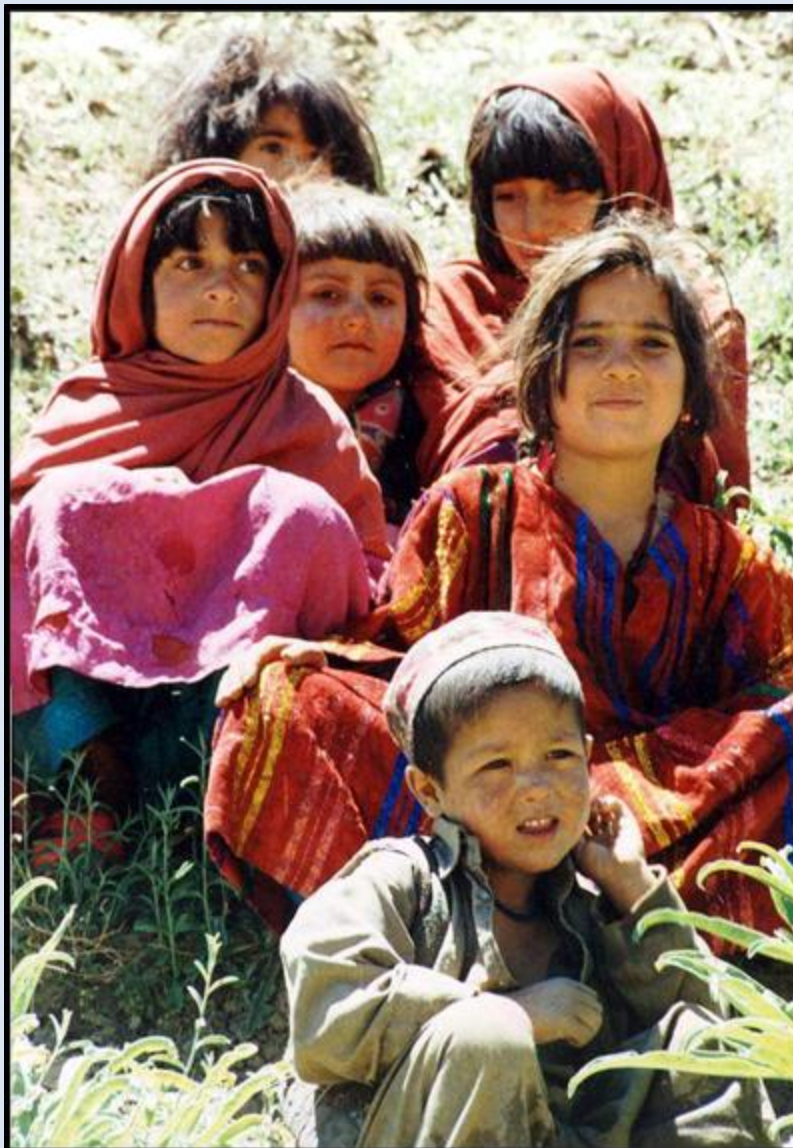




National Mental Health Strategy 2009-2014

For a Mentally Healthy Afghanistan



Islamic Republic of
Afghanistan
Ministry of Public Health
General Directorate of
Preventive Medicines
Mental Health & DDR
Department

2009



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ACKNOWLEDGEMENT

Today I would like to express my gratitude that technical team of mental health and drug demand reduction department have developed and prepared a credible technical document (National Strategy of Mental Health) which is offered to be used by the stakeholders of mental health.

Mental health has been accepted as one of Public Health Ministry's priorities. Mental Health became a part of BPHS in 2003 and also the psychosocial counselling was incorporated in 2010.

These measures have been taken based on the public needs who have suffered from three decades of war in Afghanistan. During these conflict years major detriments in social-economy and mental health areas have been taken place as well as health care system and public health which have been seriously devastated because of war.

Therewith, years of war affected the mechanisms of compatibility and also problems made people under pressure. They lost their family, relatives or became disabled. Their socio economic status collapsed and most Afghans immigrated to other countries. It also had a negative effect on the health system and increased psycho-somatic problems on their top peak.

The poor people and vulnerable groups of our society such as women, elders, children, and those who have disabilities face major problems. The only remaining hope for MoPH is to perform its responsibilities accordingly to provide access to mental health services for those who are living in urban areas, suffering from mental health and psycho-social disorders.

National Mental health strategy includes activities at all levels from primary health care, secondary health care or hospital care and tertiary care. It also reflects and emphasizes on the legislated issue of mental health activities, struggling with stigma and discrimination because of mental health disorders. Furthermore, there is emphasis on decentralization and promotion of health facility strategies and service in the provinces.

Now it is time for partners and donors to directly and indirectly advocate and support the Mental Health and Drug Demand Reduction Department in the implementation of mental health national strategy, in order to achieve the expected results in the upcoming five years effectively and efficiently for those people who seriously want for health services.

Ones again I want to express my appreciation and gratitude to all who participated in development process, especially European Committee that has technically supported the development of this strategy. Also I want to thank HSSP/USAID for their support in translation and printing of this document. I wish more prosperity and success in this field.

Regards

Dr. Suraya Dalil
Acting Minister of Public Health
Kabul, Afghanistan



PREAMBLE

Preventive Medicine General Directorate recognizes that the development of the mental health national strategy for 2009 to 2014 is a vital step towards effective and efficient mental health services in the health care system, and pleased that MoPH has such a technical document at the national level.

The previous data indicate that among the people of Afghanistan, 50% of them are suffering from mental problems due to thirty years of conflict. WHO assessment shows that 20% to 30% of people in developed countries are suffering from the trouble of mental problems. Considering these data which show that Afghanistan has a two-fold trouble of mental health problems compared to the developed countries.

On the other hand global general mental health status and predicted studies on Global Burden of the Diseases shows that among mental disorders just depression, is the fourth prevalent disease (6.2%) in the world in 1990 and it is predicted that it will become the first prevalent disease (5.5%) before cardiovascular disease up to 2030. It shows the magnitude of the mental health problem around the world and should be considered.

I want to mention that mental health services in Afghanistan have improved compared to past year and the impact of these services will be evident in the near future. We have integrated mental health services in MoPH strategies, BPHS and EPHS and will support it. We will take essential steps to legislate Mental Health services and eliminate stigma due to mental disorders in the society. We have given importance to this issue in the strategy as well. It should be mentioned that in tertiary level we do have projects which will provide effective health services for the population.

The vision of this strategy is to access and utilize community based mental health care services for all Afghans in all levels of the health system till 2020. The mission of Mental Health and Drug Demand Reduction department according to this vision is to struggle for afford of integrated mental health services in focus on community level prevention through expert and trained medical staff on all level of health system.

It is mentionable that General Directorate of Preventive Medicine in consideration of the contents of this document asks from all stakeholders and partners maintain their efforts for achieving the expected objectives of this strategy to advocate the implementation of the strategy and continue supporting Afghanistan health system.

