International Medical Corps

Afghanistan Mental Health and Psychosocial Support (MHPSS) Needs Assessment

Faryab and Sar-e Pol Provinces

TABLE OF CONTENTS

List of Acronyms

CHC	Comprehensive Health Centers
CHW	Community Health Worker
DH	District Hospital
FGD	Focus Group Discussion
GBV	Gender-Based Violence
IEC-M	Information, Education and Communication Materials
KII	Key Informant Interview
MHPSS	Mental Health and Psychosocial Support
MNS	Mental, Neurological, and Substance Use
MoPH	Ministry of Public Health
MHD	Mental Health Department
MD	Medical Doctor
PFA	Psychological First Aid
PSS	Psychosocial Support Services
PSSC	Psychosocial Support and Counseling
PHC	Primary Healthcare
PTSD	Post-Traumatic Stress Disorder
PPHD	Provincial Public Health Department
RHDO	Relief Humanitarian Development Organization
STC	Save the Children
SAF	Solidarity for Afghan Families
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization
WVI	World Vision International

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Introduction

International Medical Corps conducted this assessment to identify MHPSS needs and resources in two northern provinces: Faryab and Sar-e Pol. The assessment aims to inform program design and implementation and assess the sources of psychosocial distress, the availability of existing MHPSS services and critical gaps in services, the accessibility and barriers to services, community attitudes toward people with mental health disorders, as well as traditional coping mechanisms and help-seeking behaviors among affected populations, and mental health and psychosocial issues associated with the COVID-19 pandemic. The report provides recommendations for all key actors and stakeholders to improve the delivery of MHPSS services in Afghanistan, where 40 years of war, recurrent natural disasters, chronic poverty, drought and the COVID-19 pandemic have left 24 million people in need of humanitarian assistance.[1] The recent escalation in conflict and resulting upheaval have exacerbated needs and further complicated an extremely challenging operational context.

Methodology

The proposed approach is based on International Medical Corps' global good practice and a desk-based review of available MHPSS data from countrywide and regional program assessment documents, focus-group discussions (FGDs) and key informant interviews (KIIs). The data was collected in December 2021 through a total of 32 FGDs (16 per province) with 319 community members (159 male and 160 female) and 39 KIIs (31 male and eight female) with community leaders, stakeholders and heads of the health facilities in these two provinces. The data was analyzed in January 2022, and assessment findings were considered in program implementation and shared through MHPSS-TWG with stakeholders in March 2022. The International Medical Corps MHPSS team considers the findings and recommendations of the report still valid, as no major changes in the context have occurred, and no other assessment showing different findings has been conducted in this area recently.

Results

The assessment findings show war and conflict, recurrent natural disasters, chronic poverty, drought, violence, displacement, the recent political changes in Afghanistan, and the humanitarian emergency, which has become even more dire, are the main sources of psychological distress. Sadness, aggression, stress, anxiousness, fear, hopelessness, despair and unexplained physical symptoms like headaches and body pains are the most frequently reported mental health problems in both provinces. Moreover, the assessment shows that the COVID-19 pandemic also caused mental health problems such as fear, stress, anxiety and social withdrawal.

Another finding of this assessment is the lack of MHPSS integration into healthcare services, including the availability of medicines, capacity-building and workforce. Furthermore, most of the health facilities are too far from residential areas, and case identification, referral services and awareness-raising are not provided in a standardized and structured way.

The main reported service barriers included financial constraints, cultural sensitivity/stigma, the distance of clinics and a lack of mental health professionals. Other barriers, according to key stakeholders, were the lack of MHPSS awareness among community members, living in remote rural areas and the lack of MHPSS services and medications in health centers, especially in Sar-e Pol province. The assessment revealed that mental conditions are highly stigmatized in Afghanistan, with 50% of the respondents stating that community people have negative thoughts and attitudes toward people with mental health problems. Furthermore, more than 50% of the respondents stated that the community people have misbehavior (isolating, stigmatizing, ignoring for making decisions, beating, etc.), and they refuse to interact with people suffering from mental health problems. The reported common coping mechanisms and help-seeking behaviors among affected populations included: taking medication for relaxation, going to the shrine, doing chores to make them busy, reading, talking with others, sleeping, seeking medical help, sharing sympathy with them, attending community gatherings, being with friends, recitation of the Holy Quran, going to mullahs (religion leaders) and isolating in a small room.

Recommendations

1. Provide and scale up the community-based psychosocial interventions, including PFA and PSS to specific vulnerable groups such as children, persons with disabilities, and women.
2. Build the capacity of the new and existing mental health and social service providers to deliver evidence-based psychosocial interventions.
3. Conduct MHPSS awareness-raising campaigns for community members.
4. Advocate with livelihood and protection actors to meet basic needs and consider self-sufficiency activities and services for community people.
5. Develop preventive mental health actions for children and youth—train International Medical Corps and other active MHPSS actors' staff on group interventions, such as International Medical Corps' evidence-based Youth Empowerment Program.

1 Afghanistan Flash Appeal: Immediate Humanitarian Response Needs (Sept-Dec 2021): https://reliefweb.int/report/afghanistan/afghanistan-flash-appeal-immediate-humanitarian-response-needs-sept-dec-2021

6. Establish new health facilities in the assessed provinces, where the HFs are too far from residential areas, including the center of the Sar-e Pol, Sayyad and Sozmqala, and the Almar district of Faryab province.
7. Advocate via MHPSS Technical Working Group (TWG) members to encourage donors for funding to enhance the integration of MHPSS into the BPHS package in the health facilities with trained and specialized MHPSS staff to address mental, neurological, and substance use conditions in non-specialized care settings in each health facility.
8. Provide adequate essential WHO psychotropic medications in each capacitated Health facility, with a clear linkage/referral pathway with sub-health centers.
9. Train the service provider organizations' staff on evidence-based scalable psychological interventions, like WHO's Problem Management Plus (PM+), Thinking Healthy, Self Help Plus (SH+), and others.
10. Encourage actors/implementers to design their programs based on the Interagency Standing Committee (IASC) Guidelines of Mental Health and Psychosocial Support in emergency settings.
11. Develop coordination and referral mechanisms among organizations and agencies, including the HFs, to strengthen the referral process and provide need-based, comprehensive services to community people.
12. Advocate for investment in the education, clinical training and supervision of psychologists and psychiatrists to enable them to better deliver comprehensive and specialized mental health services.
13. Engage key members of the community with relevant backgrounds (e.g., psychologists, social workers, teachers) as community outreach workers (representing different ethnic groups) who can help identify, support, and refer people with mental health needs.

Section 2: Assessment methodology and data sources

International Medical Corps conducted this needs assessment in Almar, Khwaja Sabz Posh, Qaisar, and Pashton Kot districts in Faryab province and Sozmaqala, Sar-e Pol Center and Sayyad districts in Sar-e Pol province to identify the different sources of psychosocial distress, key needs for psychosocial support services, and strengths and weaknesses of the available services. The assessment in these new locations, which were already identified as geographic areas for implementing MHPSS programs with Save the Children, our implementation partner, will complement the findings of International Medical Corps' previous MHPSS assessment in other provinces and provide a broader picture of the PSS needs in the northern provinces. Sharing the recommendations with different stakeholders and actors will help to better design the MHPSS programs and services based on the needs of the communities.

The primary objectives of this MHPSS needs assessment are:

1. To understand the community's perceptions of mental health and well-being and the attitude of the community toward people with mental health problems.
2. To identify the coping strategies, traditional practices and structures for help-seeking behaviors among affected populations.
3. To identify the current MHPSS services and resources, as well as available technical capacity and gaps in targeted areas, and barriers to accessing mental health services.
4. To identify MHPSS needs and sources of psychosocial distress, including COVID-19 mental health-related issues faced by women, girls, men and boys.
5. To share recommendations based on the MHPSS need assessment for further MHPSS programming.

Methodology

The proposed approach, based on International Medical Corps' global good practice, combined a desk-based review of available MHPSS data from countrywide and regional programs or assessment documents, specific peer-reviewed literature across relevant databases, focus group discussions and key informant interviews. The assessment also makes use of the existing internal International Medical Corps program data and reports and beneficiary feedback. A desk review of relevant documents included:

1. HeRAMS Afghanistan Baseline Report 2022: Noncommunicable disease and mental health services https://cdn.who.int/media/docs/default-source/documents/emergencies/herams/herams-afg-baseline-report-2022-ncd-and-mental-health.pdf?sfvrsn=d4f41888_1&download=true
2. OCHA. Rapid Capacity Survey. August 2021 https://reliefweb.int/sites/reliefweb.int/files/resources/rapid_capacity_survey_summary_report_august_2021.pdf

3. OCHA. Afghanistan Flash Appeal: Immediate Humanitarian Response Needs (Sept-Dec 2021), https://reliefweb.int/sites/reliefweb.int/files/resources/afghanistan_immediate_humanitarian_response_needs_sep_-_dec_2021.pdf
4. WHO Mental Health ATLAS 2020- Afghanistan, https://www.who.int/publications/i/item/9789240036703
5. Provincial Background (World data Atlas- Afghanistan); https://knoema.com/atlas/Afghanistan/Sar-e Pol
6. A national survey on depressive and anxiety disorders in Afghanistan, published on June 22, 2021: https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-021-03273-4
7. Humanitarian needs overview Afghanistan 2022; https://reliefweb.int/report/afghanistan/afghanistan-humanitarian-needs-overview-2022-january-2022
8. National Strategy for Mental Health 2019-2023: https://moph.gov.af/sites/default/files/2019-09/Mental%20Health%20Staregy%202019-2023.pdf
9. National Mental health Survey and Assessment of Mental Health Services: https://moph.gov.af/index.php/dr/%D8%B1%D9%87%D9%86%D9%85%D9%88%D8%AF-%D9%87%D8%A7
10. The impact of persons with mental health problems on family members and their coping strategies in Afghanistan 2022 https://www.interventionjournal.org/article.asp?issn=15718883;year=2022;volume=20;issue=1;spage=28;epage=35;aulast=Oriya

In addition to the literature review, focus group discussions (FGDs) and key informant interviews (KIIs) were used to collect data at the community and health facilities level. A total of 32 FGDs (16 per province) were conducted with a total of 319 community people (159 males and 160 females) with two different age groups—under 18 years old and over 18 years old—to obtain information on common mental health (MH) problems in the community, at-risk/most affected groups, cultural perceptions regarding MH, coping methods, where communities access MH services (formal and informal) and their views on this access and COVID-19 MH-related issues. We conducted a total of 16 KIIs (eight per province) with community leaders/community representatives/women's association leaders.

