

In the name of Allah



Integrating Mental Health in Primary Health Care in Afghanistan

STRATEGY PAPER

*Ministry of Public Health
Afghanistan*



*Prepared by:
Mental health workers Kabul, Afghanistan
Date: August, 2005*



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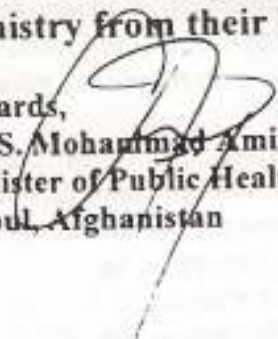
Preface

This national mental health strategy paper, which describes ways and attitudes for the integration of mental health into primary health care, deserves to be accepted as an official document and to be used as a guide in providing mental health care on the primary level in Afghanistan, as it sets forth the easiest, most applicable and most acceptable way to deliver mental health care in developing countries like Afghanistan.

This newly established strategy, and its final acceptance as a standard and approved document has been made possible by the sustained effort of a few National Mental Health Taskforce members, especially Dr. S. Shukrullah Wahidi, whose idea it was to integrate mental health into PHC in Afghanistan; Dr. Ruhullah Nassery, the National Mental Health Co-ordinator for the Ministry of Public Health (MOPH); Dr. S. Azimi, from the World Health Organization (WHO); and Dr. Peter Ventevogel, an expatriate psychiatrist working for HealthNet International- TPO (HNI-TPO). The document was presented to and approved by the Executive Board of the Ministry of Public Health.

The MOPH wants to express its gratitude to all national and expatriate Mental Health Taskforce members who took part in efforts to develop this strategy and hope they will not deprive this Ministry from their kind cooperation in the future.

Regards,
Dr. S. Mohammad Amin Fatimie
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INTEGRATING MENTAL HEALTH IN PRIMARY HEALTH CARE IN AFGHANISTAN

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Mental health as one of the health priorities in Afghanistan

Amidst the array of health problems in Afghanistan mental problems deserve due attention. War and poverty have had profound effects on the mental health status of the Afghan population. An epidemiological study in Ningerhar Province showed that large part of the population has indications for common mental disorders such as depression and anxiety (Scholte et al 2003). Worldwide prevalence and disabling neuropsychiatry disorders, such as schizophrenia and epilepsy are significant (around 1-2%). Mental disorders are also highly disabling. According to a report by World Bank and World Health Organization, Neuropsychiatry disorders account Burden of Disease, second only to infectious disorders (Murray and Lopez 1996). Workers in primary care frequently do not recognize these disorders, and prescribe non-specific treatments such as analgesics, vitamins, and hypnotics. Effective and affordable treatment options are available, and there is increasing economic evidence to support the argument that interventions for mental disorders are cost effective (WHO 2003: 32, Baingana 2003b)

There is a strong relationship between mental disorders and psychosocial problems. psychosocial problems may lead to expression of mental disorders in people who have an already pre-existing vulnerability for these diseases, due to hereditary factors or somatic illnesses. Especially at risk are children and adolescents, experiencing disrupted nurturing and traumatized by war and violence, and women overburdened in the family or suffering from domestic violence and discrimination. Reduction of psychosocial problem and stressors is important to prevent the expression of mental disorders and to improve their outcome.

Addressing mental health is worldwide gradually being recognized as an important development issue, especially in the case of conflict-affected countries (Baingana 2003, Vranesic 2003). Interventions dealing with mental health care are desirable and feasible in order to support post conflict recovery.

Mental health care and psychosocial interventions can be carried out on several levels, both within and outside the formal health care system:

- 1) Mental health services integrated in the general health services.
 - a) Primary health care (treatment and prevention of mental problems by primary health care professionals)
 - b) In general hospital (allocated beds or OPD)
- 2) specialized mental health services
 - a) mental health hospitals
 - b) private sector (private practitioners)
- 3) community mental health and psychosocial health services (self help groups, support group, halfway houses, etc)

The ultimate goal would be a configuration of services that contains of (a) mental health care in PHC settings, connected with (b) community psychosocial services and (c) acute inpatient care in general hospitals (and some from of temporary intermediate duration inpatients care for a subset of chronic psychiatric patients. In this paper we focus on the development of mental health activities within the primary health care structure of Afghanistan.

Why integration of mental health services in PHC?