We, in behave of Preventive Medicine General Directorate, want to thank those who had full cooperation in developing of the strategy; Her Excellency Dr. Surya Dalil Acting Minister of Public Health, Her Excellency Dr. Nadira Hayat Burhani Deputy Minister of Health Service and members of Mental Health and Drug Demand Reduction Department, Europeans Committee (EC), Health Services Support Project (HSSP) and technical working group of Mental Health and Drug Demand Reduction Department, and wish them further success in implementation of this strategy.

Regards

MASHAL, Mohammad Taufiq M.D,Ph.D
General Director of Preventive Medicine
Ministry of Public Health
Kabul, Afghanistan



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ABBREVIATIONS/ACRONYMS

AIHRC	Afghanistan Independent Human Right Commission
AOP	Any Other Program
APHI	Afghan Public Health Institute
ANDS	Afghan National Development Strategy
BHC	Basic Health Center
BPHS	Basic Package of Health Services
BSC	Balance Score Card
CCS	Country Cooperation Strategy
CHC	Community Health Center
CHW	Community Health Worker
<i>DSM-IV</i>	<i>Diagnostic and Statistical Manual of Mental Disorder-IV</i>
<i>EC</i>	<i>European Commission</i>
EPHS	Essential Package of Health Services
GOA	Government of Afghanistan
HF	Health Facility
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMIS	Health Monitoring Information System
HNSS	Health & Nutrition Sector Strategy
<i>ICD 10</i>	<i>International Classification of Diseases 10</i>
<i>IEC</i>	<i>Information, Education and Communication</i>
<i>KAP</i>	<i>Knowledge, Attitude, Practice</i>
MH	Mental Health
MH&DRD	Mental Health and Demand Reduction Department
NGO	Non-governmental Organization
NMHS	National Mental Health Strategy
PFA	Psychological First Aid
NMHSC	National Mental Health Steering Committee
PHC	Primary Health Care
PPHD	Provincial Public Health Directorate
PS	Psychosocial

PTSD	Post Traumatic Stress Disorder
SAMHSA	Substance Abuse & Mental Health Service Administration
ToR	Terms of Reference (ToR)
HNTPO	Health Net Transcultural Psychiatry Organization
UN	United Nation
USAID	United States Agency for International Developemnt
WB	World Bank
WHO	World Health Organization

BACKGROUND

After more than 25 years of war and still early in the post-conflict phase, Afghanistan is identifying priority health issues and developing interventions to address them. The challenges are significant, particularly given the disruption to social and human capital, small government income, the transitional phase of the political system, and the receipt of relatively little international aid. All these challenges are adding to the complexity of health sector development (National Health Policy, 2005).

Mental Health

The World Health Organization's *Country Cooperation Strategy for WHO and Afghanistan 2006-2009* (CCS) summarizes the mental situation as follows:

In the recent decades, Afghanistan faced a series of long term disasters deeply affecting the coping mechanisms of the population and the capacity of the health care system to respond to mental health needs. Over 2 million Afghans are estimated to suffer from mental health problems. Due to the long period of conflict it is estimated that most Afghans suffer from some level of stress disorder. Mental diseases have not been addressed over the last decades in Afghanistan and little is known about disease pattern in Afghan society.

The few publications from the pre-war period about mental health and mental health care in Afghanistan give the impression that Afghanistan was not very different from any other developing country in the region (Gobar 1970; Waziri 1973). Further, the start of the violence in the late 1970s led to the migration of many mental health professionals. Little is known about the early effects of the war on the mental health status of Afghans during the Russian occupation and the armed resistance of the mujahedeen. However, in the refugee camps in Pakistan, clinicians reported that they saw many patients with anxiety and depressive symptomatology¹

A review of studies conducted during the Taliban regime reveals high rates of anxiety and depression among women. In a survey of 160 Afghan women in Kabul and Pakistan during the Taliban regime, 42% showed symptoms diagnostic of post traumatic stress, 97% had major depression, and 86% had severe anxiety. The vast majority (84%) of the women reported that one or more family members were killed during the war (Rasekh, 1998). A study conducted in 2000 by the Physicians for Human Rights compared the mental health status of women living in a Taliban-controlled area versus that in a non-Taliban controlled area.

Major depression was almost three times more prevalent among women living in the Taliban controlled area (78%) than among women living in a non-Taliban controlled area (28%) (Amowitz, 2003). Even more alarming were the high rates of suicidal ideation which, were also three times as high in the Taliban controlled area as in the noncontrolled area (65% in the Taliban controlled area versus 18% in the noncontrolled area). Finally, actual suicidal attempts were almost double in the Taliban controlled area (16% in the Taliban controlled area and 9% in the non-Taliban controlled area). High rates of depression and anxiety among women were also found in a qualitative study in Taliban controlled villages near Herat in Western Afghanistan (De Jong, 1999). These high rates of psychiatric morbidity may be related to Taliban policies of

¹ Ventevogel, P., van Huuksloot M, Kortmann, F. (2006) Mental health in the aftermath of a complex emergency: The case of Afghanistan. In: J.O. Prewitt Diaz, R. Srinivasa Murthy, & R. Laashminarayana (Eds). *Advances in Psychological and Social Support after Disasters*. (pp. 83-93). New Delhi, India: Voluntary Health Association of India Press.)

gender segregation and denial of basic human rights to women. The fall of the Taliban regime, however, has not resulted in an improvement in the mental health status of the population. A nationwide survey conducted in the first year after the US - led invasion, found high levels of depressive symptoms (male: 59.1%, female: 73.4%), anxiety symptoms (male 59.3%, female 83.5%) and symptoms of post traumatic stress (male: 32.1%, female: 48.3%). Respondents with physical disabilities had an even higher chance of developing psychopathology (Lopez, 2004).

An in-depth survey in Nangarhar Province conducted in 2003 confirmed the high rates of depression and anxiety, in particular among women, with elevated scores on depression questionnaires in 58.4% of all women, anxiety symptoms in 78.2%, and Post Traumatic Stress Disorder (PTSD) symptoms in 31.9% of the female respondents (Scholte, 2004). The study found a clear relationship between the number of traumatic events and the likelihood of developing psychopathology. Supporting these findings, a recent study among widows in Kabul also reported depression symptoms among 78.6% of these women (CARE, 2004).

Many families have been rendered dysfunctional or partially so as a result of continued stress, exposure to traumatizing events, loss, drug abuse, and poverty. Those psychological and psychosocial stressors make people vulnerable to psychological and social dysfunction. Mental disorders are highly prevalent and highly disabling. They may have serious social consequences including chronic poverty, stigmatization, and exclusion.

The effects of trauma, the rise of substance abuse, suicidal tendencies,² and violence can affect psychological functioning on all levels.³ These effects can also prevent normal development in a significant number of children. Without appropriate and timely intervention it is possible that society at large will become even less functional over time.

The disintegration of basic values as a result of prolonged war and conflict has contributed to a loss of the social and cultural identity, changing values and gender roles.