Further, six KIIs (two in Sar-e Pol and four in Faryab) were conducted with MHPSS stakeholders/organizations and agencies—for simple MHPSS 4W mapping, MHPSS needs, resources and gaps—as well as organizations and agencies that are providing health, protection (child protection and GBV) and nutrition services.

Furthermore, a total of eight KIIs to assess the level of MHPSS integration into healthcare services were conducted with the heads of the health facilities, including comprehensive health centers (CHCs) in Sar-e Pol Center, Sozmaqala and Sayyad districts of Sar-e Pol province and nine KIIs in Faryab with the heads of the health facilities, which consisted of CHCs, comprehensive health center plus (CHC+), basic health centers (BHC) and a provincial hospital. Information regarding the availability of essential WHO psychotropic medicines at the centers was collected along with details regarding the number of staff trained on the clinical management of mental health disorders, the number of patients with mental health disorders observed in the last month in each center and the established referral pathways for mental health care.

Section 3 : Background and context

Humanitarian context in Afghanistan

Forty years of war, recurrent natural disasters, chronic poverty, drought and the COVID-19 pandemic have left 24 million people in need of humanitarian assistance.[1] The recent escalation in conflict and resulting upheaval have exacerbated needs and further complicated an extremely challenging operational context. While all population groups across the country have been affected, the consequences for women and girls have been most immediately felt.[2] Based on the press release by HNI on October 6, 2021, one in two people living in Afghanistan suffers from psychological distress. Findings of a recent study[3] on the prevalence of poor mental health among adolescents in Kabul, Afghanistan, indicated that being female and of younger age is associated with poorer mental health.

Humanitarian emergencies have become direr since the recent political changes in Afghanistan. Since August 2021, political, social and economic shocks have reverberated across the country with massive deterioration of the humanitarian and protection situation in

1 https://www.unocha.org/afghanistan
2 https://reliefweb.int/report/afghanistan/afghanistan-flash-appeal-immediate-humanitarian-response-needs-sept-dec-2021
3 https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2793513

the fourth quarter of 2021, and the outlook for 2022 remains profoundly uncertain. An unprecedented number of civilians were killed and injured in the early months of 2021, and at least 560,000 people were displaced, including nearly 120,000 fleeing to Kabul as they sought refuge from Taliban advances. Those numbers represent the worst period in one of the world's deadliest conflicts. Eighty percent of those fleeing violence since the end of May 2021 have been women and children. Thousands of displaced people in Kabul have been sleeping in the open air, and only a minuscule portion of them escaped during the international airlift that ended on August 30, 2021.[1]

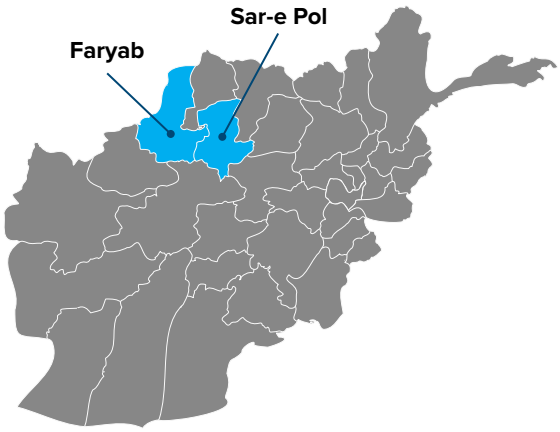
A multi-sectorial rapid assessment analysis by the UNHCR[2] shows that households have lost income and are struggling to survive, resulting in families resorting to harmful coping mechanisms. One year after the political changes in the country, a World Bank survey showed that two-thirds of households in the country continue to struggle to meet basic food and non-food needs.[3] Severe socioeconomic situations trigger psychosocial problems, gender-based violence, and serious child protection issues, including child labor and exploitation, and inhibit access to education as children may be forced to work or beg. Another assessment by OCHA found that in terms of mental health, three-quarters (74%) of the assessed households reported having at least one member that showed a behavioral change (excessive sad mood or crying) in the year before data collection, including both male and female adults (29% and 36% respectively). The most frequently reported reason for this behavior change was "poverty or financial stress."[4]

According to the Mental Health Atlas 2020 Afghanistan Country Profile, the total number of mental health professionals (gov. and non-gov.) is 1,086, the total number of mental health workers per 100,000 population is 2.85, and the total number of child psychiatrists (gov. and non-gov.) is two. It is reported that there is one mental hospital and four psychiatric units in general hospitals in the country that serve as inpatient care facilities.[5]

Geographic aspects

Afghanistan is a landlocked, mountainous country located at the crossroads of Central and South Asia. The country is the 40th largest in the world in size, occupying 652,864 square kilometers (252,072 square miles). It is bordered by Pakistan to the east and south, Iran to the west, Turkmenistan and Uzbekistan to the north and Tajikistan and China to the northeast.

Faryab is one of the 34 provinces of Afghanistan, which is in the north of the country bordering neighboring Turkmenistan. It has a population of approximately 1.1 million, which is multi-ethnic and mostly a tribal society. The province encompasses 15 districts and more than 1,000 villages. The capital of Faryab province is Maymana. It also borders other provinces, including Jowzjan, Sar-e Pol, Ghor and Badghis. The main languages are Uzbek, Turkmen, Dari and Pashto.[6]



Sar-e Pol is another province in Afghanistan, located in the north of the country. It borders Jowzjan and Balkh to the west and north, Ghor to the south and Samangan to the east. The province is divided into seven districts and contains 896 villages. It has a population of about 632,000, which is multi-ethnic and mostly tribal. The city of Sar-e Pol serves as the provincial capital. The main languages are Dari-Persian, Uzbek and Turkmen.[7]

Demographic aspects

The population of Afghanistan is around 40 million as of 2021. The nation is composed of a multi-ethnic and multilingual society, reflecting its location astride historic trade and invasion routes between Central Asia, Southern Asia and Western Asia. Ethnic groups in the country include Pashtun, Tajik, Hazara, Uzbeks, Nuristanis, Aimaq, Turkmen, Baloch and some others which are less known. Approximately 46% of the population is under 15 years of age, and 74% of all Afghans live in rural areas. The average woman gives birth to five children during her entire life, the highest fertility rate outside of Africa. About 6.8% of all babies die in childbirth or infancy. The average life expectancy of the nation was reported in 2019 at around 63 years, and only 0.04% of the population has HIV. The country's official languages are Dari and Pashto.[8]

1 https://reliefweb.int/report/afghanistan/afghanistan-s-growing-humanitarian-crisis
2 UNHCR Afghanistan 2021 Multi Sectorial Rapid Assessments Analysis: https://reliefweb.int/report/afghanistan/unhcr-afghanistan-2021-multi-sectorial-rapid-assessments-analysis
3 https://reliefweb.int/report/afghanistan/afghanistan-welfare-monitoring-survey-awms-round-2-november-2022-enfaps
4 OCHA, Whole of Afghanistan Assessment (WoAA) 2021, https://reliefweb.int/sites/reliefweb.int/files/resources/REACH_AFG_Key-Sectoral-Findings_Factsheet-Booklet_WoAA-2021_September-2021.pdf
5 https://cdn.who.int/media/docs/default-source/mental-health/mental-health-atlas-2020-country-profiles/afg.pdf?sfvrsn=d701faec_6&download=true%20
6 https://en.wikipedia.org/wiki/Faryab_Province
7 https://en.wikipedia.org/wiki/Sar-e_Pol_Province#Healthcare
8 https://en.wikipedia.org/wiki/Demographics_of_Afghanistan

The population of Faryab province is 1,109,223; the average age is 35, based on a survey by Forsvarets Forsknings Institutt (FFI) in 2015.[1] Common languages in this province include Uzbek, Turkmen, Dari and Pashto; the education/literacy rate was 29.6 % in 2012.[2] Ethnic groups of this province are multi-ethnic and mostly tribal.

The population of Sar-e Pol province was reportedly 632,000 in 2013, and 41.54 % were males under 18 years of age.[3] Languages spoken in this province are Dari-Persian, Uzbek and Turkmen. The overall literacy rate (6+ years) was 23 % in 2011,[4] 18% for males and 6% for females. Religious groups in this province are Sunni, Shi'a, Isameli (minority), Syyed Shi'a and Sufis (minority), and the province is multi-ethnic and mostly a tribal, consisting of an Uzbek majority, Pashtun, Hazara and Syyeds, and some small Arab and Tajik communities.[5]

Groups especially at risk of suffering in humanitarian crises

Since the Taliban retook control of Afghanistan in August 2021, the country has been grappling with twin economic and humanitarian crises, in addition to the purely economic impacts of the shock. And decreases in aid devastated social services in Afghanistan, one of the success stories in the country over the past 20 years. Basic health services, previously funded entirely by donors' development programs, are collapsing, with health facilities running out of medical supplies and health workers going unpaid for several months. Education, a more controversial sector than health, especially regarding girls' schooling and curriculum issues, is affected greatly, with hundreds of thousands of teachers—who are civil servants in Afghanistan's education system and many of whom are women—not getting paid due to a lack of funds in the Afghan budget.[6] Women, returnees, internally displaced persons (IDPs), persons with disabilities, children, older persons and ex-soldiers, and ethnic groups, such as the Kuchi nomads, are generally considered vulnerable groups.[7]

General health system

Afghanistan's health system has been steadily progressing over the past 17 years, with increasing coverage of health services throughout the country. In 2018, a total of 3,135 health facilities were functional, which ensured access to almost 87% of the population within two hours. Afghanistan's National Health Policy 2015-2020 included five policy areas: governance, institutional development, public health, health services and human resources. The recently developed One UN strategy focuses on health system strengthening, among other health topics.[8] WHO and UN agencies were helping the government to implement the National Health Policy 2015-2020 and Strategy 2016-2020.