Introduction a mental health component in general basic health care system is a relatively efficient method that provides an opportunity to organize mental health services in a way that avoids isolation, stigma and discrimination and strengthens access and use of the social support system (family and community) as an important resource for healing and rehabilitation of mentally ill patients. The WHO worldwide advocates the inclusion of mental health care as a part of primary health care (world health report 2001). A requirement is the existence of a reasonably well functioning basic health care system with a strong connection to the communities it serves. Strategies to integrate mental health in primary care have worked well in several of Afghanistan neighboring countries (Murthy 1998), yasami et al. 2003, Mubbashar & saeed 2003) and have several advantages above other strategies. ¹

- Primary care workers can save time by addressing the mental health needs of people who present to services with physical complaints that have a psychological etiology
- Active health education and early identification at the primary care level will lead to improved outcomes.
- Less stigma is associated with seeking help from primary care services.
- Access is good since the facilities are close to the users.
- Primary care services have a high acceptably for mental patients partly because they provide both physical and mental health care.
- Services are relatively inexpensive for the health care system (low human resources costs, reduced costs of physical facilities, lower indirect costs.
- Services are relatively inexpensive for patients (travel distance, early detection)

Requirements:

- Training of existing basic health care staff in the promotion of mental health and in the prevention and treatment of priority mental disorders.
- Embedding in a supportive structure where the use of new skills is reinforced and adequate supervision and maintenance of knowledge in available.
- Availability of psychotropic medication.
- Involvement o local communities though promotional and educational activities by CHWs and other primary health care workers.

¹ In many developed countries, existing mental health services have been modernized and decentralization and by establishing community mental health services connected to inpatient care (preferably in general hospitals). This requires a reasonable infrastructure, both in terms of human resources and in terms of roads and communication. For Afghanistan, whose inhabitants are concentrated in isolated valleys, loosely connected but a poor network of long distance roads, this strategy is not a viable option, perhaps with the exception of some urban centers, as Kabul.

An implementation strategy for Afghanistan

Mental health is one of the components of the basic package of health services. With the actual implementation of first tier of the BPHS underway, it is time for policy development and around the mental health component of the BPHS. Any realistic mental health policy for Afghanistan needs to keep the financial and socio-economic realities into account. It may not demand a significant increase in number of health workers in the basic health system, or require large investments in infrastructure, and should focus on using existing resources in a more efficient way.

To provide a minimum set of mental health services to the Afghan population the following is necessary:

- A reasonable investment in training of PHC workers to treat a limited number of priority conditions and use basic principle of counseling and psychosocial interventions.
- Delivery of essential psychotropic medicines.
- Sustained skill training and active follow-up/supervision embedded in the health care structure.

In Afghanistan the experience of mental health in PHC is limited: some NGOs and WHO. The taskforce process an approach in 3 phases to introduce mental health in primary health care system.

Phase 1: introduction phase (has started)

- Establishment of mental health unit within primary health care department, and appointment of a national coordination mental health in PHC, and allocated of funding for this unit.
- Evaluation of service training initiatives and demonstration project by NGOs and WHO.
- Definition of limited number of priority conditions (based epidemiological figures, disability and availability of easily administer treatment/ intervention options.
- Development of standard curriculum for training of PHC workers on several levels of PHC system (CHW, midwife, nurse, doctor).
- Development of treatment interventions protocols for priority mental disorders .
- Selection of a limited number of essential psychiatric drug and ensure availability of protocols of rational prescriptions.

Phase 2: implementation on a limited scale in some selected geographical areas where the following activities will be undertake .

- Development of an implementation plan, outlining a timeline and resources required to ensure mental health care in PHC in a selected geographic area.
- Coordinated implementation of this plan under the leadership of Ministry of health, with technical assistance of WHO and implemented by NGOs supporting the provincial health

care authorities. These programmes have to be carefully monitored and to be conducted in diverse setting (eg rural, urban).

- External funding is needed for these activities.
- Encouragement of appointment of provincial mental health coordinators, and development of provincial mental health policies, and involvement of specialized mental health personnel in the training and supervision activities.
- Encouragement intersector linking between health care structures and other governmental structures (Ministries of Women's affairs, Ministry of education, Ministry for refugees)
- Development of community based psychosocial activities in which locally available resources (women's group, religious leaders, traditional healers, community leaders) are involved.
- Dissemination of the results to stakeholders (MoH on national and provincial level, NGOs and donors)

Phase 3: Nation wide implementation of mental health in basic health in basic health care. ²

- Development of an implementation plan, outlining a timeline and resources required to ensure mental health care in PHC in the country.
- Developing national training capacity to MoH and NGOs implementing the basic package of health services.
- Planning and conduct training of health workers in all parts of Afghanistan.
- Make essential psychiatric drugs available in all districts

Kabul, March 18th 2004

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- Prof. Dr. Frank Kortman, HNI/University of Nijmegen
- Dr. M. van Ommeren, Department of Mental Health and Substance Dependence, WHO Geneva

