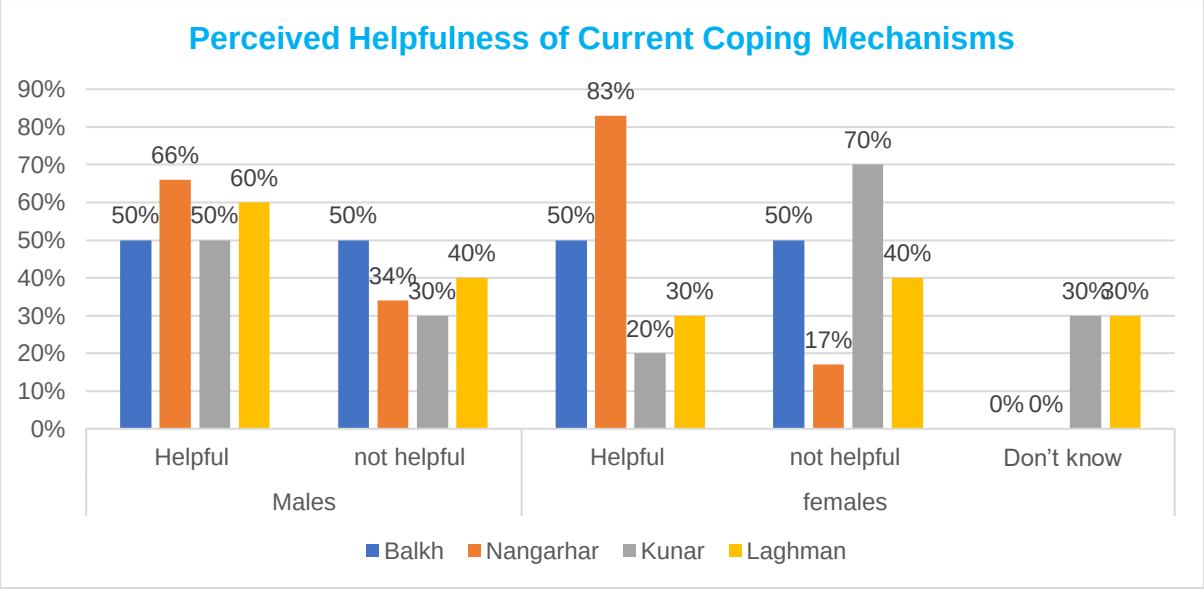
Prolonged population displacement, civil unrest, armed group activity and recurring natural disasters help create barriers to accessing mental health services in the country[14]. The assessment reveals that perceived barriers include impaired infrastructure, such as electricity and road networks. Respondents also reported communication barriers that hinder effective referral pathways in most communities in Afghanistan.

4.7.2 Usefulness of existing resources and coping mechanisms

During FGDs with community members, 56.5% of males and 45.75% of females said they think that the current practices and services are helpful, while 38.5 % of male and 44.25% of female participants think that they are not. In Balkh, Nangarhar and Kunar provinces, the majority of the FGD participants (both male and female) agreed that the services and practices for mental health problems are helpful while some people believe that they are not and a few of the women said they are not sure. In Laghman, the majority of FGD participants said no services are available. Some of them said that the available services are inadequate.

13 National Mental health Survey and Assessment of Mental Health Services, 2018. Page# 15.

14 https://www.aku.edu/news/Pages/News_Details.aspx?nid=NEWS-001613



Members from vulnerable groups (children, people with disabilities), agreed that the available services help mental health patients, while some children also stated that it may not help sometimes. In Nangarhar, female participants stated that it may help or may not help, but all males stated that the services are not helpful.

4.7.3 Perceived effective coping mechanisms in the community

- During FGDs in Balkh province with males, almost half of the participants said that things that are going well in society are cultural and traditional behavior, participating in gatherings and ceremonies, and sharing sympathy messages with people in need. The other half reported that talking with mullahs or religious scholars, and resolving problems and conflicts through mediations with community elders are things that going well.
- Half of female participants in FGDs in Balkh cited awareness-raising programs on health issues, scaling up mental health services and employment opportunities. Other female participants mentioned unity, good behavior, participation in different kind of celebrations and youth empowerment programs. A few other people cited helping and supporting poor people as a benefit for society.
- In Nangarhar province, almost half of the males FGD participants cited similar things as participants in Balkh, adding education, good ethics, spiritual activities and faith-related activities. However, a few male FGD participants responded that they did not know what was going well in society.
- Women generally mentioned the same things as male participants. However, half of them added that, recently, elders had decided to allow girls to go to school and to participate in awareness programs, which they said is very good.
- In the FGDs from Kunar, responses were similar to other regions. A few of them reported that they did not know what was going well in society. Less than half of the women in FGDs added that wearing hijabs and avoiding “walwar” (when grooms spend a huge amount of money on a bride) are good practices.
- In Laghman province, the FGDs with males reported participating in community work, respecting one another, unity and psychosocial services as valuable practices in the community. Women had the same opinions.
- In Balkh province, almost all people with disabilities agreed that money helped solved many problems, and added that respecting educated people, as well as cultural and traditional issues, also helped.