According to the Human Development Index, Afghanistan is the 21st least developed country in the world. It is one of the only three remaining countries that has not eradicated polio. Its average life expectancy at birth stands around 64 years (2019). The country's maternal mortality rate is estimated at 638 deaths per 100,000 live births, and its infant mortality rate could be as high as 106 per 1,000 live births. Around 15,000 people die annually from various forms of cancer.[9]

Afghanistan is experiencing an extensive and complex humanitarian crisis characterized by political and economic instability, a severely weakened health system, food insecurity and malnutrition, ongoing infectious disease outbreaks, the COVID-19 pandemic, severe drought and several natural disasters. Universal access to emergency primary healthcare does not exist in Afghanistan. At least 1,000 health facilities located across the country are not currently supported by an institution. In these underserved areas, 70% of the population must travel more than 10 km, often on foot, to reach the nearest health center. The escalation of humanitarian needs was fueled by the political events of August 2021.[10]

Mental health and psychosocial context and mental health system

In Afghanistan, mental health has been accepted as one of the Public Health Ministry's priorities and became a part of the Basic Package of the Health Services (BPHS) in 2003, and was recognized as a public health issue in 2008. The Mental Health Department (MHD) was established in 2005 in the Ministry of Public Health (MOPH). The department consists of mental health and drug demand reduction sections. The mandate of the MHD is to ensure the continuing relevance, dissemination, implementation and monitoring of the National Mental Health Strategy.[11]

1 National Statistic and Information Authority (NSIA). April 2021. Retrieved June 21, 2021, cited in Wikipedia: https://en.wikipedia.org/wiki/Faryab_Province
2 https://knoema.com/atlas/Afghanistan/Faryab
3 https://knoema.com/atlas/Afghanistan/Sar-e-Pul/Population
4 https://knoema.com/atlas/Afghanistan/Sar-e-Pul/Overall-literacy-rate-6-years
5 https://knoema.com/atlas/Afghanistan/Sar-e-Pul
6 https://www.usip.org/publications/2021/10/afghanistans-economic-and-humanitarian-crises-turn-dire
7 https://gsdrc.org/publications/social-exclusion-issues-in-afghanistan/
8 http://www.emro.who.int/afg/programmes/health-system-strengthening.html
9 https://en.wikipedia.org/wiki/Health_in_Afghanistan
10 https://cdn.who.int/media/docs/default-source/emergency-preparedness/jmo_who_ghea-2022_afghanistan.pdf?sfvrsn=35c37990_3&download=true#:~:text=Of%20the%2024.4%20million%20people,does%20not%20exist%20in%20Afghanistan
11 https://moph.gov.af/sites/default/files/2019-09/Mental Health Staregy 2019-2023.pdf

The government spends only $7 (USD) per capita on health services annually, far below the $30 to $40 that the United Nations Commission on Macroeconomics and Health considered appropriate in 2001. The Public Health Ministry says only about 26 cents of that is spent on mental health. While the mental health budget has increased since 2006, it remains below the $3 to $4 per capita the World Health Organization (WHO) has determined is an appropriate investment for mental health systems in low-income countries such as Afghanistan.[1]

Mental health strategy

A national mental health strategy was developed in 2009 and executed in 2010. The strategy was developed for five years (2010-2014) and revised in 2015. The strategy's strong points are the integration of mental health services into the BPHS, EPHS, and specialty hospitals at the tertiary level and a strong referral system at the three tiers of the healthcare system in Afghanistan, and the identification and referral of mental disorder cases at the community level. The national mental health strategy for 2019-2023 has been developed based on the evaluation of previous one and based on international documents and conventions.[2]

In Faryab province, there are 17 CHCs actively providing PSS services, mainly counseling, throughout the 14 districts of Faryab province. Particularly, there is one CHC in every district of Faryab and three CHCs in Maimana city, the center of Faryab province.

In 2012, there were 16 basic health centers, two district hospitals, and eight comprehensive health centers for Sar-e Pol.[3] Per discussions with the mental health department of the MoPH, there is no confirmed, updated number of MHPSS-trained staff in each health facility.

Mental health and psychosocial problems and resources

Forty-one years of war have had a devastating impact on the mental health of millions of Afghans. A 2018 European Union survey found that 85% of the Afghan population had experienced or witnessed at least one traumatic event. Half of those surveyed had experienced psychological distress, with one in five Afghans "impaired in his or her role because of mental health problems.[4] "According to the National Mental Health Survey and Assessment of Mental Health Services in Afghanistan (December 2018), diagnosis by household informants by region "at the time of the interview" was 5.8% for dementia (age > 65), 4.17% for behavior problems, 3.64% for depression, 2.61% for any addiction, 1.35% for epilepsy, 1.14% for psychosis and 0.97% for mania, while the 12-month diagnosis rates were 8.32% for substance use disorders, 7.25% for suicidal thoughts (for suicidal plan 3.96%, and for suicidal attempt 3.43%), 5.34% for post-traumatic stress disorder (PTSD), 4.86% for a major depressive episode and 2.78% for generalized anxiety disorder.[5]

Living with a family member with mental health conditions in Afghanistan has been shown to impact caregivers' behavior and practical life and causes severe stigma for the family.[6] Families feel helpless, caregivers experience high levels of distress, and they need emotional support and effective, healthy coping mechanisms.

A national survey on depressive and anxiety disorders in Afghanistan, published June 22, 2021, showed that 80% of the population lives in very dangerous areas, with 64.67% of the Afghan population has experienced at least one traumatic event and 78.48% having witnessed one such event. In addition, 60.77% experienced collective violence with war, though this differs across regions and levels of danger. Women are less at risk for trauma except for sexual violence, and women 35 years and above are more at risk than younger women. The 12-month PTSD prevalence rate is 5.34%, and the major depressive episode rate is 11.71%, whereas the generalized anxiety disorder rate is 2.78%, the rates for suicidal thoughts are 2.26%, and the lifetime suicidal attempts rate is 3.50%.[7] A recent report from Save the Children also found that one in four girls were showing signs of depression or anxiety, and that two-thirds of children said they felt negative feelings, including feeling more worried, sad and angry.[8]

In the latest report of the HeRAMS Afghanistan Baseline Report 2022 series focusing on the availability of noncommunicable disease treatment and mental health services, the main barriers impeding service delivery include the lack of staff, training, financial resources, and medical supplies and equipment.[9] In a press release in October 2022, Save the Children reported that the majority of children and adults who need psychosocial support services cannot access them because the services don't exist in their communities.[10]

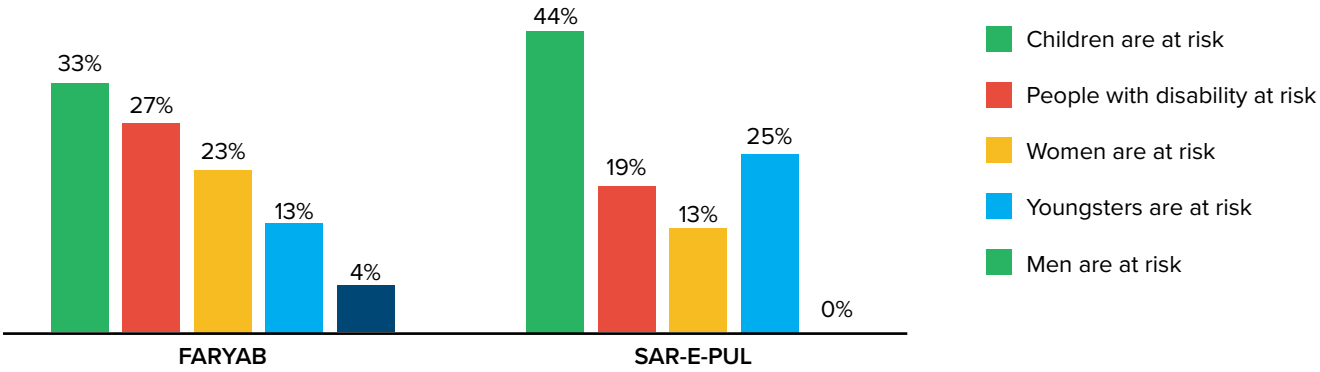
1 https://reliefweb.int/report/afghanistan/afghanistan-little-help-conflict-linked-trauma
2 https://moph.gov.af/sites/default/files/2019-09/Mental%20Health%20Staregy%202019-2023.pdf
3 https://knoema.com/atlas/Afghanistan/Sar-e-Pul/Basic-Health-Centers
4 https://reliefweb.int/report/afghanistan/afghanistan-little-help-conflict-linked-trauma
5 European Union: National Mental health Survey and Assessment of Mental Health Services (December 2018)
6 The impact of persons with mental health problems on family members and their coping strategies in Afghanistan, Spozhmay Oriya, Tayeba Alekozai, Intervention vol: 20 issue: 1 first page: 28 year: 2022
7 https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-021-03273-4
8 https://reliefweb.int/report/afghanistan/breaking-point-life-children-one-year-taliban-takeover
9 https://www.who.int/publications/m/item/herams-afghanistan-baseline-report-2022-ncd-and-mental-health-services
10 https://reliefweb.int/report/afghanistan/she-would-hit-her-head-wall-continuously-afghanistan-brink-mental-health-catastrophe-children-pushed-limit

Section 4: Results of the assessment

At-risk groups

Children, women, people with disabilities, young people (10-18 years old) and men were reported by most of the FGDs' participants as at-risk groups in both Faryab and Sar-e Pol. In Faryab province, 46.8% of participants reported children, 26.2% reported people with disabilities, 13.7% reported young people, 12.5% reported women and 1.5% participants reported men as at-risk groups. In Sar-e Pol province, 32.7% of participants reported children, 34.5% reported people with disabilities, 12.5% reported women, 14.4% reported youth, and 5.6% participants reported men as at-risk groups. Of the KIIs participants, 43.75% reported children, 25% reported women, 18.75% reported people with disabilities, and 12.5% reported youth as those suffering the most from the current crisis in both provinces. In Faryab, in addition to the aforementioned groups, those who have medical problems, government employees, people with mental health disorders, and poor people were also reported as at-risk groups by the stakeholders during the KIIs.

Chart 1: At-risk groups reported through KIIs



Further, during the KIIs with stakeholders, the enumerators asked how MHPSS services and access to these services can be tailored to the at-risk groups' needs. In Sar-e Pol, they suggested having more appropriate procedures and services—such as having professional and trained staff deliver interventions based on needs—in the clinics, awareness-raising should be done, and more professional staff should be hired. Similarly, KIIs respondents in Faryab suggested building a health center for both men and women with psychological problems. MHPSS professionals should be recruited in the clinics, and mobile teams should be increased, including house-to-house consultations, awareness sessions regarding mental health issues and mental health services supervised by MHPSS experts.

