International Medical Corps

Rapid Mental Health and Psychosocial Support Needs Assessment

Nuristan Province, Afghanistan

TABLE OF CONTENTS

Section 1: Acknowledgments

International Medical Corps is thankful for the generous support of the Bill & Melinda Gates Foundation, which funded this rapid mental health and psychosocial support (MHPSS) assessment under an emergency response project. We thank our informants in the administrative structures, health facilities managers and NGO partners in the community for their input. Moreover, International Medical Corps thanks the mental health department in Afghanistan's Ministry of Public Health and Afghanistan MHPSS Working Group members for their unwavering support for data collection and desk review.

This report and MHPSS rapid needs assessment was undertaken by Afghanistan MHPSS Manager Mr. Roman Naseri, technically reviewed by Afghanistan MHPSS Coordinator Dr. Vail Alraas, and technically supervised by Global MHPSS Advisor Dr. Georgia Karoutzou, on behalf of International Medical Corps' Afghanistan country office.

We thank International Medical Corps enumerators who agreed to explore different challenging, hard-to-reach areas of Nuristan province where security issues, transport, and even walking are not secure.

Finally, thanks to the International Medical Corps team, especially Dr. Shamail Azimi, Dr. Kameen Wali, Dr. Muhammad Zahir Khan Sardar, Dr. Abdulrahman Adil, Dr. Georgia Karoutzou, Dr. Vail Alraas, and Claire Whitney, MIA, LICSW. Your support, advice and feedback were invaluable in carrying out this work.

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

For questions or to learn more about International Medical Corps' work in Afghanistan, kindly contact: Matthew Stearns, Country Director, at mstearns@internationalmedicalcorps.org.

Section 2: Goal

The goal of this rapid mental health and psychosocial support (MHPSS) assessment is to identify MHPSS needs and resources in Nuristan. The assessment aims to inform program design and implementation and assess the availability of existing, integrated MHPSS services in health facilities, accessibility and barriers to services, community perceptions of mental health and well-being, as well as coping mechanisms among affected populations, and mental health and psychosocial issues associated with the COVID-19 pandemic. The outcome of this assessment will inform International Medical Corps' upcoming MHPSS programming, referrals and coordination mechanisms.

Section 3: Methodology

The Rapid MHPSS Needs Assessment was conducted by International Medical Corps' MHPSS team, with technical support from Dr. Georgia Karoutzou, MD, Global MHPSS Advisor, Roman Naseri, MHPSS Manager, project field staff and with technical support from the monitoring and evaluation team, from December 1 to December 22, 2021. The assessment tools were adapted from the World Health Organization (WHO)/United Nations High Commissioner for Refugees (UNHCR) (2012) MHPSS assessment toolkit and the International Medical Corps MHPSS Basic Rapid Assessment Tools. The proposed approach, based on International Medical Corps' global good practice, combined a desk review of available MHPSS data from the country and regional programs and assessment documents—National Mental Health Survey and Assessment of Mental Health Services[1], National Strategy for Mental Health 2019-2023[2], WHO, Mental Health ATLAS 2020[3], and the Rapid MHPSS Needs Assessment conducted by International Medical Corps in 2021[4]—and specific peer-reviewed literature across relevant databases, focus group discussions and key informant interviews.

- **Service Mapping:** A simple MHPSS 4Ws (who, what, where and when, using Interagency Standing Committee (IASC) global guidance) mapping in the targeted areas was completed in collaboration with the MHPSS Technical Working Group for better coordination and information sharing. In this regard, a key informant interview was conducted with the organization Première Urgence-Aide Medical International, PU-AMI, (known globally as Première Urgence International, PUI), which provided MHPSS services in the targeted areas of Nuristan province.
- **Focus group discussions (FGDs):** International Medical Corps' 2017 Basic Mental Health Service Assessment Tools are used for conducting FGDs with community members from the implementation areas. Using this assessment tool, 16 FGDs were conducted with 162 community people (95 males and 67 females) with three different age groups—under 18 years old, 18-50 years old and over 50 years old—to obtain information on common mental health problems in the community, at-risk/most affected groups, cultural perceptions regarding mental health, where communities access mental health services (formal and informal) and their views on this access, as well as coping mechanisms among affected populations, and COVID-19 mental health-related issues.
- **Key informant interviews (KIIs):** A total of 12 KIIs with 12 heads of health facilities were conducted, consisting of two basic health centers, eight sub-health centers, one comprehensive health center and one district hospital in the target area of Nuristan province, to assess the level of MHPSS integration into healthcare services. Information regarding the availability of essential WHO psychotropic medicines at the centers, as well as details regarding the number of staff trained on the clinical management of mental health