Issues of honor and dignity, as well as the feeling of having little control regarding these situations as well as over one's own emotions possibly due to traumatic war experiences, often strengthens the restrictive side of tradition. As a result, domestic violence rises and excessive control of women and children easily produces new trauma. This cycle continues to the extent that reconciliation and the prospect of a peaceful society seem to be out of reach.⁴

Somatization and a lack of awareness of the origin of the suffering can lead to the belief that only medication can help. This problem is reinforced by the limited knowledge of medical staff regarding mental health and psychosocial issues. This limited knowledge leads to misidentification and misdiagnosis and in turn poses a significant barrier for client access to appropriate services. It adds to the victimized state of the Afghan population and creates new dependencies. People drift into social isolation and the family as a self-helping system breaks down.

To date, the treatment of mental health problems is often limited to medication; therapeutic care is predominantly unknown and unavailable to the population with only a very few mental health specialists available to provide such treatment.

² cp.: Medica mondiale-self immolation report 2006-2007: Dying to be heard

³ Breslau, N. (2001). Outcomes of posttraumatic stress disorder. *Journal of Clinical Psychiatry*, 62, 55-59.

⁴ Mismahl, I. (2006). Psychosoziale Hilfe und Traumaarbeit als ein Beitrag zur Friedens- und Versöhnungsarbeit am Beispiel Afghanistans. *Psychotherapieforum*, 14(4).

There is an urgent need to build the skills and capacity of the human resource to be used now and in the future for the treatment of mental illness and psychosocial distress. This major capacity building effort will require cooperation especially with medical institutions in the country. Lack of knowledge among health staff is resulting in inappropriate and irrational use of psychotherapeutic medication by health professionals certainly it is not restricted to mental health field. The difference between a learned behavior in a certain social and cultural context and a psychological symptom has to be understood. Often emotional difficulties are expressed in ways that may look like the symptoms of a mental disorder but can be better understood as sociocultural expressions of distress.

The specific cultural expression and long-term consequences of traumatic experiences as well as the impact on the family system in Afghanistan must be understood. Experience shows that diagnostic descriptions derived from classification systems such as Diagnostic and Statistical Manual⁵ and International Classification of Diseases 10 (ICD 10)⁶ have a limited utility in the Afghan context.

The issues affecting mental health of people within Afghanistan are wide ranging and pervasive. They include community perceptions of individuals displaying abnormal behaviors in public or within the family setting as well as the quality and structure of interventions available to those in need. Addressing the causes of mental illness is a significant challenge for the government as the etiology is directly linked to many factors including the social and political turmoil that exists within the country and the disruption to families resulting from poor security and the underdeveloped economy of the country.

Although these problems may impact the mental health of community members, they cannot be addressed in a single government strategy. However, intersectoral collaboration in assisting those with mental health disorders should be encouraged. Law enforcement agencies, the private sector, schools, universities, the workplace, detention centers, faith-based and social forums, other government departments, plus the community itself have roles to play in preventing and addressing mental disorders.

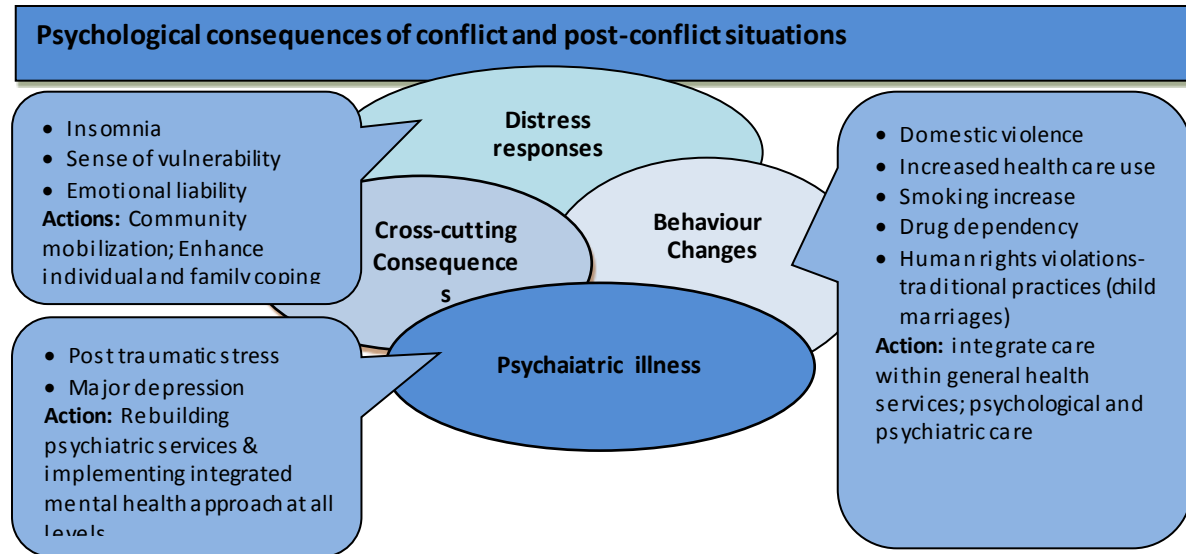
Little or no intersectoral collaboration currently exists and the referral system for mental health patients is almost nonexistent. What patients are likely to receive is an intervention based on medication and the risk that their condition will be misdiagnosed with little differentiation between physiological or organic and functional disorders.

Given the situation in Afghanistan, three levels of mental health needs may be identified: (a) distress symptoms, (b) behavioral changes, and (c) psychiatric disorders. All of them require interventions at three levels: (a) at the individual and family levels, (b) at the level of general health care services, and (c) at the specialized psychiatric service level.

Addressing these three broad groupings of mental stress will require attention to community level interventions, strengthening primary health care interventions, plus secondary and tertiary services. Additionally, the support services to introduce and maintain these levels of intervention need to be strengthened where they are weak or introduced where they are nonexistent.

⁵ American Psychiatric Association (2000). Diagnostic and Statistical Manual of Mental disorders (4th ed., text revision). Washington, DC.

⁶ World Health Organisation (2007), International Statistical Classification of Diseases and Related Health Related Problems (10th revision).

Figure 1: Psychological Consequences of Conflict

Modern systems of treatment and in particular community-based treatments are not currently reflected in mental health practice. Legislation and regulation and policy should not be limited to care and treatment but should address important issues including access to high quality care, rehabilitation, aftercare, the full integration of individuals with mental disorders into communities, the prevention of mental disorders and the promotion of psychosocial well-being.⁷

Legislation should offer important mechanisms to ensure adequate and appropriate care and treatment, the protection of human rights of people with mental disorders, and the promotion of mental health for the population. Consequently, effort should be directed toward developing comprehensive mental health legislation as soon as practicable.

Specific research on mental health has not been undertaken sufficiently to the point of informing policy and planning.

Intersectoral liaison is almost nonexistent and, to date, the little mental health planning that has been undertaken has been done at the central level. Collaboration with higher education facilities on specialized training for mental health workers has yet to be attempted. There is no documentation on any decentralization of the national mental health initiatives to the Provincial Public Health Directorates (PPHDs) across the country.