- In Nagarhar, male responses about things that are going well were similar to ones stated by the other groups.
- During KIIs with stakeholders in Blakh province, the representative of DoWA stated that nothing is going well in this society but said that accepting reality and practicing tolerance is what helps things go well. The PPHD of Balkh mentioned that greeting each other and sightseeing together are valuable practices for community members, in addition to most practices mentioned by other groups. The representative of WoW added that "it is different in each society; in our society money is a value."
- The stakeholder in Nangarhar province (representing mainly the east), mentioned what had already been discussed in many groups in addition to the representative of DoWA but added that helping one another during times of grief or happiness ceremonies is one of the examples of things that are going well.
- The PPHD representative added that going out together and having parties, playing cricket and sports, going to the gym, playing local games, praying, reading the Quran and girls playing with dolls are good practices.
- During KIIs with beneficiaries in Balkh, around 50% of males said that nothing is going well in their community and there is no action taken for poor people.
- 25% of males said that being with family, having a peaceful environment, rehabilitation works and establishment of health facilities are things that are going well in the communities, while 25% of males stated that family relationships, support of family and friends, and religious beliefs are valuable practices, along with respecting religious scholars, elders, teachers, doctors and social and cultural issues.
- KIIs in Nangarhar had 60% of the males reporting that good relationships, good behavior, fostering friendships, visiting relatives and awareness programs are valuable practices, and 40% of males said that religious practices, praying, reciting from the Quran and the recent program of president Ghani for supporting people (mele dastarkhwan) are valuable practices that are going well.
- During KIIs with female in Nangarhar, 66% females stated similar observations, while 18% of the interviewed women said that friends' support, visiting sick people, participating to ceremonies (weddings) and avoiding high walwar are valuable practices. However, 16% female KII participants said that nothing is going well, and they are not satisfied with the situation.
- 60% of male KII participants in Kunar said that Islamic beliefs, counseling and International Medical Corps' awareness programs are among the valuable practices. 40% of males said that, bad traditions like prohibiting women from inheritance and getting high walwar from grooms are not good practices and need to be ended.
- Similarly, 66% of females said that involving people in country-level decisions such as participating in loya jerga (local assembly), participating in grief ceremonies, participating in weddings and hospitality practices are valuable practices. 34% of females said that awareness programs, eliminating ignorance, reinforcing peace and increasing levels of education and religious issues are valuable.
- In Laghman, 50% of males reported one issue differently: they said that respecting Islamic resources, religious scholars, elders, educated people and cultural issues are valuable.
- 35% of males said that having a job, having a good income, awareness and humanity are valuable and that decreasing violence and education is going well. 15% of the interviewed people said that nothing is going well.
- 34% females said that respecting relatives, keeping friendships with them and participating in grief or happiness ceremonies are valuable and going well, 33% of females said that nothing is going well, while 33% more females had no opinion about it.

Section 5: Summary

In summary, the rapid need assessment report highlights some strengths within Afghanistan community; At government level, the MoPH has strong motivation to help non-government organizations expand MHPSS programs. The MHPSS Working Group also helps to coordinate MHPSS programming according to IASC guidelines. In the community, influential people are willing to help promote MHPSS programs and reduce stigma.

Key areas of the assessment include the following general and humanitarian concerns: poverty, unemployment, insecurity, war, fighting, economic problems, disunity, oppression, sexual and gender-based violence, theft, bribes, addiction to narcotics, violence and adequate supplies of clean drinking water, food, shelter and safety were mentioned. Further, the impact of COVID-19 has made people's lives even more difficult.

Stress, depression and anxiety are the most common mental health problems mentioned. People also mentioned narcotics, excessive anger, epilepsy, psychosis, PTSD, personality disorder, OCD, GAD, ADHD and loss of concentration.

People in the community address mental health problems in a number of ways, but most of them report that they have to accept and tolerate the current situation because it is from Allah. Coping activities reported include visiting shrines and/or mullahs, distributing foods or money with relatives and poor people (Nazir), studying, sightseeing, visiting friends and relatives, watching movies, sports, sharing with others and so on.

Section 6: Recommendations

This needs assessment proposes urgent and long-term recommendations to various actors in Afghanistan.