[1] National Mental health Survey and Assessment of Mental Health Services, 2018, MoPH
[2] https://moph.gov.af/sites/default/files/2019-09/Mental%20Health%20Staregy%202019-2023.pdf
[3] https://www.who.int/publications/i/item/9789240036703
[4] https://app.mhpss.net/resource/imc-afghanistan-2021-mhpss-need-assessment-report

disorders, number of patients with mental health disorders observed in the last month in each center and the established referral pathways for mental health care. In Mandol district, the enumerator team was unable to hold FGDs with females under 18 and over 50 years old together. Instead, the team conducted separate KIIS with these groups—two KIIs with females under 18 and two KIIS with females over 50.

Further, gender, age and vulnerability were taken into account when conducting the assessment. Specifically, focus groups were segregated by gender and age with FGDs for youth, women and men. The team also conducted remote interviews with some stakeholders/organizations and agencies who provide MHPSS services in Nuristan province.

3.1 Geographical Scope

Region: Eastern
Province: Nuristan
Districts: Noorgram, Mandol and Kamdish

3.2 Timeline

The assessment was conducted December 1–December 22, 2021
Total duration: 3 weeks

Section 4: Background and Context

4.1 Country and Local Context

Afghanistan is a landlocked mountainous country located at the crossroads of Central and South Asia. It is bordered by Pakistan to the east and south—including a short border with Pakistani-controlled Kashmir, claimed by India—Iran to the west, Turkmenistan and Uzbekistan to the north, and Tajikistan and China to the northeast. Its population as of 2020 is 31.4 million, composed mostly of ethnic Pashtuns, Tajiks, Hazaras and Uzbeks. Kabul is its capital and largest city.[5]

Nuristan is one of the 34 provinces of Afghanistan, located in the eastern part of the country. It is divided into seven districts and is Afghanistan's least populous province. As of 2021, the total population of the province was about 166,676. According to the Naval Postgraduate School, 87% of people are Nuristanis, 10% are Pashtuns, and less than 3% are Gujars and ethnic Tajiks. Parun is the provincial capital. Nuristan is bordered on the south by Laghman and Kunar provinces, on the north by Badakhshan province, on the west by Panjshir province.[6]

[5] https://en.wikipedia.org/wiki/Geography_of_Afghanistan
[6] https://en.wikipedia.org/wiki/Nuristan_Province

The prevailing situation in Nuristan is complex and highly volatile. People's access to support services and the capacity of humanitarian responders to reach them is severely hampered by poor road infrastructure as well as seasonal and security-related closures. Insecurity along the main roads and lack of government control outside the provincial capital and major urban towns, and internal tribal conflict, restrict access to a number of districts for humanitarian partners, especially Barge-Matal and Kamdesh areas.[7]

Humanitarian activities continued in multiple locations across Afghanistan to meet lifesaving needs. Access challenges persist, including the limited participation of female humanitarians. Limited cash availability remains the most severe impediment to operations, though there are indications this is slowly beginning to ease with increased withdrawal limits from bank accounts; alternative solutions include *hawalas* (informal money transfers that don't involve banks). The security situation remains volatile and unpredictable, particularly in the Eastern Region.[8]