Although the specialist categories for psychiatrists, psychiatric nurses (*recommended only*), and the allied health specialist position for psychologist are recognized within the MoPH Human Resource Strategy, there is no other mention of related behavioral health positions such as social workers and psychologists; training courses for general health staff or lay people to acquire basic skills in mental health monitoring, gate keeping counseling, care or rehabilitation, are infrequent. Given the severe shortages in all disciplines relevant to mental health in Afghanistan, a comprehensive plan to address these shortages must be a priority for the MoPH.

⁷ Although mental health legislation is for the protection of people, it does not alone guarantee the respect and protection of human rights. According to WHO-AIMS Afghanistan (WHO 2006) a national human rights review body exists (Afghanistan's Independent Human Rights Commission -AIHRC) which has the authority to examine human rights issues in mental health hospitals and other health facilities. Only one review/inspection of human rights protection of patients occurred in 2004.

Careful and ongoing collaboration between the MOPH, the Ministry of Higher Education, and other relevant institutions, such as Kabul Medical University, is needed to address Afghanistan’s human resource needs that are outlined in Component 6, “Strengthen preventive intervention and service delivery resources and infrastructure.”

Mental health was, along with disability, the first health priority outside of maternal and child health and communicable diseases to be given serious consideration by the MOPH and donor agencies. However, despite sometimes significant funding being committed to ad hoc projects, mental health is only just becoming mainstreamed into primary health care service delivery.

Although there has been strong and successful advocacy for inclusion of mental health into the Basic Package of Health Services (BPHS), the MOPH primary care service delivery package managed by non-governmental organizations (NGOs), there are few resources available at the provincial and central levels to ensure that the national strategies are implemented or that minimal levels of safety standards are developed and complied with by workers providing direct services to mental health patients.

Nationally, despite the broad range and often conflicting focus of technical advice provided, the limited resources and capacity of the MH&DRD restricts the ability to concentrate on the various ranges of possible interventions now identified (see Figure 2).

Likewise, the Provincial Health Directorate teams have been unable to undertake their role as stewards of the health system and strategically plan for a more comprehensive coverage of possible mental health interventions because of a lack of a clear direction and support from the national directorate.

At the implementation and support levels, there has yet to be an infrastructure and mechanism developed to ensure that all interventions and services are implemented within the constraints facing health workers in Afghanistan today and within the limitations of a primary care delivery system that is bound by contractual obligations between donors and implementing partners. The problems and challenges can be classified as follow:

- Overall security and safety environment related
- Health and social sector policies and legislation related:
- Health System related
- Social sector related
- Capacity and resource constraints related
- Informational paucity related
- Stigma and discrimination related

BPHS and EPHS

Mental health treatment and diagnosis were strengthened in the 2005/1384 Basic Package of Health Services (BPHS). Among the improvements is an increased emphasis on community-based mental health interventions. Mental health education and awareness, case detection, and identification and treatment of mental illness have been added to all levels of service within the BPHS. Although a significant development, it is not adequate to sufficiently address the mental health burden experienced by the Afghanistan population.

Various efforts and models have been developed to reduce the burden of mental health problems by international non-governmental organizations (NGOs) since 2002; such NGOs include Health Net TPO, IAM, Caritas Germany, and Medica Mondiale.

All these efforts and the significant contributions by WHO, the Substance Abuse and Mental Health Services Administration (SAMHSA) of the US Department of Health and Human Services, and the European Commission (EC) have drawn attention to the importance of mental health in Afghanistan and give evidence through research and awareness to the country's mental health situation. The national taskforce that accompanies and supports the MH directorate has also played a major and important role in this process.

A National Mental Health Strategy (NMHS) has been developed based on observation and experiences to date within the Afghanistan health sector that includes the input of clinical specialists, working groups, taskforces, conferences, mental health project outcomes, plus consideration of international research, strategic approaches and suggested guidelines, past draft documents along with the influence of donor priorities and medium-term funding restrictions. The resulting data, statements, comments, recommendations, restrictions, and technical advice have been well considered in this strategy and inform the various strategic components and areas of intervention.

The strategy is presented as a realistic tool for managing implementation at both the central and provincial levels within the structure and processes of the MOPH. The Strategy recognizes that it will not be able to implement all identified components of an ideal mental health system that will achieve the highest impact and immediate effect on personal health and well-being.

Different programs in the country have shown that psychosocial care could significantly ease the mental health burden and help people to regain their psychological and mental well-being. In 2008 a health program across Afghanistan due to many constraints. As such, the various components have been prioritized for introduction as capacity and resources become available with 8/1387 the BPHS was again revised and the psychosocial component was included as a key part of the integrated mental health component, which covered the medical care and approach to mental health problems and now psychosocial care. Mental health training materials, curricula, and flowcharts for the referral system were newly developed and revised by the Mental Health Dept of MOPH in 2008.

Consequently, the integration of psychosocial care requires new training for the health staff. This means that professional psychosocial counseling will be offered at the CHC level to patients. This is an addition to the already partly existing psychosocial community-based programs outside the BPHS. Nevertheless, those community-based psychosocial programs will be integrated into the referral system and both will add value to each other.

The expected benefits of the integration of psychosocial care are the following:

1. Fewer chronic patients and fewer suicides
2. Increased cost effectiveness; medication use and costs will be reduced significantly.
3. Reduced dependency on medication and reduced hospital admissions
4. Prevention of ill health
5. More reliable diagnosis regarding mental health and somatic symptoms and problems
6. Reduced domestic violence
7. Positive impact on addiction
8. Reduction of social stigma connected to mental health problems
9. Addresses the root of the problems and thus helps people to regain self-confidence and

control over their lives

10. Health staff will feel less powerless and motivation will increase, less turnover of health staff
11. Cooperation of the whole team: A balance of medical treatment and psychosocial treatment will result in a win-win situation for the patient.
12. Positive impact on the next generation

The next step after implementing the integration of psychosocial care in BPHS will be to streamline this approach in EPHS and to revise all treatment protocols.

PSYCHOSOCIAL COUNSELING

Psychosocial counseling is a solution and resource-oriented approach that helps patients to connect to their resources and their own potential and helps to identify problems and main complaints. Psychosocial counseling is an approach that helps to solve conflicts and thus improves conflict solving abilities.

Psychosocial counseling helps people to create good relationships and therefore be less socially isolated and integrates the family or family members as a support. Through the process of counseling, patients learn that they can influence their lives again and shape them according to their own value system.

The counseling must be oriented on meaning and a future perspective. Central themes are human dignity, justice, consolation and meaning of life, and regaining a sense of coherence.

Given the efficacy of psychosocial counseling, the MH&DRD revised the BPHS in 2009 and added psychosocial counseling to the mental health component. Basic counseling will be available at the BHC level and professional counseling on the CHC level. New flowcharts for the referral system have been developed.

This integrated approach was implemented in 2009 in three CHCs in Bamyan, Herat, and Mazaar. Training materials for all levels of health staff have been developed and approved by the MH&DRD. Health staff in health facilities need to be trained or retrained to be able to fulfill their mental health care responsibilities to adequately deliver the integrated mental health components of the revised BPHS.