Mental health-related problems

Sadness, aggression, stress, insomnia, anxiety, fear, hopelessness and despair are the mental health-related symptoms that were mostly reported during the FGDs by males and females of both age groups in both provinces. The percentages reported problems are in Tables 1-3.

Table 1: General mental health-related problems by FGD participants in both provinces

PROVINCE	GENDER	AGE GROUPS (UNDER 18 AND ABOVE 18)	% OF REPORTED PROBLEMS						
			SADNESS	AGGRESSION	STRESS	INSOMNIA	FEAR	HOPELESS	ANXIETY
Sar-e Pol	Male	UNDER 18 Y	31%	27%	19%	13%	5%	4%	2%
		ABOVE 18 Y	23%	21%	18%	18%	6%	0%	14%
	Female	UNDER 18 Y	28%	29%	8%	22%	1%	0%	12%
		ABOVE 18 Y	22%	14%	15%	19%	9%	4%	17%
Faryab	Male	UNDER 18 Y	12%	17%	30%	21%	8%	1%	11%
		ABOVE 18 Y	6%	11%	21%	16%	21%	5%	20%
	Female	UNDER 18 Y	25%	14%	24%	27%	2%	5%	3%
		ABOVE 18 Y	10%	8%	34%	17%	6%	6%	19%

During the KIIs with the project stakeholders, including World Vision International (WVI), Save the Children and Solidarity for Afghan Families (SAF) in both provinces, respondents reported sadness, suicide, aggression, anxiousness, stress, loneliness and social withdrawal as the main mental health or stress-related problems that people have in the respective communities.

In Sar-e Pol, participants stated aggression, suicide, anxiousness and loneliness, while in Faryab province, participants stated anxiousness, stress, grief, anger and sadness as the most important problems. Furthermore, they have reported that good behavior, giving proper advice, providing financial support, awareness-raising and counseling could help people with MH problems. Having good communication, being friendly, providing cash support and life skills training, hiring more mental health experts and having appropriate services based on needs to overcome the issues are also required to help these people. KII stakeholders stated that children, people with disabilities, elders, women and government employees are suffering from the current crises. As reported by the interviewees, MHPSS needs among the most vulnerable are being met by visiting clinics that do not have appropriate procedures, services and awareness-raising. The MHPSS needs of the most vulnerable people should be tailored, and the provision of equipment to the clinics, awareness-raising and recruitment of more professional staff are needed; this is further explored in Table 4.

Table 2: Mental health-related problems by gender and age group in Faryab province reported in FGDs

GENDER	AGE GROUP	HOPELESS	FEAR	ANXIETY	STRESS	INSOMNIA	AGGRESSION	DEPRESSION
Male	Under 18 Y	1%	8%	11%	30%	21%	17%	12%
	Above 18 Y	5%	21%	20%	21%	16%	11%	6%
Female	Under 18 Y	5%	2%	3%	24%	27%	14%	25%
	Above 18 Y	6%	6%	19%	34%	17%	8%	10%

Table 3: Mental health-related problems by gender and age group in Sar-e Pol province reported in FGDs

GENDER	AGE GROUP	HOPELESS	FEAR	ANXIETY	STRESS	INSOMNIA	AGGRESSION	DEPRESSION
Male	Under 18 Y	4%	5%	2%	18%	13%	27%	31%
	Above 18 Y	0%	6%	14%	18%	18%	21%	23%
Female	Under 18 Y	0%	1%	12%	8%	22%	29%	28%
	Above 18 Y	4%	9%	17%	15%	19%	14%	22%

Table 4: Mental health-related problems reported through KIIs with stakeholders

MENTAL HEALTH ISSUES REPORTED BY KIIS WITH STAKEHOLDERS IN SAR-E POL AND FARYAB PROVINCES			
PROVINCE	**MOST IMPORTANT PROBLEMS**	**WHAT IS BEING DONE TO HELP PEOPLE WITH THIS PROBLEM?**	**WHAT MORE COULD BE DONE TO HELP PEOPLE WITH THIS PROBLEM?**
Sar-e Pol	People at risk of suicide and self-harm	Talking and empathizing with people with mental health problems	Good communication—we must be friendly with those at risk of suicide and self-harm, providing life skills training/orientations
	Sadness	Good behavior (acceptance and good interactions with them)	Support people with mental health problems through their daily life and daily activities, like education, working space/area and treatment support.
	Aggression, anger	Psychological consultations, being empathetic with them and supporting them in solving their basic problems	Cash support; vocational courses; provide employment opportunities for those with mental health problems
Faryab	Grief, loneliness, and sadness	Talking and empathizing with people with mental health problems	A comprehensive approach/complex of services should be made for them to overcome the issues (having all; basic, focused, and specialized services).
	Intense anger	Flexible behavior and financial support	Short-term anger management training
	Anxiousness, stress, and sadness because of economic conditions	Awareness-raising and counseling	More specialists (professionals and/or people trained in mental health interventions) should be hired in health facilities

In Sar-e Pol province, aggression, stress, and sadness were reported as the most serious problems by community leaders, while the stakeholders, including WVI, Save the Children and SAF, reported sadness, aggression, loneliness and people at risk of suicide and self-harm as the most serious problems. In Faryab province, anxiousness and fear were reported as the most serious problems by community leaders, while the above-mentioned stakeholders reported additional anxiousness, grief, sadness, intense anger and stress as the most serious problems.

Tasks that are difficult for someone who suffers from mental health problems

In Sar-e Pol and Faryab provinces, people with mental health problems are reported as having potential difficulties in performing their routine activities, such as women facing challenges in caring for their children and in concentrating. The children have difficulties taking part in school/education classes, and generally, people with mental health conditions have challenges in decision-making and building relationships.

Table 5: Mental health issues and tasks which are difficult for someone with mental health issues

NO.	MENTAL HEALTH/ PSYCHOSOCIAL ISSUES	TASKS/ACTIVITIES THAT ARE DIFFICULT FOR PEOPLE WITH MH PROBLEMS
1	**Sar-e Pol** • Insomnia • Sadness • Aggression	• Unable to perform daily activities and lack control over daily performance • Not taking part in home affairs; not giving time to family members. • Cannot decide, lose interest in life affairs and prefer to be isolated • Unable to perform chores, cannot focus on tasks and cannot maintain a relationship with family and neighbors. • Cannot wash clothes, cannot feed a child, cannot pray, cannot do anything, cannot forgive.
2	**Faryab** • Sadness Continuous unexplained fear and anxiousness	• Cannot do anything due to fatigue and insomnia • They cannot concentrate or focus • Being unable to maintain family and relative relationships

Table 6: Coping methods used by community members

PROVINCE	COPING METHODS USED BY COMMUNITY MEMBERS	
Sar-e Pol	• Taking medication for relaxation • Going to the shrine • Doing chores to keep them busy and reading • Keeping themselves happy talking with others • Sleeping • Seeking help related to health • Sharing sympathy with them	• Inviting them to community gatherings • Going out with friends • Recitation of the Holy Quran • Drinking cold water • Going to Mullah and the doctor • Providing them with consultants
Faryab	• Taking to mullahs (religion leaders) • Keeping them in a small room • Keeping them away from the community members • Taking them to the doctor	

Community attitudes toward people with mental health conditions

The local language used to describe mental health problems: The participants of FGDs provided the below responses in Sar-e Pol and Faryab provinces when the enumerators asked about the local language used to describe mental health problems:

Table 7: The local language used to describe mental health problems

LOCAL LANGUAGE USED	MEANING OF THESE WORDS
Sar-e- Pol province	
Rawani	Unusual condition, confusion during activities and interactions with others,
Diwana	Unusual condition, mad, doing everything wrong, weak-minded. Abnormal behavior (e.g., strange appearance, self-neglect, incoherent speech, wandering aimlessly, mumbling or laughing to oneself)
Ahmaq	Weak-minded, has difficulties in interactions and doing activities, absurd (irritable or moody)
Lawda	Ineffective performance and interactions, the person is doing things that should not be done
Faryab province	
Diwana	Uncommon acts or misbehavior, doing everything wrong, weak-minded. Abnormal behavior (e.g., strange appearance, self-neglect, incoherent speech, wandering aimlessly, mumbling or laughing to oneself).
Ahmaq	Weak-minded, hair-brained or foolish, absurd (a temperamental person who gets angry easily or quickly changes from one mood to another)
Rawani or Lawdah	Unusual condition, mentally disturbed

Community perceptions about people with mental disorders:

In Sar-e Pol province, 60% of male youth and 50% of men over 18 years old reported that the community people think that people with mental health problems are weak-minded, and the other 40% of youth males and 50% of men over 18 years old consider them as vain and irrational (ineffective/ineffectual), respectively. Similarly, among female respondents, women under 18 years old perceive people with mental health disorders as weak-minded (53%), vain and irrational (ineffective/ineffectual) (47%), while 80% of females over 18 years old think that people with mental health disorders are weak-minded and 20% think they are vain and irrational (ineffective/ineffectual).

In Faryab province, 45% of FGD male youth participants reported perceiving people with mental health problems as aggressive, while the rest (55%) of them reported that people with mental health problems have “abnormal” behavior/misbehave. Sixty percent of adult males reported considering people with mental health problems as aggressive, and the other 40% perceived them as people with “abnormal” behavior/misbehaving. As for the female respondents, 48% of youth females perceive people with mental health problems as being aggressive, and 52% of them reported as people with “abnormal” behavior/misbehaving, while 50% of adult females reported that people with mental health conditions are aggressive, and 50% of responders reported them as people with “abnormal” behavior/misbehave.