² This phase includes the mapping of the mental health care situation in the present primary care system in (representative parts of) Afghanistan including per province what resource exists. Some of the following indicators may help in mapping resource to make plans:

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Appendix 1: prevalence of mental disorders in Afghanistan

Prevalence figures of mental disorders among Afghans are scarce. Early 2003, the University of Amsterdam, in collaboration with Health Net International and the Centers for Disease Control, Atlanta, conducted a population based epidemiological survey in Nangarhar Province, the Province in which the described project is situated (Scholte et al, 2003). The study uses a cross sectional two stage multi-cluster sample survey with a total of 1013 participants, aged 15 years and older. Among the used instruments were Pashto versions of the Hopkins Symptom Checklist- 25 (HSCL-25) and the Harvard Trauma Questionnaire (HTQ). The results of this study give some indications about the prevalence of common mental disorders in Nangarhar Province. Data on prevalence in Afghanistan of severe neuro-psychiatric conditions such as schizophrenia and epilepsy is not available, so we used figures of other Countries.

Schizophrenia Based on results of surveys in other low income countries we estimate the prevalence of schizophrenia between 0.14 to 0.46% (Jablensky, 2000). The treatments of schizophrenia is relatively easy when the right medication is available. Schizophrenia treatment with chlorpromazine costs around US\$ 2 per month in Afghanistan. In focus group discussions about mental problems, invariably case histories were told of patients with chronic psychosis. Most schizophrenia will require **also psychosocial rehabilitation through community (eg occupational therapy, family psychosocial support, income generating activities, etc). The PHC will need to work with community mental health services.**

Depression The recent survey in Nangarhar Province (Scholte et al, 2003) showed that 16% of the male adult population had elevated scores on the depression subscale of the HSCL-25 (with the usual cut off point of 1.75). For women, this figure was much higher: 58%. These figures are alarming, even keeping in consideration that the HSCL-25 measures self reported symptoms, and not mental disorders. Important contributing factors to the development of depressive and anxiety symptoms in Afghan women are probably war related traumatic losses, sexual violence, and the culturally sanctioned social deprivation of women through a system of strict gender segregation. In focus group discussions, the participants mentioned *khafgan* (literally: 'sadness') as a condition that can refer to a person who has deep sadness and worries a lot, always thinks about the bad things of life, isolates himself, does not eat properly, and cannot sleep well. Somatic features are 'constrictedness of the chest' (*jegar khonee*), 'heaviness', and stomach problems. When the condition worsens it is thought to lead to 'craziness' (*levany*).

Anxiety The study of Scholte et al (2003) demonstrated elevated scores on the anxiety scale of the HSCL-25 in 22% of the male adults and 78% of the female adults (cut off point 1.75). These dramatic figures do not indicate that the majority of the population is suffering from an anxiety disorder, but they do show that the self reported incidence of anxiety symptoms is extremely high. The rate of possible post-traumatic stress disorder (PTSD) cases in the study of Scholte et al (2003) is also high (7% for men, 32% for women).

Epilepsy The prevalence of epilepsy in developing countries is estimated to be around 1% (Scott, Lhatoo & Sander, 2001). In rural Pakistan, a prevalence of 1.5% was found (Aziz et al, 1994). Effective and cheap Medications for these conditions exist, but are often not available in the government run clinics in Afghanistan. Stigma attached around epilepsy is considerable, and often children with epilepsy are sent away from school.

Mental retardation As in most low income countries, prevalence figures of mental retardation in Afghanistan are unknown, but the figure can be expected to be high. In neighboring Pakistan, the prevalence of mental retardation was found to be considerably higher than in industrialized countries:

Nearly one in 50 children had severe mental retardation, and one in 15, mild mental retardation (Durkin, Hassan & Hassan, 1998). Many of the risk factors for mental retardation in the Pakistan study are Present in Afghanistan: prenatal difficulties, consanguineous marriages, high rates of neonatal infections, post-natal brain infections (cerebral malaria), malnourishment of pregnant women and young children, head trauma. Good information given to the family about the nature of the condition can help the family to focus on adequate training of the child, instead of spending endless sums of money in search of a cure that will never be found.

Substance abuse Afghanistan is infamous for its poppy cultivation. The idea that the farmers only *grow* poppy, and do not consume their products is only partially true. In these days, addicted patients roam around in the trading places for opium and heroin. Use of cannabis is widespread. Abuse of alcohol used to be a rare problem, but anecdotal reports indicate that its use is on the rise, now the severe restrictions imposed by the Taliban are lifted. It is a severe taboo, and people find it more painful to admit use of alcohol than use of cannabis or opium.

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