In addition, the Ministry of Public Health (MoPH) will need to formulate strategies to overcome culturally specific barriers to the treatment of mentally ill individuals and to adapt treatment models that may not be compatible with Afghan traditions and belief systems so these systems may be effectively used to alleviate suffering resulting from mental illness.

POLICY AND TARGETS

GOVERNMENT PRIORITY AND COMMITMENT FOR MENTAL HEALTH IN AFGHANISTAN

The Government of Afghanistan (GoA) has recognized mental health as a priority public health issue:

as a direct consequence of the years of conflict, Afghanistan has a large number of disabled and mentally ill people for whom treatment and rehabilitation services need to be developed and for whom assistance will be required in order to re-integrate them into the daily life of the country (HNSS, 2008, p. 9).

The GoA has made a definite and clear commitment to address mental health issues with the strategic service delivery statements of a commitment to:

Develop a flexible range of integrated mental health support and care services at all levels of the health system (ANDS, 2008, p. 241).

In addition, to ensure that those service and interventions can be implemented in a sustainable manner with the commitment that:

Formalized mechanisms need to be in place so that extremely marginalized individuals among groups such as the Kuchis, poorest families, unsupported poor women, unsupported disabled especially mentally impaired, drug addicts, street people ... are not denied access to more substantive medical or surgical interventions on account of their socio-economic marginalization (ANDS, 2008, p. 236).

This will be accomplished through:

Strategy 3.6 Mental Health: HNS will work with the social and other sectors to develop a flexible range of integrated mental health support and care services at all levels of the health system. Particular attention will be given to post-traumatic counseling through the training of more community mental CHWs and psychologists and their placement in accessible community health facilities (HNSS, 2008, p. 31).

Vision

The mental health strategy envisions that all people in Afghanistan have access to a community-based yet comprehensive and coordinated system of mental health care supports, treatment, and follow up of mental illness and related disorders. It will promote a system of recovery and mental wellness that is integrated with the other primary healthcare service provisions by the year 2020.

Mission

The mission is to provide evidence based, quality mental health care for all citizens with proactive emphasis on the mental health needs of the poor, underserved, disadvantaged and vulnerable in our population. Such services will be integrated into the healthcare system, will be community focused, have a strong preventive focus and be delivered at all levels of care by well-trained, skilled, and motivated personnel.

Aim

The main aims of the National Mental Health Strategy are:

- To promote mental health of the people of Afghanistan;
- To minimize the stigma and discrimination attached to mental disorders ;
- To reduce the impact of mental disorders on individuals, families, and the community;
- To prevent the development of mental health problems and mental disorders, wherever possible;
- To provide quality, integrated , evidence and rights based care for individuals suffering from mental disorders at all levels of health system.

Values and Principles

The following values and principles shall guide the National Mental Health Strategy:

1. Provide high quality and professional mental health care delivered at a standard set by the MoPH
2. Increase equity and accessibility through integration of mental health with existing community-based primary healthcare services and provisions for rehabilitation
3. Prevent mistreatment and abuse and reduce the stigma associated with mental health in the society through information, education and communication (IEC) activities, as well as increased community involvement and participation to promote the concept of health of the people, by the people, and for the people
4. Facilitate the empowerment of individuals, families, and communities for human rights promotion through intersectoral coordination
5. Recognize the needs of the underserved and vulnerable populations (e.g., children and adolescents, women, the disabled, internally displaced persons, returnees, the elderly etc.)
6. Prevent mental health disorders where possible and promote mental well being through development of qualified mental health professionals and resources at all levels and through intersectoral collaboration

Strategic Goals

The following best describe the two key strategic goals of service and support on which this National Mental Health Strategy is based:

- To develop, introduce, and monitor a broad range of mental health initiatives to support individuals and families across the range of preventive interventions, primary and secondary service provision, referral and rehabilitation, with special focus on immediate delivery of the most essential services to those with the greatest needs

- To introduce or strengthen legislation, regulation, organizational, and operational activities to support the delivery of interventions and services within the public and private health sectors plus related interventions within other sectors.

Objectives

The objectives required to achieve the stated strategic goals are:

- Service strengthening
 - Introduction and support for the provision of preventive, gatekeeper, and maintenance initiatives (monitoring, school health, health promotion, psychological first aid, working with community organizations, and non-health gatekeeper organizations such as police and other social services)
 - Accessible and strengthened provision of primary care interventions and services (assessment, counseling, first line treatment, chronic care, referral, and rehabilitation)
 - Appropriate, functioning, and acceptable standards of provision of secondary and tertiary services including chronic care, referral, and rehabilitation
- Service support and quality
 - Strengthen national strategic interventions with MH&DRD support, oversight of the national strategy, intersectoral collaboration, monitoring of strategy indicators and targets, providing direction and support for strategic implementation, development of standards and quality improvement strategies, project monitoring, research and needs identification, legislation and regulation, development of meaningful terms of reference (ToR) for the MH&DRD, and working according to these agreed ToR
 - Ensure the provinces develop and implement strategic plans consistent with the NMHS
 - Strengthen provincial support by oversight of implementation, including service delivery monitoring and quality improvement, participatory intersectoral strategic planning and collaboration (including with police, prisons, education, private sector, and other stakeholders), and monitoring compliance with regulations
 - Strengthen preventive and service delivery resources and infrastructure (e.g., human resource planning, pre-service and in-service training and coaching, specialist training, training of intersectoral staff, supervision of service and intervention staff, infrastructure development)

Targets to be achieved by end of the strategic period

Increase BPHS based mental health service by 75% from 2009 levels. This involves training of health care staff, adding new staff such as psychosocial (PS) counselors, availability of supervision, a functioning referral system, and the availability of Essential Medicine List of psychiatric drugs which will lead to a measurable improvement in mental health.

Increase by 75% the number of provinces with integrated EPHS based mental health services. This includes psychiatric services available in provincial hospitals, functional referral and counter referral systems with BPHS facilities, and a functioning mental health unit in each PPHD which will lead to a measurable improvement in mental health.

- Increase referrals by 75 % over 2008 levels.
- Increase awareness of mental health issues in the general population through school health initiative in 80% of schools in the country
- Functional MH units in 100% of provinces
- Mental health legislation revised and implemented in 100 % of mental health units and mental hospital by 2014
- Increase basic psychosocial counseling in 70% of PHC facilities under BPHS
- Ten psychiatric graduates deployed in systems by 2014

COMPONENTS

Strategy Components

The NMHS is designed to build a comprehensive mental health system that will contribute to key areas of prevention, identification and referral, care and treatment if required plus the creation of a robust functioning support system, including legislation and regulations, oversight, and resource availability, including human resources.

This national mental health program is presented in the following components and strategic approaches:

COMPONENT 1: Provision of preventive, gatekeeper, and maintenance initiatives

(Monitoring, school health, health promotion, psychological first aid, working with community organizations, non-health gatekeeper organizations (police and other social services.).)