Chart 2: Community perceptions about people with mental health problems in Faryab

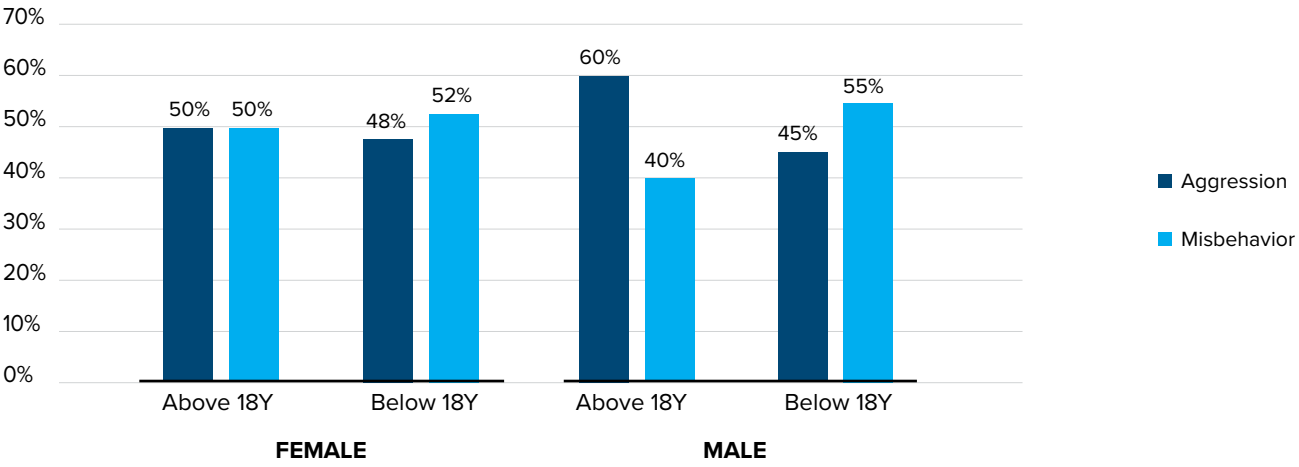
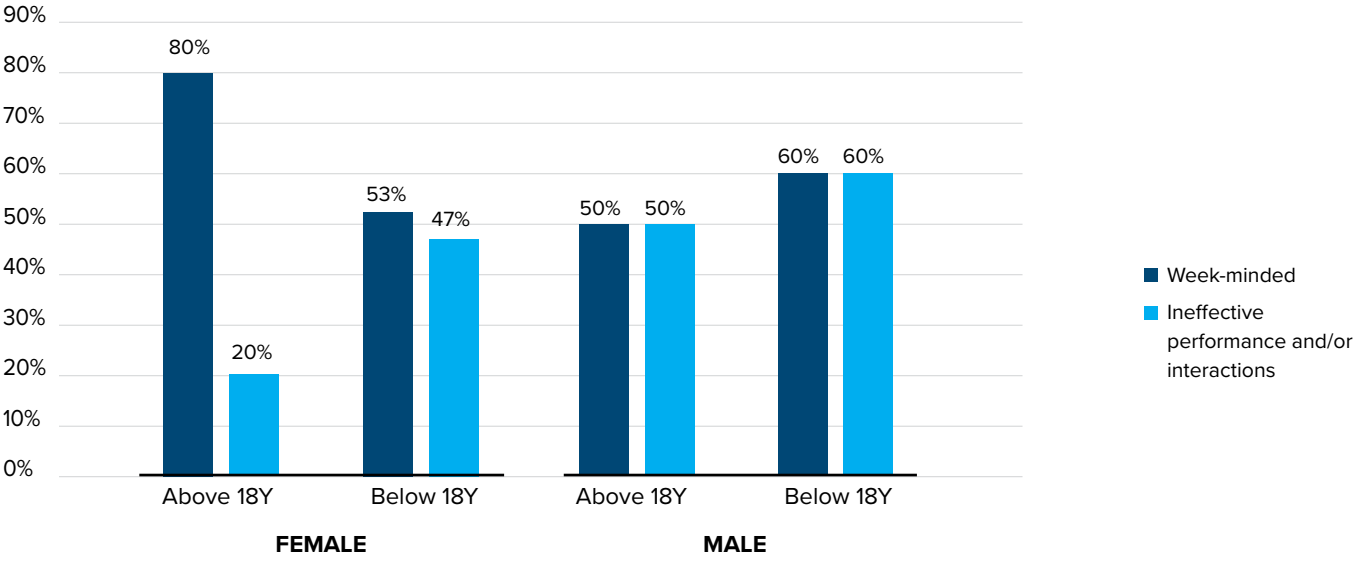


Chart 3: Community perceptions about people with mental health problems in Sar-e Pol

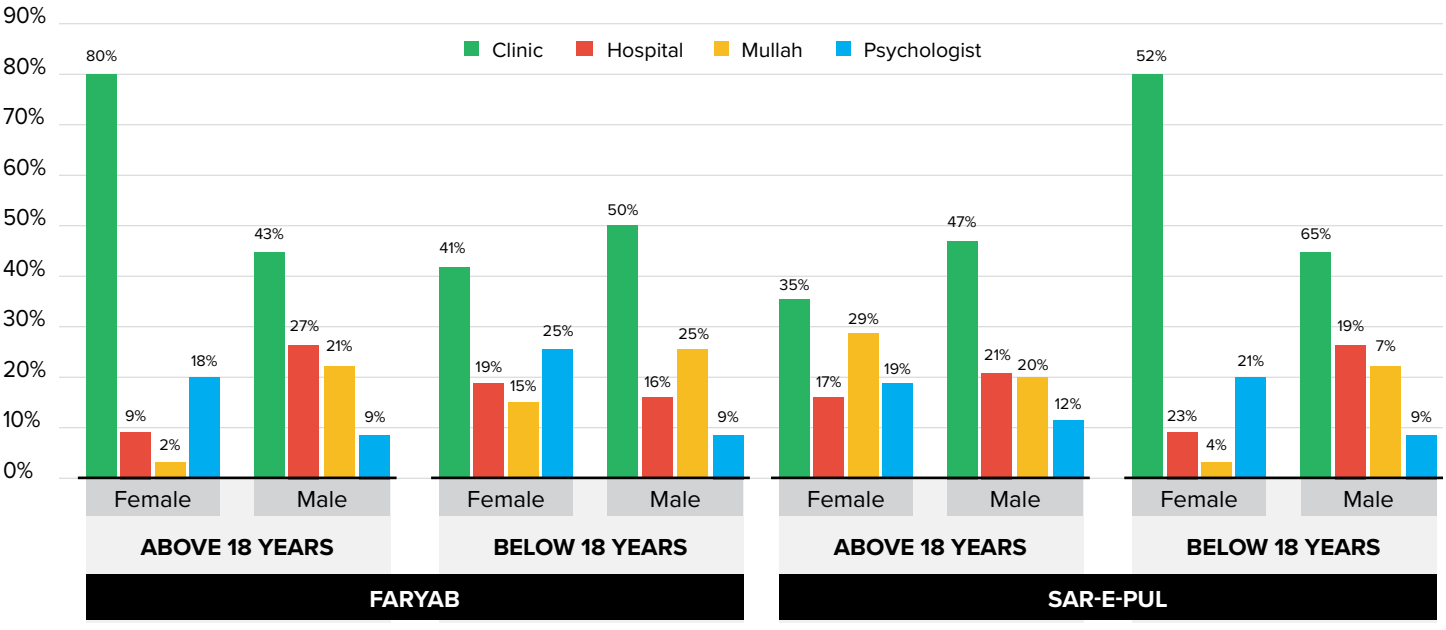


During the FGDs with community members in Sar-e Pol province, participants reported that people with mental health problems are disobedient, they are aggressive (stoning other people), as well as community people are afraid of people suffering from mental health problems. The same issues were reported during the FGDs with community members in Faryab province and KIIs with community leaders of both provinces.

Community resources and support for people with mental health conditions

In both provinces, community resources and support include financial support, good behavior (acceptance, not stigmatizing, and helping them in their daily work), providing advice and emotional support and inviting them to social gatherings. Further, during the FGDs, when asked about the references and options for supporting people with mental health problems, participants reported clinics, hospitals, Mullah and psychologists/counselors in both provinces; further details and percentages are provided in Chart 4.

Chart 4: Resources and support for people with mental health issues reported by FGDs

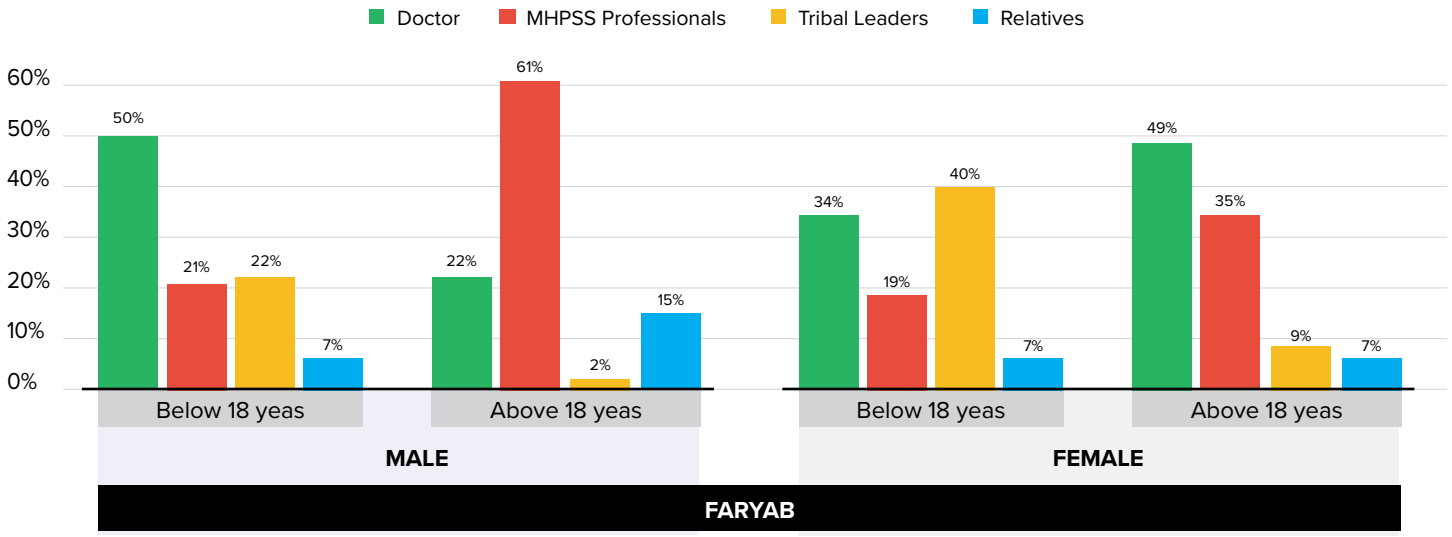


*Clinic: included the health facilities in CHC, CHC+, SHC, etc.