4.2 Mental Health Policies, Strategies, Workforce and Financing

In Afghanistan, mental health has been accepted as one of the Ministry of Public Health's (MoPH) priorities. Providing mental health services became part of the Basic Package of Health Services (BPHS) in 2003, and mental health was recognized as a public health issue in 2008. 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 strong points of this strategy are the integration of mental health services into the BPHS, Essential Package of Health Services (EPHS) and specialty hospitals at a tertiary level and a strong referral system in the three tiers of the Afghanistan healthcare system—primary, secondary and tertiary—and further identification and referral of mental disorder cases at the community level.[9] The national mental health strategy for 2019-2023 has been developed based on the evaluation of previous one and based on scientific evidence and international documents and conventions, such as the UN Sustainable Development Goals, the UN Convention on the Rights of Persons with Disabilities, the regional mental health strategy 2013- 2020, and within the framework of national health policy, national health strategy and the Afghan government's Mental Health Act.[10]

Further, based on Mental Health Atlas 2017 Afghanistan Country Profile, the total number of mental health professionals (governmental and non-governmental) is 561, with a rate of 1.66 mental health workers per 100,000 people, whereas the total number of child psychiatrists (governmental and non-governmental) is, "none or not reported." Inpatient care (total facilities) is reported at one mental hospital and four psychiatric units in general hospitals in the country.[11]

[7] https://reliefweb.int/sites/reliefweb.int/files/resources/Nuristan%20-%20Humanitarian%20Profile%20%28Jan%202014%29.pdf
[8] https://reliefweb.int/report/afghanistan/iom-afghanistan-situation-report-7-23-29-september-2021
[9] http://www.emro.who.int/afg/programmes/health-system-strengthening.html
[10] https://moph.gov.af/sites/default/files/2019-09/Mental%20Health%20Staregy%202019-2023.pdf
[11] https://www.who.int/publications/m/item/mental-health-atlas-country-profile-afghanistan

4.2.1 Mental health and psychosocial problems

Afghanistan is a multifaceted country with exposure to multiple, significant forms of adversity largely varying within regions and ethnicities, and personal exposure to potentially traumatizing events has been identified as a crucial mental health determinant.[12] Then gender, age, education level and level of danger of the environment mediate mental health risks. In 2018, the first National Mental Health Survey and Assessment of Mental Health Services was conducted in 16 provinces in eight zones in Afghanistan. Findings indicated that one Afghan out of two (47.72%) is suffering from psychosocial distress, and one out of five (24.30%) is reporting impaired functionality due to mental health problems. The overall one-year prevalence of depression reported is 4.86%; generalized anxiety is 2.78 %; PTSD is 5.34 %; misuse of substances is 8.22%; suicide ideation is 7.28 %; suicide attempt is 3.96 %, and suicide is 3.43%.[13] PTSD prevalence is similar to what was reported in countries exposed to war.[14]

An MHPSS needs assessment conducted by International Medical Corps in four northern and eastern provinces (Balkh, Jalalabad, Laghman and Kunar) at the beginning of 2021[15] showed that both male and female respondents consider stress, depression and anxiety as the most common issues of mental health in their communities, while they also talked about substance use, epilepsy, psychosis, PTSD, excessive anger, generalized anxiety and loss of concentration.

4.2.1.1 Major sources of distress

The same MHPSS need assessment conducted by International Medical Corps at the beginning of 2021[16] showed that FGD respondents identified the main difficulties/sources of distress that the people are facing in their communities as poverty, unemployment, insecurity, war, fighting, economic problems, disunity, violent behavior, oppression, relationship problems, theft, bribery, child abuse, substance misuse and violence. Some FGD male participants also stated that the lack of opportunities in agriculture, specifically harvesting, climate change, electricity and shelter, are problems that need to be addressed in all four provinces (Balkh, Jalalabad, Laghman and Kunar).