1. Increasing MHPSS programing to increase mental health awareness and reduce stigma.

The findings here show high levels of stigma and discrimination among people living with mental illness. We propose community awareness sessions to opinion leaders, such as community and religious leaders, to raise awareness on mental health conditions and the psychosocial challenges facing communities. These sessions can be prioritized to target the most vulnerable groups, such as women and girls. We also propose raising awareness for specific mental health conditions that were reported as high across the regions. For instance, participants across the regions where we conducted this evaluation reported depression and anxiety. Providing information on these conditions will help the community better accept those living with symptoms of these disorders.

2. Implementing evidence-based, scalable psychological interventions to address depression, anxiety and stress.

Findings revealed that three most common mental health problems in the humanitarian context of Afghanistan are stress, depression and anxiety. The findings point to the existence of small-scale psychosocial programs in Afghanistan, but most of the

organizations are providing only small-scale, basic psychosocial services and PFA. International Medical Corps proposes additional evidence-based psychological interventions that are widely implemented in global humanitarian contexts. In Afghanistan, to address stress, depression and anxiety, we propose implementation of brief, evidence-based interventions, such as WHO Problem Management Plus (PM+), WHO/Columbia University Group Interpersonal Therapy (Group IPT), WHO Self-help Plus (SH+) or the Common Elements Treatment Approach (CETA). A more comprehensive approach can be adopted by training community health workers in the use of with PM+ and PFA, while training healthcare and frontline workers to provide mhGAP in outpatient departments across the regions.

3. Developing specific and adapted approaches/interventions for children and persons with disabilities.

International Medical Corps found similar challenges among people living with disabilities, but the findings also highlight the challenges that come with living with disabilities, such as a loss of opportunities. International Medical Corps found the regions to be lacking special programs in education and other related services for people living with disabilities. We recommend the following measures.

Disability-focused organizations should develop specific interventions that fit into the special needs of their constituents. We particularly recommend special psychotherapy programs for intellectually challenged children and their families.

The government of Afghanistan should develop child-friendly spaces focusing on play therapy, art therapy and drama for children living with disabilities.

NGOs, such as International Medical Corps, should coordinate activities with organizations that support children living with disabilities to develop life-skill curriculums and share with appropriate organizations and communities.

The government and states in Afghanistan should formulate and implement policies relating to housing and basic facilities that support people living with disabilities.

4. Establishing a strong referral pathway between specialized mental health hospitals and public health facilities.

The findings on existence of mental health services show that most communities utilize general healthcare facilities rather than specialized ones. But the respondents also had no information on the existence of specialized services. Shortages of essential psychotropic medications, lack of knowledge of medical staff on psychotropic drug administration and absence of pharmacotherapy training in most public health facilities is a known barrier to an effective referral system in many regions of Afghanistan.

We recommend ongoing capacity-building initiatives that will support integration of facilities, and creation of a referral system across healthcare programs that will spread from the community level. This includes establishment of referral centers that address mental health from a biopsychosocial perspective.

The government should also allocate resources to build basic infrastructure that can support sustainable referral and integration mechanisms. We propose purpose-built mental health hospitals with essential services, such as electricity and water systems.

International Medical Corps should closely coordinate with other MHPSS working groups and all mental health service providers at the provincial levels, to ensure complete integration of mental health services with general healthcare. This would include providing regular coordinated training to frontline workers.

5. Training first responders on PFA and effective communication skills at the community level.

This needs assessment shows that problems and challenges in Afghanistan are far from over given that in this year alone, more than 15,000 people have been displaced because of war and conflict.

There should be ongoing training and capacity-building of first responders on PFA, and basic essential services should be accessible to vulnerable communities and individuals. A more appropriate response would be for International Medical Corps to conduct training-of-trainers sessions in PFA. Those trained would continue to build the capacity of frontline healthcare workers.

6. Addressing the treatment gap by providing mental health care within general healthcare programs.

WHO advocates that every primary healthcare center should have at least one health professional trained in how to identify and manage mental disorders. Mental health integration is part of the national strategy of Afghanistan that has yet to be implemented. We recommend that the government work with International Medical Corps to integrate mental health into the primary healthcare system. We also recommend:

- helping the Ministry of Public Health implement the national mental health strategy;
- ensuring that various mental health actors conduct services in line with existing national mental health policies and plans; and
- reviewing the national mental health policy stipulation regarding authorization for doctors and nurses to prescribe or continue prescription of psychotropic medications, advocating for mhGAP-trained and supervised health professionals to be given the rights to prescribe such medications, as part of efforts to address the treatment gap.

see WHO Mental Health Gap Action Program (mhGAP)-Humanitarian Intervention Guide and see and accompanying mhGAP operations manual

see International Medical Corps' Toolkit for the Integration of Mental Health into General Healthcare in Humanitarian Settings