** Hospital: include district hospitals, provincial hospitals, and regional hospitals

Additionally, related to the above question, the participants in both provinces reported the most qualified people to support mental health services include MHPSS professionals, tribal leaders and relatives. Further details and percentages are provided in Chart 5. During FGDs with community members, all participants responded with “financial support” when asked, “What more could be done to help the affected person?”

Chart 5: Most qualified people to support people with mental health problems reported by FGDs



Barriers to people seeking and accepting MHPSS services

In Sar-e Pol and Faryab provinces, the reported barriers included financial constraints, cultural sensitivity, long distances from clinics, and lack of professional staff and appropriate services.

Table 8: Barriers reported by FGDs in Faryab province

FARYAB PROVINCE						
GENDER	**AGE GROUP**	**FINANCIAL CONSTRAINTS**	**CULTURAL SENSITIVITY**	**DISTANCE OF CLINICS**	**LACK OF PROFESSIONALS**	**SHORTAGE OF MEDICINES**
Female	Above 18 Y	15%	30%	27%	8%	20%
	Below 18 Y	33%	21%	20%	19%	7%
Male	Above 18 Y	44%	6%	19%	10%	21%
	Below 18 Y	25%	10%	22%	19%	24%

Table 9: Barriers reported by FGDs in Sar-e Pol province

SAR-E POL PROVINCE						
GENDER	**AGE GROUP**	**FINANCIAL CONSTRAINTS**	**CULTURAL SENSITIVITY**	**DISTANCE OF CLINICS**	**LACK OF PROFESSIONALS**	**SHORTAGE OF MEDICINES**
Female	Above 18 Y	14%	27%	41%	12%	6%
	Below 18 Y	22%	21%	16%	11%	30%
Male	Above 18 Y	27%	10%	27%	30%	6%
	Below 18 Y	30%	19%	27%	5%	19%

Furthermore, the interviews with KII stakeholders, including WVI, Save the Children and SAF, identified as the main barriers the lack of MHPSS services, lack of qualified service providers and medications in the health centers, financial problems, lack of community awareness regarding mental health and mental health conditions and living very far from the village or province. Further, due to the stigma around MHPSS, most people with MH issues are not willing to disclose their MH problems to others.

Mental health problems related to the COVID-19 pandemic

In both provinces, fear, stress, being anxious, social withdrawal and social issues, such as education avoidance, were reported as mental problems related to the COVID-19 pandemic by both age and gender groups. Further details and percentages are provided in Table 10.

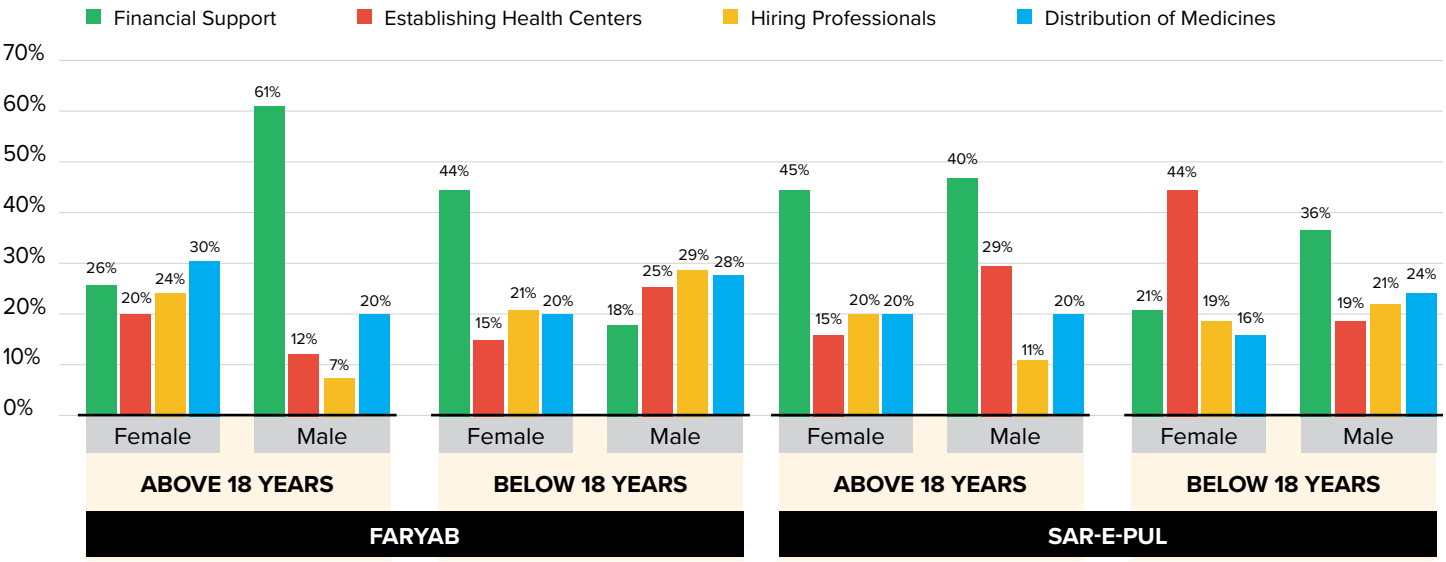
Table 10: Mental health-related issues associated with COVID-19 reported by FGDs in Sar-e Pol and Faryab

FARYAB PROVINCE						
GENDER	**AGE GROUP**	**FEAR**	**STRESS**	**ANXIETY**	**LONELINESS**	**EDUCATIONAL PROBLEMS**
Female	Above 18 Y	12%	37%	15%	19%	17%
	Below 18 Y	26%	15%	28%	17%	14%
Male	Above 18 Y	12%	20%	18%	15%	35%
	Below 18 Y	20%	30%	21%	9%	

Community suggestions regarding the MHPSS services and mental well being

The participants in this assessment were asked to share their suggestions regarding MHPSS services and strengthening the community members' well-being. In both provinces, they recommended financial support, establishing health centers, hiring MHPSS professionals and ensuring the availability of medicines.

Chart 6: Community suggestions regarding MHPSS and well-being



During the KIIs, the stakeholders suggested MHPSS awareness-raising activities, increasing health staff, availability of relevant medicines, hiring MHPSS specialists, building and establishing clinics, providing MHPSS services as part of primary healthcare services by CHCs, distribution of food to the health centers for staff and inpatients and financial support.

MHPSS integration into the primary and secondary healthcare services

Workforce (health facility staff)

During the KIIs with the heads of health facilities in Faryab province, the provincial head of the provincial hospital reported that there are 231 staff members (148 males and 83 females) working as health facility staff at the hospital. Of the staff, 147 are medical doctors, 50 CHWs, 29 nurses, one social worker, one psychiatrist and/or one medical doctor (MD) trained on MHPSS interventions and two psychosocial (PSS) counselors. They provide services for an average of 300 patients in eight daily clinical hours; 138 staff (66 males and 72 females) are working

in seven primary healthcare facilities in four districts, of which 14 are medical doctors, 94 CHWs, 10 nurses, 12 midwives, two social workers, one psychiatrist, and/or one MD trained on MHPSS interventions and five psychosocial counselors, providing services for an average of 93 patients in each health facility within eight daily clinical hours. In Sar-e Pol province, there are 65 staff members (19 males and 46 females) working in eight primary healthcare facilities in four districts, of which 22 are medical doctors, 19 CHWs, 13 midwives, four social workers, three nurses, one psychiatrist and/or one MD trained on MHPSS interventions and two PSS counselors. An average of 69 patients are served within eight daily clinical hours in each health facility in Sar-e Pol. Based on the reported numbers, for every two facilities, there is one mental health staff member (psychologist, PSS counselor, psychiatrist or MD trained on MHPSS interventions).

Medications availability in health facilities

The medications in Table 11 were available in the pharmacy or near the primary care clinic in the previous month in all CHCs, BHCs, CRCs, and provincial hospitals covered under this assessment in the targeted districts of Sar-e Pol and Faryab province. There was a variance of (never, often, and usually) in the availability of psychotropic medications in all locations. Notably, antipsychotic and antiparkinsonian medications were not available in the assessed facilities in Sar-e Pol, whereas in Faryab province, only antiparkinsonian medications were not available.

Table 11: Medication availability reported by the head of health facilities in Sar-e Pol and Faryab

PROVINCE	MEDICATION	AVAILABILITY DURING THE PAST MONTH
Sar-e Pol	Generic antidepressant medication	Usually
	Generic anxiolytic medication	Usually
	Generic antipsychotic medication	Never in 5 HFs out of 8
	Generic antiepileptic medication	Often
	Generic antiparkinsonian medicine	Never
Faryab	Generic antidepressant medication	Often
	Generic anxiolytic medication	Often
	Generic antipsychotic medication	Usually
	Generic antiepileptic medication	Usually
	Generic antiparkinsonian medicine	Never

Basic laboratory services

Based on the KIIs with the heads of health facilities in Sar-e Pol and Faryab provinces, out of the eight health centers in each province, five of them have some laboratory services such as toxicology screening tests, thyroid function tests, serum lithium levels, rapid blood sugar test, liver function test, creatine clearance and complete blood count tests. The types are listed in Chart 7.

Chart 7: Number of health facilities and availability of basic laboratory services of health (facilities in Sar-e Pol and Faryab)

BASIC LABORATORY SERVICES AVAILABILITY IN HEATH CENTERS		
Sar-e Pol	Toxicology screening test	3
	Thyroid function test	3
	Serum litium Level	4
	Rapid blood sugar test	3
	Liver function test availble	4
	Creatine clearance test	3
	Completed blood count	5
Faryab	Toxicology screening test	3
	Thyroid function test	2
	Serum lithium level	0
	Rapid blood sugar test	4
	Liver function test available	1
	Creatine clearance test	3
	Completed blood count	4

Health staff training in the past two years

Within the past two years in all assessed health facilities in both provinces, the CHC staff received a variety of MHPSS-related capacity-building training, including communications skills, basic support to bereaved people, PFA, management of mental health priority conditions, basic problem-solving counseling approach, ethics and the rights of people with mental health problems. Post-training supervision was also provided.