4.2.1.2 Help-seeking patterns

As per International Medical Corps' MHPSS need assessment (2021)[17], north region male respondents reported the following as help-seeking behaviors: studying, watching movies, sports, getting encouraged and motivated by others in the community, walking outside, accepting reality, talking to *mullahs* (religious leaders) for some religious beliefs and treatment purposes, and to a lesser extent substance misuse, traditional medication, or medical treatment. Female respondents reported visiting shrines, receiving religious guidance, doing *Nazir* (distributing food or money to relatives and poor people), a smaller number cited receiving support from their families, while some women also

[12] A national survey on depressive and anxiety disorders in Afghanistan: A highly traumatized population (22 June 2021) https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-021-03273-4

[13] European Union: National Mental health Survey and Assessment of Mental Health Services (December 2018)

[14] https://app.mhpss.net/resource/imc-afghanistan-2021-mhpss-need-assessment-report

[15] Ibid.

[16] Ibid.

[17] Ibid.

mentioned that coping mechanisms depend on everyone's level of perception, ability and understanding. For example, 56.5% of males and 45.75% of females said they think that the current practices and services are helpful, while 38.5% of males and 44.25% of females stated the opposite.

Section 5: Assessment Results

5.1 Mental Health Issues and Resources Reported in Focused Group Discussions

5.1.1 Mental health problems faced in the community

During focus group discussions (FGDs) with three different age groups of males and females, participants were asked about the kind of mental health problems people face in their community. It is worth noting that enumerators couldn't tackle addiction/substance misuse due to community restrictions. The results of each targeted location/district are summarized in Table 1.

Table 1: Common Mental Health Problems Reported in FGDs

	Male	Female
Mandol District	**Under 18 years old group:** sadness, sleeping problems, memory problems, loss of appetite, low self-esteem, angriness **18-50 years old group:** fatigue, sleeping problems, angriness, sadness, heart tightness **Over 50 years old group:** feeling helpless, sadness, fear, body pain	**Under 18 years old group:** fear, sadness, headache **18-50 years old group:** fatigue, hopelessness, fear, sleeping problems, stress **Over 50 years old group:** sadness, sleeping problem, body pain, psychosomatic problems
Noorgram District	**Under 18 years old group:** anxiousness, sleeping problems, memory problems, sadness, low self-esteem, angriness, loss of appetite **18-50 years old group:** Sadness, loneliness, anger, anxiousness, addiction, body pain, headache, negative thinking **Over 50 years old group:** severe headache, anxiousness, sadness, hopelessness, negative perspective about everything, angriness, loneliness, heart tightness	**Under 18 years old group:** loneliness, headache, angriness, sadness, feeling worthless, feeling inferior, low self-esteem, overthinking **18-50 years old group:** anxiety, anger, sadness, body pain, headache, crying **Over 50 years old group:** angriness, trouble sleeping, anxiousness, heart tightness, headache, loss of appetite, and sadness.
Kamdish District	**Under 18 years old group:** sadness, overthinking (excessive thinking about problems), unwanted thoughts and compulsive behaviors, anger, fear, negative self-talk **18-50 years old group:** epilepsy, obsession, negative thinking, sadness, being suspicious or distrustful, suicidal ideation **Over 50 years old group:** epilepsy, obsession, negative thinking, sadness, low self-commitment, irresponsible, social withdrawal	**Under 18 years old group:** Sleeping problems, fear, headache, angriness, hopelessness **18-50 years old group:** Fear, hopelessness, sadness, heart tightness, obsession **Over 50 years old group:** trouble sleeping, fears, headache, angriness, hopelessness, obsession, stress, negative thinking and substance misuse

5.1.2: Mental health issues, problems and resources

During the FGDs, the participants were asked about the cause, resources and more affected individuals and groups by above mentioned mental health problems in Table number 1.

Table 2: FGDs with Females

1) Mandol District, 2) Kamdish District, 3) Noorgram District.				
Mental health or stress-related problems	Main causes	Available or ongoing resources/services	Suggested ways to help these people more	More affected individuals/ groups
In general, all or most of the FGD participants reported that:				
Feeling hopeless, sadness, fear, feeling angry, obsessive thinking, negativity, low self-esteem, body pain, insomnia, headache, loss of appetite, heart tightness, fatigue, memory problems, epilepsy	Family problems, poverty, unemployment, conflict, recent political changes, security deterioration	Prayer, recitation of the Holy Quran and support from family, friends and relatives, scholars and teachers, consultation with a doctor, motivational counseling, taking medications	Public awareness and health education, motivation, support of health facilities, go to the doctor, use medications, social activities, counseling	Men, women, boys and girls.
Less/ some groups reported that:				
Substance misuse (*Hashish*), stress, being irresponsible, social withdrawal, thinking about suicide, low self-confidence, self-talk, overthinking	National conflict, threats, floods, fear of lightning and high mountains, no education, immigration, failure in love	Staying busy in agriculture, staying at home	Guidance for relevant problems, getting a job, building schools, exercising, going to parks	Elders, young adults