Strategic Approach 1.1: Child and adolescent mental health and well-being: Growing into adulthood as a well balanced and contributing individual is the right of every child in Afghanistan. Interventions will be developed and delivered for prepubescent and adolescents within schools and in conjunction with the National Child and Adolescent Health Strategy. Future research will be undertaken to identify the needs and possible interventions for the most vulnerable of children and adolescents isolated from the benefits of the education system. Special consideration will be given to exploring the mental health needs of married adolescents. Interventions within schools for early detection and lifestyle development will include teacher skills, curriculum, support systems, peer-to-peer, support and promotion opportunities.

Strategic Approach 1.2: Mental Health Support Initiative: The majority of community members who display abnormal behaviors or suffer from psychiatric illness do not present to a health facility to receive counseling, care, or treatment. In this situation, the importance of non-health related gatekeepers in monitoring the health of community members is essential for a complete mental health program and to identify individuals who could benefit from appropriate attention including Psychological First Aid (PFA) and emergency counseling and referral to professional services in emergencies. Gatekeepers will be identified in schools, organized forces (police and armed services), government offices, faith based organizations and other community level organizations, groups and cooperatives. Another key gatekeeper group is the private sector. Contact and partnership development with the private sector will be encouraged and supported. Support will be given to all groups to develop appropriate knowledge, skills, and competencies for first aid counseling in conjunction with the development and support of community referral systems.

Strategic Approach 1.3: Community based mental health: The goal of the National Mental Health Strategy is a mentally healthy Afghanistan. Health starts in the home. Partnerships will be encouraged between families and communities with first line and professional health workers and services to maintain healthy family members through informed KAP (Knowledge, Attitude and Practice) and respect of the mental health rights of individuals. These partnerships will help identify discrete referral processes for those in need of more specific care and attention and will help establish processes for shared care of chronic mental health sufferers residing within and supported by families and the broader community. Activities will include interventions both to strengthen health workers and formal systems and address community and family issues, including unhealthy attitudes and practices that may otherwise compromise shared responsibility between the community and the health system.

Implementing this approach could include providing life skills and resiliency education in schools, mental well-being and mental health public awareness campaigns and establishment of family and mental health services consumer groups and setting up community based services like half way homes, supervised /unsupervised hostels in communities, supervised rehabilitation services in communities besides strengthening of the traditional support structures in the communities.

COMPONENT 2: Provision of primary care interventions and services

(Assessment, counseling, first line treatment and drug use, psychotropic drug availability, chronic care, referral, rehabilitation)

Strategic Approach 2.1: Community-based mental health: Community-based mental health is the first level of intervention within the health system. This is a relatively new endeavor within the Afghanistan health sector as community-based health workers are still being introduced and their roles are being more clearly defined. Support for health workers with mental health responsibilities will include development of appropriate training plus appropriate supervision and support. The health workers will be trained to address the most common morbidities as determined by presentations for care and surveys. The common tasks for community health workers include mental health awareness, case identification, referral and follow up. Community Health Workers can be trained on delivery of psychological first aid in emergencies

Strategic Approach 2.2: Primary Mental Health Care: This level of the mental health program covers the fixed clinics plus mobile health teams plus the linkages between first line intervention and secondary care through a referral system. It is essential that those presenting for services are appropriately triaged. The PHC level of intervention will be developed according to international standards and best practice as defined by

WHO⁸. The level of psychiatric care and treatment at the PHC will be clearly defined and provided by trained health workers with adequate clinical supervision and support. Professional development needs will be recognized and development and training opportunities will be made available. To ensure adequate integration of mental health care into mainstream health services will require support and advocacy at the provincial level. Principles of integration of mental health into PHC are as follow:

- Policy and plans need to incorporate primary care for mental health.
- Advocacy is required to shift attitudes and behavior.
- Adequate training of primary care workers is required.
- Primary care tasks must be limited and doable.
- Specialist mental health professionals and facilities must be available to support primary care.
- Patients must have access to essential psychotropic medications in primary care.
- Integration is a process, not an event.
- A mental health service coordinator is crucial.
- Collaboration with other government non-health sectors, nongovernmental organizations, village and community health workers, and volunteers is required.
- Financial and human resources are needed.

Strategic Approach 2.3: Monitoring of Private Mental Health Provision: The stewardship role of the MOPH, both centrally and provincially, will be extended to privately provided mental health services. This oversight and compliance responsibility will be jointly developed by the MOPH and the private sector within the period of this strategy to ensure that primary mental health service provision (counseling and care) by the private sector adheres to acceptable standards with a focus on the hygiene, health, and safety of patients and members of the public.

COMPONENT 3: Provision of Referred Tertiary Secondary and Forensic Medicine

Strategic Approach 3.1: Secondary acute mental health care: To ensure a seamless continuum of mental health care, the linkages between primary and secondary services will be strengthened. The referral system will be strengthened across all provinces for psychiatric and psychological care. Minimum standards will be developed consistent with WHO standards. Secondary hospitals will be monitored for these standards and will be supported to develop systems and protocols to treat patients. Specific secondary care centers in all provincial and regional hospitals will be established.

⁸ the 2008 report: WHO and Wonca. Integration of mental health into primary health care A global perspective.. Geneva: World Health Organization Geneva, 2008.
http://www.who.int/mental_health/policy/services/mentalhealthintoprimarycare/en/

- Strategic Approach 3.2: Tertiary acute mental health care and attention:** Access to appropriate higher level mental health care referred from the secondary system will be strengthened through secondary care centers. Appropriate standards of care provision plus sound process, practice, and quality checking will be established for the treatment and management of very severe and complicated cases of mental illness. An assessment of existing tertiary mental health facilities and services, particularly the Kabul Mental Health Hospital, will be undertaken with the results informing the development of an upgrade of infrastructure and equipment to an agreed standard for a tertiary care center for the treatment and management of very severe and complicated cases of mental illness.
- Strategic Approach 3.3: Chronic care and rehabilitation:** An assessment will be undertaken in larger urban centers to establish the need for chronic care centers to compliment acute care. Where an established need exists, centers will be supported in establishing chronic care services.
- Strategic Approach 3.4: Forensic Psychiatry:** There needs to be a capacity for forensic psychiatric to provide assessment and other services for the judicial system. Given the current constraints, the provision of forensic psychiatric services is considered a low priority. However, the provision of services and supporting legislation will be actioned when appropriate.
- Strategic Approach 3.5: Services for Prisoners:** Psychiatric services shall be available to prisoners and staff working in the high stress environment of the prison service.