Table 12: Health staff training indicator reported in Faryab and Sar-e Pol provinces

PROVINCE	DISTRICT	TRAINING TOPICS	% OF STAFF TRAINED?	HOW MANY SESSIONS OF SUPERVISION WERE PROVIDED?
Faryab	Almar	Communication skills, offering basic support and PFA	50%	3
	Khwaja Sabz Posh	Offering basic support to bereaved people	68%	4
	Qaisar	Management of MH priority conditions, basic problem-solving, and counseling approach	37%	2
	Pashton Kot	Management of MH priority conditions, communication skills, and offering PFA	54%	4
Sar-e Pol	Sozmaqala	Offering PFA, ethics and the rights of people with mental health problems	50%	2
	SRP Center	Management of MH priority conditions, offering PFA	71%	4
	Sayyad	Communication skills and the basic problem-solving counseling approach, and ethics and the rights of people with mental health problems	50%	1

Health facilities' staff's capacity for clinical management of Mental, Neurological and Substance use (MNS) conditions

In Sar-e Pol province, depression, anxiety/stress-related disorders (e.g., PTSD) and medically unexplained somatic complaints were the most frequently reported MNS conditions managed by the staff of the health facilities, while none of the eight assessed health facilities had staff capable of managing substance use disorders. In contrast, nearly all of the eight assessed health facilities in Faryab province reported having staff capable of managing depression, psychosis/bipolar disorder, epilepsy/seizures, developmental and behavioral disorders, dementia, alcohol and substance use disorders, self-harm/suicide, anxiety/stress-related disorders (e.g., PTSD) and medically unexplained somatic complaints.

Table 13: Health Facilities' staff's capacity for clinical management of MNS

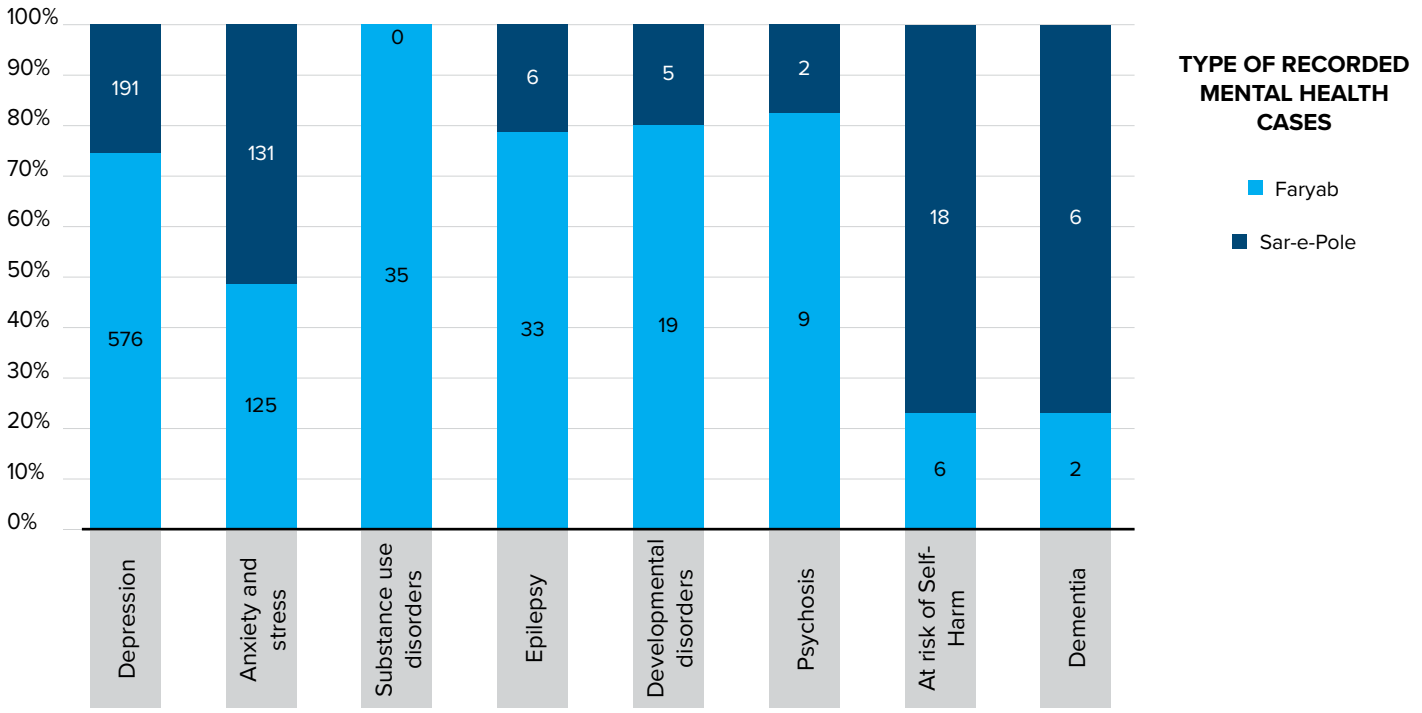
MNS CONDITIONS	NUMBER OF HEALTH FACILITIES THAT CAN MANAGE THE LISTED MNS CONDITIONS IN	
	SAR-E POL	FARYAB
	OUT OF EIGHT HEALTH FACILITIES	OUT OF EIGHT HEALTH FACILITIES
Depression	6	8
Psychosis	2	8
Epilepsy/seizures	3	8
Developmental and behavioral disorders	2	7
Dementia	1	8
Substance use disorders	0	8
Self-harm/suicide	3	7
Anxiety/stress-related disorders (e.g., PTSD)	6	7
Medically unexplained somatic complaints	6	8

Health information system indicators

In Sar-e Pol province, more than seven mental disorders are documented in the monthly morbidity report. According to the health information system, in the previous month, 191 cases of depression, 131 of anxiety/stress-related disorders (e.g., PTSD), 18 of self-harm/suicide, six of epilepsy, six of dementia, five of developmental disorders, two of psychosis and 860 cases of other mental health-related problem cases were recorded at these CHCs.

In Faryab province, eight mental disorders were documented in the health facilities' monthly morbidity reports. According to the health information system, in the previous month, 576 cases of depression, 125 of anxiety/stress-related disorders (e.g., PTSD), 35 of substance use disorders, 33 of epilepsy, 19 of developmental disorders, nine of psychosis, two of self-harm/suicide and two cases of dementia were recorded at these CHCs.

Chart 8: Health information system indicators in Sar-e Pol and Faryab



Social indicators

In Sar-e Pol province, six out of the eight health facilities are within safe walking distance for the catchment population, with the longest distance being 75 km and the shortest distance being 4 km. Five health centers are organized in a way that respects privacy (e.g., a curtain around the consultancy area; private room). In six CHCs, procedures are in place to ensure that patients provide consent before major medical procedures, and five of the CHCs provide free-of-cost services, while three charge fees for consultations and at least one staff member in all eight CHCs speaks the local language.

In Faryab province, seven out of the eight assessed health facilities are within safe walking distance for the catchment population, the longest distance is 40 km, and the shortest distance is 4 km. Four health centers are organized in a way that respects privacy (e.g., a curtain around the consultancy area; private room), whereas in all eight CHCs, procedures are in place to ensure that patients provide consent before major medical procedures. All eight CHCs provide free-of-cost services, and at least one staff member speaks the local language.

Referral indicators

In Sar-e Pol province, referral options for cases in need of further mental health care are available in five CHCs, while a referral and follow-up protocol for emergency cases, including at-risk patients (e.g., cases of self-harm/suicide), is available in two CHCs. In addition, CHCs receive mental health-related referrals from mental health specialists and seldom from CHWs and other community workers, schools, social services and traditional /religious healers.

In Faryab province, referral options for cases in need of further mental health care are available in all eight CHCs, while referral and follow-up protocols for emergency cases, including at-risk patients (e.g., cases of self-harm/suicide), are available in five CHCs. In addition, CHCs frequently receive mental health-related referrals from mental health specialists and seldom from (CHWs), other community workers, schools, social services and traditional/religious healers.

Community outreach indicators

The awareness-raising, health promotion initiatives and poster distribution are organized through CHWs in both Sar-e Pol and Faryab provinces at the community level.

When asked whether any awareness-raising/health promotion initiative relevant to mental health was organized in the last year, all the heads of health facilities responded that none were organized.

Impact of the emergency/humanitarian situation on the provision of MHPSS services

The emergency did not have an impact on the availability and provision of MHPSS services. In Sar-e Pol province, 105 staff members were working at any given time in the assessed HFs—that number remained the same before and after the emergency. Four of the HFs had, on average, two types of psychotropic medicines available (the medications referenced in the "Medications availability in health facilities" section), with a total of 666 patients per day seeking help for any health problem in all eight CHCs in Sar-e Pol.

In Faryab province, 226 staff members were working at any given time, and some of the psychotropic medicines were available in all assessed HFs sometimes. A total of 815 patients per day were seeking help for any health problem in all eight CHCs in the targeted health facilities. Even though the findings of this assessment are not indicative of a deterioration of the MHPSS services provision due to the current emergency which resulted from the political changes in August 2021, the lack of MHPSS integration into healthcare services, including the availability of medicines, capacity-building and workforce is apparent.

Representatives of the captioned NGOs (HEWAD, SAF, RHDO, SCI, WVI, SCI, INC) were asked about emergency responses in Sar-e Pol and Faryab provinces and how the conflict had affected services provided by their organizations. They reported that before August 2021, they couldn't reach most districts because of conflict. In the current context, it's extremely challenging to implement GBV-related activities, and the coverage of protection, MHPSS and nutrition programs is not sufficiently meeting the needs of the most vulnerable populations.

MHPSS service mapping

There are five organizations in Sar-e Pol and four organizations in Faryab province engaged in mental health and psychosocial activities and services.