5.1.3 Local language words used to describe mental health problems

The FGD participants were asked for the local language words used for people with mental health problems/people who have unusual/strange behaviors in the community and the meaning of these words. Further details are provided in Table 4.

Table 4: Local language word used to describe mental health problems

Local language word	Meaning of the word
Liwani	People who have thought blocking, bizarre behavior, known as “wood behavior,” and are suspicious, or people that have increased energy/hyperactivity, are aggressive, overconfident and have changes in mood (low/high mood, psychosis, bipolar disorders)
Nashai	A person who has a mental problem such as irritability and abusing drugs, perhaps due to loneliness
Ghosanak	A person who gets angry easily
Janjali	A person who is irritable, has difficulty getting along with others and argues with people a lot.

5.1.4 Community perceptions and reactions for people living with mental disorders

It was highlighted across many of the locations that individuals are treated in neglectful or abusive ways such as beating, torturing and chaining in Mandol and Noorgram districts and stoning in Kamdish district, and tying people identified as having mental health issues inside the home or ignoring them in public and not accepting them in the community. In many cases, traditional/religious methods are applied in an attempt to dispel and cure mental health issues, such as praying, keeping amulets and going on a religious pilgrimage. Additionally, Kamdish residents reported referring mentally ill people to doctors and scholars.

5.1.5 MHPSS issues associated with the COVID-19 pandemic

During the FGDs, participants were asked about the MHPSS issues/problems associated with the COVID-19 pandemic and the most affected people in the community. Both male and female participants reported the following issues/problems.

MHPSS issues associated with the COVID-19 pandemic	Most affected/at-risk people
Under 18 years old: staying away from each other due to fear of transferring the COVID-19, fears, loneliness, obsession, increased heart palpitations due to fear	The younger generation, women and elders are more affected by the pandemic.
18-50 years old: repeating hygiene acts like handwashing, general fear, being afraid of each other, loss of appetite, nausea, vomiting, headache	
Over 50 years old: being afraid of each other, obsession, hypertension, general fear, staying at home, loneliness, not going to work and the mosque	

5.2 Organizations and Agencies Providing MHPSS Activities

In the targeted areas of Nuristan province, just one NGO, PU-AMI was providing MHPSS services, including individual counseling, group counseling and referral services in Wama district, which were available by the end of September 2021. So far, no other agency has provided MHPSS services in this province.

5.3 Integration of MHPSS Into Health Services

5.3.1 Availability of essential WHO psychotropic medicines at health centers

Based on the Head of the Health Facilities' report during the KIIs, generic medicine for bipolar disorder, medications for addiction rehabilitation programs, and generic antiparkinsonian drugs are not available in any of the health centers in the targeted districts. In Noorgram district, health facilities face the most severe shortage of the essential WHO psychotropic medicines listed below. While in Mandol district health facilities, generic antidepressants, antipsychotic medications, diazepam, and medications for the treatment of epilepsy are usually available. Further details are provided in the table below.