COMPONENT 4: Strengthen national strategic interventions

(MH&DRD support, oversight of national strategy, intersectoral collaboration, monitoring against strategy indicators and targets, provision of direction and support for strategic implementation, developing standards and quality improvement, project monitoring, research and needs identification, legislation and regulation)

- Strategic Approach 4.1: Development and support:** The MH&DRD will be staffed at approved levels. The MH&DRD will provide oversight for the development, implementation, and quality of the mental health system. A review of the MH&DRD will identify current gaps and future MH&DRD activities.
- Strategic Approach 4.2: Oversight of national strategy:** A Mental Health Steering Committee will be convened by the MH&DRD and will consist of key stakeholders who will advise the MOPH on policy and strategic matters, including the monitoring of implementation of the NMHS.
- Strategic Approach 4.3: Interdepartmental collaboration (national level):** Mental health is a multisectoral health priority. The MH&DRD will establish and support a process for intersectoral collaboration for the development, implementation, and quality improvement of the mental health

services. At the higher policy level, all mental health policies will be presented to the Interministerial Council to ensure top level ownership and endorsement of policy direction. Such collaboration is particularly important for substance abuse prevention and the need for collaboration with the Ministry of Counter Narcotics.

For strategic and technical matters, forums for collaboration will include the Mental Health Steering Committee, national working groups, standing and ad hoc committees.

Strategic approach 4.4: Interministerial collaboration: A number of MoPH health strategies including school and prison health and HIV/AIDS refer to mental health. To ensure an appropriate level of planning and service delivery, the MOPH will ensure that the MH&DRD contributes to the development of interministry mental health interventions and provides an oversight and support to sustain adequate mental health interventions.

Strategic Approach 4.5: Direction and support for provinces: The MH&DRD will ensure the NMHS activities are included in provincial strategic and operational plans.

Strategic Approach 4.6: Mental health funding: NMHS funding will be variously sourced including GOA, donors, BPHS contracts, and specific and ad hoc project funding. The MH&DRD will maximize funding opportunities for the support and implementation of the NMHS and distribute available funds on the basis of local need. Factors likely to impact fund distribution include provincial demographics. These criteria may include geographic and demographic characteristics and provincial capacity to deliver mental health services. The Mental Health Department will inform each PPHD of the allocation or potential allocation of funding to support their strategic and operational planning processes.

Strategic Approach 4.7: Monitoring and evaluation: Interventions will be monitored against agreed indicators. Monitoring and evaluation will include both public and private services.

Strategic Approach 4.8: Research and needs identification: To strengthen evidence based decision making, research programs will be developed to identify current issues and future needs. The research will be undertaken collaboratively with relevant MOPH research departments, the Afghan Public Health Institute (APHI) and external researchers and technical partners. Areas of research may include:

- Traditional mental health treatment
- Family systems models
- Community care models
- Perinatal health care
- Substance abuse
- Similarity of symptoms: 1. Epilepsy and going to shock 2. Schizophrenia and projection (traditional beliefs)

- Common mental disorders
- Severe mental disorder
- Diagnosis and cultural norms
- Suicide prevalence
- Stigma and access to MH services
- Public attitude towards people with mental disorder
- Difficulties to access publicly funded mental health care by rural communities
- Difficulties in provision of training in MH
- Constrains on MH service delivery in rural areas
- Barriers to the provision of MH treatment
- Attitude of users and providers towards psychosocial care in PHC

Ideally, targeted mental health surveys incorporating social determinants of mental health, quality of life, disability, and measures of illness need to be created and administered. Mental health research will involve a collaborative approach with a wide range of stakeholders and health service agencies, including WHO and NGO health providers.

The issue of mental health surveillance in conjunction with APHI will also form an integral part of this strategy.

Strategic Approach 4.9: Legislation and regulation: The GOA will develop legislation to protect the rights and safety of those receiving or affected by publicly or privately provided mental health services. Areas for legislation and regulation could include:

- Regulation of service provision by non-government providers
- Regulation regarding education and training for staff involved in the provision of mental health services
- Regulation setting standards of mental health treatment
- Supply of pharmaceuticals
- Prescription and administration of pharmaceuticals
- Rights and management of individuals with mental illness detained or in detention by police
- Defense of prisoners claiming mental illness and management of individuals with mental illness
- Rights of mentally ill people to the least restrictive forms of treatment

Support for the development of legislation and regulation requires both expert knowledge and experience in mental health issues and the Afghanistan legal framework. As such, technical expertise will be sought from appropriate experts who may not be employed within the current MOPH organogram – WHO being one such example.

COMPONENT 5: Strengthen provincial strategy oversight and implementation

(Service delivery monitoring and quality improvement, participatory intersectoral strategic planning and collaboration (police, prisons, education, private sector, others), monitoring compliance with regulation)

Strategic Approach 5.1: Service delivery monitoring and quality improvement: The province is the implementation level of the national health system. Mental health interventions will be preventive (intersectoral) and responsive with psychological first aid for people in highly traumatic events and emergencies. Although the majority of mental health services will be delivered within the BPHS and EPHS under contract, the Provincial Public Health Directorate (PPHD) will adopt a stewardship role, including intersectoral collaboration. The MH&DRD will ensure that each PPHD is fully conversant with the NMHS, relevant indicators, targets and quality standards, and is supported in the monitoring and reporting process through the provision of leadership and technical and clinical support. Regular monitoring visits

Strategic Approach 5.2: Strategic implementation planning: The implementation of the NMHS will be facilitated through the formal integrated planning process at central and provisional levels. The MH&DRD will ensure that negotiations with participating PPHDs include NHMS appropriate technical and clinical advice and known or potential sources of funding. Individual PPHD strategic plans will be consolidated at the national level to form the Consolidated Strategic Mental Health Plan for the department and the MOPH. Regular monitoring visits from the MH&DRD or workshops for the PPHDs will ensure good communication, monitoring and supervision monitoring, and supervision.

Strategic Approach 5.2: Strategic implementation planning: The implementation of the NMHS will be facilitated through the formal integrated planning process at central and provisional at the national level to form the Consolidated Strategic Mental Health Plan for the department and the MOPH.

Strategic Approach 5.3: Intersectoral collaboration: Collaboration is required at all levels to effectively deliver the NMHS. Collaboration with the Ministry of Counter Narcotics has commenced and the Ministry of Woman's Affairs is seen as another key stakeholder. Collaboration with Ministry of Higher Education will focus on undergraduate and postgraduate training also mental health of university students. Collaboration at the provincial level is important to implement the national strategies. The PPHD will take the lead at the provincial level to establish appropriate mechanisms across sectors to plan, implement, and monitor interventions that will contribute to the implementation of the national strategy. The PPHD will report its activities quarterly to the MH&DR department.

Strategic Approach 5.4: Regulation compliance (public and private sector): As the regulatory framework for mental health is developed, the PPHD will have responsibility for assigning responsibilities to relevant officers to ensure that services within the public and private sectors are functioning within the legislation and regulations. This stewardship role will be undertaken in a constructive manner to ensure positive and productive outcomes.

COMPONENT 6: Strengthen preventive intervention and service delivery resources and infrastructure

(Human resource planning, pre-service and in-service training and coaching, specialist training, training of intersectoral staff, supervision of service and intervention staff, infrastructure development)

Strategic Approach 6.1: Human resource planning: Mental health services are included in the BPHS. However the BPHS constitutes a limited range of service interventions provided mostly from fixed health facilities. As mental health services expand and community expectation increase, the health system will experience significant pressure to provide skilled staff. One of the highest priorities for the national strategy is to develop a medium-term plan to ensure adequate numbers of skilled mental health workers are available to deliver services. Staff will include social workers, psychologists, psychiatric nurses, and psychiatrists plus mental health administrators. A national Mental Health Training Institute linked to the mental health hospital in Kabul will be established.