Table 14: MHPSS actors in Faryab province

FARYAB			
Organization	**Services and Activities**	**Working areas**	**Time period**
SAF	Identifying the people with mental health problems, providing basic solutions, and dealing with GBV problems.	They work in all 14 districts in CHCs	Ongoing
WVI			
Save the Children			
International Medical Corps			

Table 15: MHPSS actors in Sar-e Pol province

SAR-E POL			
Organization	**Services and Activities**	**Working areas**	**Time period**
International Medical Corps	FPC, Case Management and Counseling	SRP Center, Sayyad and Sozamqala	Ongoing
HEWAD	FPC, Case Management and Counseling	SRP Center, Sayyad and Sozamqala	Ongoing
SAF	MHPSS Counseling	All districts in Sar-e Pol	Ongoing
RHDO	MHPSS Counseling	All districts in Sar-e Pol	Ongoing
Save the Children	MHPSS Counseling	SRP Center, Sayyad and Sozamqala	Ongoing

Section 5: Summary and recommendations

Summary

The assessment findings show that children, people with disabilities and women are the most at-risk groups in both Sar-e Pol and Faryab provinces. Depression, sadness, aggression, stress, anxiety, headache, fear, hopelessness and despair are the mental health-related problems most reported during the FGDs by males and females of both age groups of both provinces. In addition, aggression, suicide, anxiousness and loneliness were among the most important and serious problems reported in Sar-e Pol. The identified mental health problems reportedly caused limitations in performing routine activities, insufficient care for children, concentration difficulties, children with MH problems being unable to attend a school or becoming less active in classes and an inability to maintain healthy family relationships. Moreover, the COVID-19 pandemic also caused mental health problems such as fear, stress, anxiety and social withdrawal.

The report shows that most of the community members have negative thoughts and attitudes toward people with mental health problems. Furthermore, more than 50% of the respondents stated that the community people have negative behaviors toward people suffering from mental health problems—isolating them, stigmatizing them, ignoring them in decision-making, beating them—and they often refuse to interact with them due to lack of awareness on mental health-related problems and lack of family and community support for people with mental health problems.

The assessment revealed a lack of community-based MHPSS interventions, such as a lack of awareness-raising and psychoeducation on mental health and mental health conditions, inadequate availability of basic services, lack of community and family psychosocial support and focused non-specialized supports.

The main reported barriers and gaps in service provision and access included financial constraints, cultural sensitivity/stigma, the distance of clinics and a lack of mental health professionals. According to the KIIs with stakeholders, the main barriers are the lack of MHPSS services and the lack of mental health specialists and medications in health centers, especially in Sar-e Pol province. Other identified barriers by the KIIs stakeholders included cultural issues/ stigma (shame and fear of disclosing mental health problems), financial problems, lack of MHPSS awareness to community members and living in remote rural areas.

The assessment shows that MHPSS integration into healthcare services is not much considered, as the head of the provincial hospital in Faryab province indicated that in the provincial hospital, there are only two MDs trained on MHPSS interventions and one MHPSS counselor out of 231 staff members, providing services for an average of 300 patients with general health problems, including mental health. There are MHPSS services at the PHC, even though one MHPSS-trained staff member is not adequate to address the needs, and there should be at least two per facility. In Sar-e Pol, one specialized mental health staff member per two health facilities is available. Within the past two years, most of the CHC staff received the following MHPSS-related training: communication skills, offering basic support to bereaved people, PFA, management of mental health priority conditions, basic problem-solving and counseling approach and ethics and rights of people with mental health problems in the health facilities of both Faryab and Sar-e Pol provinces.

In Sar-e Pol province, CHC centers are well-competent in identifying and managing MNS conditions. In this province, more than seven mental disorders are documented in the monthly morbidity report. According to the health information system, during the past month, there were 191 cases of depression, six of epilepsy, two of psychosis/bipolar disorder, five of developmental disorders, six of dementia,

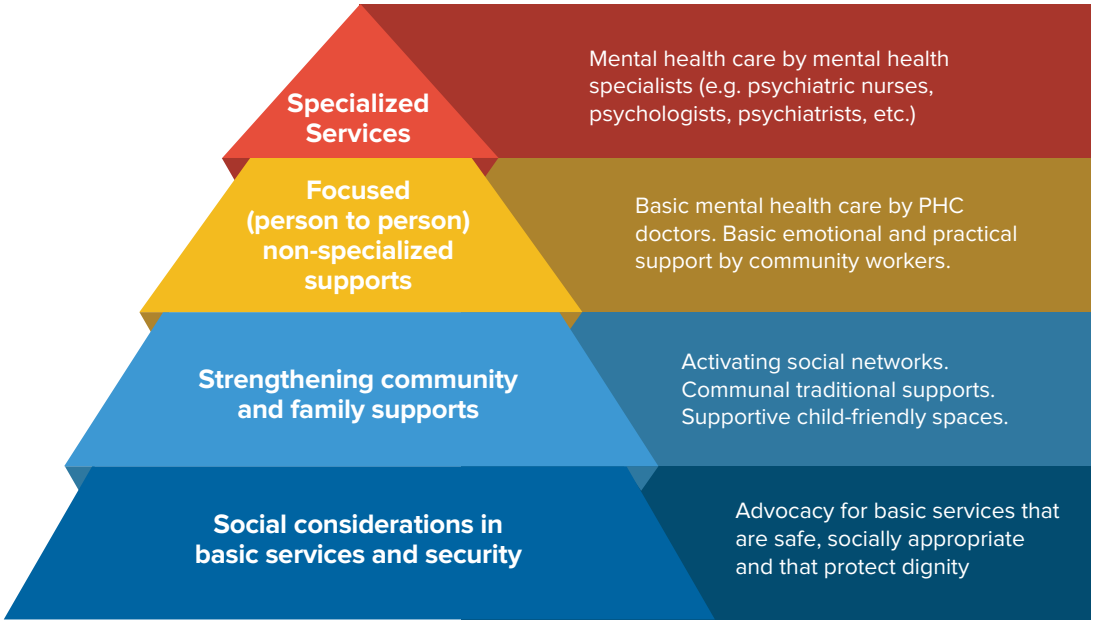
131 of anxiety/stress-related disorders (e.g., PTSD), 18 of self-harm/suicide and 860 cased of other mental health problems recorded at the CHCs. In Faryab province, eight mental health disorders are documented in the monthly morbidity reports. According to the health information system, during the past month, there were 576 cases of depression, 33 of epilepsy, 9 of psychosis, 19 of developmental disorders, two of dementia, 35 of alcohol and substance use disorders, 125 of anxiety and stress-related disorders (e.g., PTSD) and six cases of self-harm/suicide cases recorded at the CHCs.

MHPSS awareness-raising, health promotion and poster initiatives (providing IEC materials) at the community level of some catchment areas are organized by community health workers (CHWs) in both Sar-e Pol and Faryab provinces. There are five organizations in Sar-e Pol and four organizations in Faryab province that provide mental health and psychosocial activities and services. Two organizations in Sar-e Pol and four organizations in Faryab are engaged in health and nutrition activities and services. Three organizations in Sar-e Pol and two organizations in Faryab are engaged in protection activities and services.

Recommendations

Global standards outlined in the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007) include recommendations on different levels of mental health and psychosocial interventions using a pyramid approach, with basic needs and social considerations at the base, and increasingly advanced mental health services moving upward. The following recommendations address the various MHPSS needs and gaps identified in Sar-e Pol and Faryab provinces to enhance the quality and comprehensiveness of MHPSS services.

Chart 9: The IASC MHPSS Intervention Pyramid



Source: International Medical Corps

1. Provide and scale-up community-based psychosocial interventions through social activities, support groups and PSS to specific vulnerable groups such as children, people with disabilities and women, as there is a lack of community and family support interventions.
2. Build capacity of the new and existing mental health and social service providers to address the lack of professionals and trained staff in communities and health facilities, which will help provide additional clinical management for priority MNS conditions, mental health case management and other evidence-based PSS interventions, creating a comprehensive response for the needs and care of people with mental health problems.
3. Conduct MHPSS awareness campaigns for community people to raise awareness on normal stress reactions to adversity, mental health conditions and mitigation of stigma on mental health conditions, to cope with mental health-related problems, as the results of this assessment show lack of awareness on mental health and coping with mental health-related problems in communities.
4. Advocate with livelihood and protection actors for addressing basic needs and considering sustainable activities and services that enhance the self-sufficiency of communities, as the findings of the assessment show that financial problems and unemployment are identified as important barriers to receiving mental health care.

5. Develop preventive mental health actions for children and youth, who have been reported as vulnerable groups in this assessment—train International Medical Corps and other active MHPSS actors' staff on group interventions, such as International Medical Corps' Youth Empowerment Program.
6. Establish new health facilities. As reported in some districts (center of the Sar-e Pol, Sayyad and Sozmqala, as well as Almar district of Faryab province), the HFs are too far from their residential areas, and relevant actors and the government recommended considering this in their programs.
7. Advocate via MHPSS-TWG members to encourage donors to fund comprehensive MHPSS services or complete the BPHS package in the health facilities and provide training—including WHO's mhGAP-HIG (Mental Health Gap Action Program-Humanitarian Intervention Guide) and training to address mental, neurological, and substance use conditions in non-specialized care settings in each health facility based on BPHS system—to specialized MHPSS staff.
8. Provide adequate essential psychotropic medications as per WHO's recommendations in each capacitated health facility, especially antidepressants, anxiolytics, antipsychotic and antiepileptic drugs, and ensure specialized mental health services/care at the district level/district hospitals, including inpatient care with clear linkages and referral pathways with sub-health centers.
9. Train International Medical Corps and other NGO service providers/MHPSS staff on evidence-based, scalable psychological intervention to safely deliver psychological support (under supervision), including WHO's Problem Management Plus (PM+), Self Help Plus (SH+), Thinking Health and Interpersonal Therapy (IPT), as there is lack of professionals and trained staff on MHPSS interventions.
10. Encourage actors/implementers to design their programs based on different levels of Inter-Agency Standing Committee (IASC) Guidelines of Mental Health and Psychosocial Support in Emergency Settings, especially the fourth layer (specialized services), and advocate for the social considerations in basic services in a way that is appropriate to ensure the dignity, confidentiality and well-being of all beneficiaries and community members.
11. Develop coordination and referral mechanisms among organizations and agencies, including the HFs, to strengthen the referral process and provide need-based and comprehensive services to community people.
12. Advocate the national stakeholders for investment in the education, clinical training and supervision of counselors, psychiatrists and non-MH staff that are trained in MHPSS interventions like mhGAP to enable them to better deliver comprehensive and specialized mental health services.
13. Engage key members of the community with relevant backgrounds (e.g., social workers, teachers) as community outreach workers (representing different ethnic groups) who can help identify, support and refer people with mental health needs.