Availability of essential WHO psychotropic medicines at health centers

Medications	Available in the pharmacy or near the primary healthcare clinic in the previous month								
	District 1-Mandol			District 1-Noorgram			District 1-Kamdish		
	Mandol CHC	Koraj BHC	Dahne Anish SHC	Milil SHC	Nangaraj BHC	Kulatan SHC	Kamdish DH	Sarit SHC	Gawherdish SHC
Generic antidepressant drug (amitriptyline, fluoxetine)	Usually	Never	Often	Never	Never	Never	Often	Often	Often
Generic anxiolytic drug (diazepam)	Usually	Usually	Often	Often	Never	Never	Often	Often	Often
Generic antipsychotic drug (haloperidol cpr and inj, chlorpromazine, thioridazine)	Often	Usually	Usually	Never	Never	Never	Never	Never	Never
Generic anti-epileptic drug (phenobarbital carbamazepine, diazepam inj, valproic acid)	Usually	Usually	Usually	Never	Usually	Usually	Never	Never	Never
Generic medicine for bipolar disorder (valproic acid, carbamazepine)	Never	Never	Never	Never	Never	Never	Never	Never	Never
Medications in addiction management programs (nicotine, substitution therapy)	Never	Never	Never	Never	Never	Never	Never	Never	Never
Generic antiparkinsonian drug for the management of side effects of antipsychotic drugs (biperiden)	Never	Never	Never	Never	Never	Never	Never	Never	Never

5.3.2 Number of staff trained in the treatment of mental disorders

All assessed health facilities in Kamdish district had no medical staff with MHPSS training on how to treat common mental health disorders. In comparison, Noorgram and Mandol districts' health facilities reported only male service providers—two doctors and one nurse in Noorgram, and two doctors and two nurses in Mandol—trained in the clinical management of mental health disorders. There are no female staff members trained on mental health clinical management in the targeted areas.

Health facility location/district: Noorgram

Role/Title	Gender			Health facility type			
	Male	Female	Total	SHC	BHC	CHC	DH
Doctor	2	0	2	1	2	0	0
Nurse	1	0	1	0	1	0	0
Other	0	0	0	0	0	0	0

Health facility location/district: Kamdish

Role/Title	Gender			Health facility type			
	Male	Female	Total	SHC	BHC	CHC	DH
Doctor	0	0	0	0	0	0	0
Nurse	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0

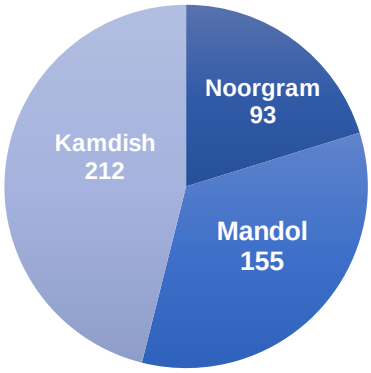
Health facility location/district: Mandol

Role/Title	Gender			Health facility type			
	Male	Female	Total	SHC	BHC	CHC	DH
Doctor	2	0	2	1	1	0	0
Nurse	2	0	2	0	1	1	0
Other	0	0	0	0	0	0	0

5.3.3 Number of patients with mental disorders that have been observed in the last month

The assessment's findings indicate that there are high numbers of patients with mental disorders seeking treatment and support; an average of 71 patients in sub-health centers, 21 patients in basic health centers and 62 patients in district hospitals in the targeted districts were observed in the last month. All referrals for defined cases are made to the provincial hospitals and health facilities in Laghman and Kunar provinces.

Chart 1: Number of patients per month per district



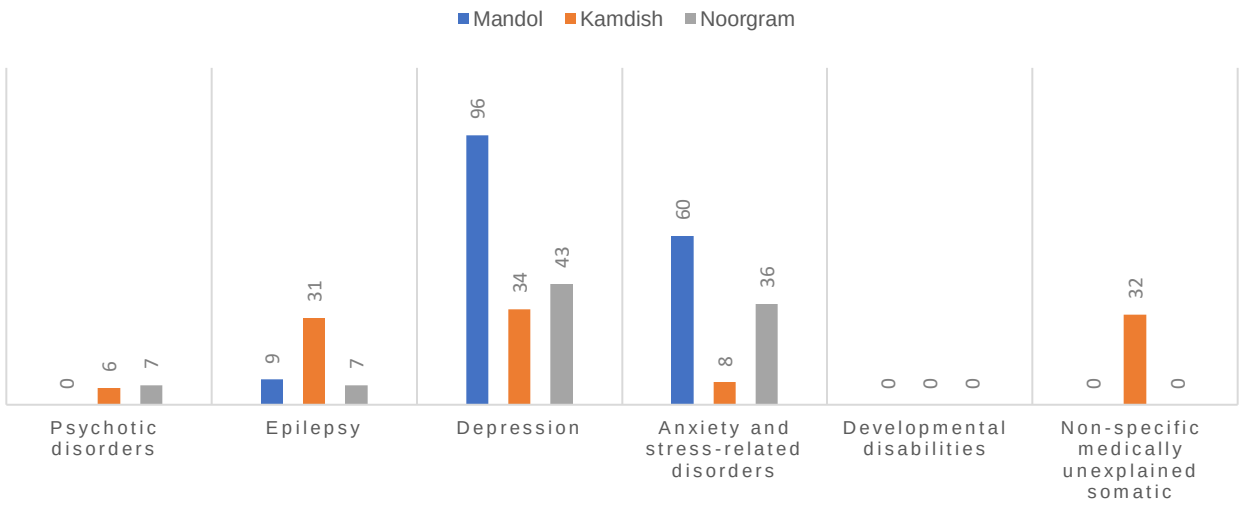
5.3.4 Mental health disorders recorded at health facilities in the previous month

Among the reported patients with mental, neurological and substance use disorders in the previous month, the highest numbers concerned patients with depression, anxiety and stress-related problems. In Kamdish district, high numbers of patients with non-specific or medically unexplained somatic complaints (without organic cause) and epilepsy were also reported.

Mental health disorders recorded at health facilities in the previous month

#	Mental Health Disorders	Number of patients	Health facility type				Health facility location/district		
			SHC	BHC	CHC	DH	Mandol	Kamdish	Noorgram
1	**Depression**	165	54	22	80	9	96	34	43
2	**Anxiety and stress-related disorders**	104	31	23	50	0	60	8	36
3	**Epilepsy**	47	11	5	4	27	9	31	7
4	**Non-specific or medically unexplained somatic complaints (without organic cause)**	32	18	0	0	14	0	32	0
5	**Psychotic disorders**	13	5	5	0	3	0	6	7
6	**Developmental disabilities (intellectual disabilities)**	0	0	0	0	0	0	0	0

Chart 2: Number and Problem of Patients with Mental Disorders Per Month in a Health Facility



5.3.5 Closest point of reference for specialized mental health care

During the KIIs, the directors/head of health facilities were asked about the closest point of reference for specialized mental health care. The average distance in the targeted districts is about 120 km. Further details are provided in the tables below.

District name: Mandol

Reference health facility	Town/location	Distance	Mode of transport
Laghman PH	Mehterlam	150 km	Rental cars

District name: Noorgram

Reference health facility	Town/location	Distance	Mode of transport
Laghman PH	Mehterlam	60 km	Rental cars

District name: Kamdish

Reference health facility	Town/location	Distance	Mode of transport
Kunar PH	Asadabad	150 km	Rental cars

5.4 Barriers to accessing mental health services

Barriers to accessing mental health services reported by the heads of health facilities include:

- no public awareness of availability of services;
- poverty;
- unemployment;
- lack of MHPSS counselors and MHPSS trained service providers;
- lack of inpatient care for mental health disorders and shortage of psychotropic medicines in health facilities; and
- poor infrastructure and bad wealth conditions (no local transportation, excessive snowing, roads blocked during winter due to snow), harmful cultural aspects.

Barriers to accessing mental health services reported by the heads or staff of NGOs include:

- culture;
- security issues;
- mental health stigma;
- personal socioeconomic problems;
- limited access to health facilities; and
- lack of opportunities for people seeking support in hard-to-reach areas.

Barriers to accessing mental health services reported by community people include:

- financial problems and poverty;
- long distances to health facilities, insecure roads and lack of transportation;
- poor road infrastructure and highlands;
- lack of MHPSS trained health providers;
- shortage of psychotropic medicines in health facilities;
- lack of available MHPSS services; and
- lack of awareness of mental health issues and mental health stigma.

Section 6: Summary and Recommendations

6.1 Summary

This assessment elaborated on the targeted population's struggle with different mental health problems in their daily life with negative perceptions and acceptance of mental disorders and limited access to psychosocial activities and resources. There is a strong need for MHPSS awareness for all demographic groups, especially among affected populations.

The assessment shows that there is a critical lack of mental health services throughout the assessed districts. Only one NGO, PU-AMI, (was providing MHPSS services, including individual counseling, group counseling and referral services in Wama district, which were available by the end of September 2021. So far, no other agency has provided MHPSS services in this province.

The assessment showed that primary healthcare centers are unprepared to offer any type of MHPSS support, with most of the assessed health facilities reporting a shortage of WHO essential psychotropic medications, and lack of trained and qualified mental health professionals and the absence of trained female staff. High numbers of patients with depression, anxiety and stress-related disorders were in demand of further specialized mental health services, to add a struggle of accessing referral endpoints upon transportation limitation for long journeys, 60-150 km.

Some of the more commonly identified mental health issues in the communities were anxiety- and depression-related issues and epilepsy affecting women, men and children. Psychosocial stress is attributed to many factors, including the increasingly desperate economic situation that many community members find themselves in with dwindling economic opportunities, reoccurring conflict, security deterioration and recent political changes.

The assessment further revealed that mental health is both poorly understood and highly stigmatized in Afghanistan, with an abusive or negative attitude (e.g., chaining or ignoring them) toward people who experience mental health issues, as well as the uncertainty of what positive steps can be taken to support individuals in the community with mental health issues. In many cases, these methods are used in an attempt to dispel families who prefer traditional, religious methods to cure people with mental health problems, and very few people seek out MHPSS services at health facilities.

With these various factors indicating the dire state of MHPSS services, in a context plagued by conflict and its associated impacts on mental health, there is an immediate need to incredible the availability of MHPSS services through the integration of MHPSS at the primary healthcare and community levels.

6.2 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 upwards. The following recommendations address the various MHPSS needs and gaps identified in Nuristan province, Afghanistan, to enhance the quality and comprehensiveness of MHPSS services.

1. Conduct MHPSS awareness campaigns for community members, both males and females, to raise the awareness of mental health conditions and normal stress reactions and decrease stigma.
2. Provide community-based psychosocial interventions, including psychological first aid (PFA) and basic psychosocial support, and target specific, vulnerable groups such as children and women who should be appropriately supported.
3. Enhance MHPSS networks in collaboration with the MHPSS Technical Working Group (TWG) actors in targeted areas by mapping out the nearest mental health and psychosocial support service providers in health facilities in Nuristan province
4. Establish referral pathways to relevant health facilities, facilitate transportation to health facilities, and conduct outreach via field visits for specialized mental health staff (e.g., psychiatrists, clinical psychologists) to rural areas.
5. Build the capacity of new and existing mental health and social service providers by delivering evidence-based psychosocial and psychological interventions, providing mental health case management and training for health facility staff on evidence-based MHPSS interventions for depression, anxiety and stress-related therapy.

6. Advocate via MHPSS-TWG members to encourage donors to fund comprehensive MHPSS services or complete the BPHS package in the health facilities and have trained and specialized MHPSS staff in each health facility based on the BPHS system.
7. Recommend that the MoPH implementers consider providing enough essential WHO psychotropic medications in each health facility, especially antidepressants, anxiolytic and antiepileptic drugs, and ensuring that specialized mental health care services are available at the district level and in district hospitals with a clear referral pathway with sub-health centers.
8. Encourage implementers to design their programs based on different levels of the Interagency Standing Committee (IASC) Guidelines of Mental Health and Psychosocial Support in Emergency Settings, and advocate for social considerations in basic services in an appropriate way to ensure the dignity, confidentiality and well-being of all beneficiaries and community members.
9. Engage key community members with relevant backgrounds (e.g., psychologists, social workers and teachers) as community outreach workers (representing different ethnic groups) who can help identify, support and refer people with mental health needs.
10. Provide further assessments of MHPSS needs and community mental health conditions in the humanitarian context for the province.