Strategic Approach 6.2: Pre-service and in-service training, coaching, and mentoring: The MH&DRD will work through the intersectoral forums, including the Ministries and Departments of Education, Police and Corrective Services, and later with specially convened working groups, to ensure a continued supply of appropriately trained mental health workers is available to provide all levels of service. The integration of mental health into curricula of medical faculties, nursing schools and faculty of psychology/education will be ensured through revision of curriculum and practical sessions. These activities will be undertaken in conjunction with the MOPH Human Resources Directorate and fall within the National Human Resources Strategy and Work Plan.

Strategic Approach 6.3: Specialist training: The MH&DRD will work with the Ministry of Higher Education to identify training, education and development needs. This includes residency program in psychiatry and post graduate training in clinical psychology, psychiatric nursing, psychosocial counseling and psychiatric social work. The MH&DRD will work with the Ministry of Higher Education to capitalize on in country and overseas, which will add value to service provision.

Strategic Approach 6.4: Intersectoral staff training: Provision of MH services will occur across sectors including education, prisons, and police. To facilitate high quality services the MOPH will work collaboratively with relevant ministries and departments to ensure that staff have the necessary skills to deliver required services including referral. The MH&DRD will develop collaborative frameworks and ensure appropriate courses are developed and delivered.

Strategic Approach 6.5: Mental health worker supervision (MOPH and supporting sectors): Given the demands of delivering mental health services, ongoing support, supervision, training and education are necessary. The MH&DRD will ensure it provides the necessary support for all staff, both public and private, providing mental health services.

Strategic Approach 6.6: Infrastructure development: In order to build a complete mental health program for Afghanistan, infrastructure must be developed to support care and treatment at all levels of the health system. Given constrained capacity and funding, the development of a comprehensive infrastructure will require further needs analysis and a phased-in approach.

INSTITUTIONAL APPROACH

Having been recognized as a national priority, mental health has been integrated into the BPHS.

Other mental health interventions, including community and special group based services, will need to be integrated into the referral system to allow for a seamless continuum of care for mental health care consumers.

THE INSTITUTIONAL FRAMEWORK

The building of a comprehensive mental health program requires a framework that articulates systems, responsibilities and stakeholders. To be effective and efficient, the mental health system must be incorporated within the BPHS and must form a significant part of contracts in those provinces where the BPHS is contracted out.

COMMUNITY LEVEL

Community based health care forms the basis for the delivery of health care through the BPHS. Consequently, first line health workers provide the first level of entry for those seeking help with mental health issues.

Although the BPHS community/health facility interaction model (Figure 2) provides some explanation of community level interaction with primary care services, there is also the additional interaction between gatekeeper workers from partner sectors (education, police, prisons, agriculture, rural development, and private providers) and organizations (cooperatives, clubs, faith based organizations, and other NGOs) that also play a key role in identifying need and making referrals for those who wish to seek further help.

It is essential that these groups are considered in the development of both strategic plans and referral systems.

DISTRICT LEVEL

The district level is not well defined within either the government administration or MOPH. Currently a pilot project is underway to introduce and clarify the role of the district health officer. Should this position be accepted and expanded, its role in facilitating intersectoral collaboration of mental health service support must be considered in conjunction with having a role to investigate and possibly mediate any issues or more formal complaints that might arise in a district health officer's geographic area of responsibility. District health officers must have sufficient capacity and terms of reference to fulfill these proposed functions.

It is at this level that interaction can be facilitated with prisons, the private sector, and emergency response services. Any activities of the district health officer in regard to the monitoring or facilitating of intersectoral mental health initiatives will be under the overall supervisory control of PPHD mental health..

PROVINCIAL LEVEL

With MoPH support, the PPHD will develop a fully integrated, intersectoral, rolling 5-year strategic plan to address mental health issues. The PPHD will consider all components of this National Mental Health Strategy along with the various identified areas for potential action for direct service provision in conjunction with public and private sector partners. The PPHD will identify and implement locally effective and viable actions, resources, partners, and monitoring mechanisms that contribute to positive impacts and targets of the interventions.

NMHS

The PPHD will ensure that all health related forums include mental health as a health priority, focusing on both alleviating mental illness and promoting positive mental health.

The MoPH will oversee clinic based mental health services, ensuring that all agencies that are contracted to provide mental health services or related interventions comply with the broad spirit and specific components of the NMHS and BPHS. The PPHD will provide all necessary support and guidance to District Health Officers to enable them to fulfill their role in ensuring the implementation of the NMHS.

The PPHD will seek support from and report to the MH&DRD on progress toward all planned mental health activities, the status of mental health, and the achievement of the indicators within the NMHS.

NATIONAL LEVEL

The MH&DRD will assume responsibility for the NMHS and will ensure that the NMHS reflects changes derived from research findings, informed debate, government-wide policy changes, and advances in clinical care and treatment protocols.

The MH&DRD will ensure that information relevant to the NMHS is articulated and disseminated, using whatever means and modalities that are available for the purpose. The MH&DRD may from time to time establish ad hoc working groups to facilitate the dissemination of information as required.

For the terms of reference (TOR) and Mental Health Department organogram see annexes.

PARTICIPATION AND COORDINATION

MECHANISMS FOR COORDINATION

Steering Committee

An MoPH standing committee, the National Mental Health Steering Committee, will be formed to ensure coordination and cooperation between the various partners involved in mental health service provision.

Membership of the committee shall be comprised of no less than 10 members, who shall be appointed by the General Director of the Directorate, having responsibility for mental health services.

The objectives of the committee will include ensuring there is no duplication of effort and waste of resources and to ensure that all partners work toward agreed goals within set policies.

The National Mental Health Steering Committee will provide a forum for NMHS implementing partners to exchange information, provide oversight of consolidated mental health plans and activities and monitor progress against objectives. It will report on activities and make recommendations to the MoPH. The terms of reference of this committee will include

- To advise and guide the Ministry of Health on National MH policy and strategy development.
- To provide advice and support for the Mental Health Department on implementing strategies within the NMHS.
- To advise and guide the Mental Health Department and allied units in mental health in the content and organization of future MH strategic and operational work plans.
- To act as a forum for the exchange of information between development and implementing partner plans and activities
- To receive and analyze NMHS implementation reports from the Mental Health Department and provide recommendations on outstanding issues and concerns when requested.

The NMHSC will convene at least every 6 months and as required at the direction of the head of Mental Health Department.

A quorum for the NMHSC will consist of two members of the Mental Health Department, two related MOPH departments, a minimum of two intersectoral members (ministries or private sector), plus a maximum of two international advisers.

This committee has the responsibility to invite further representatives of interministerial, multisectoral departments, special groups, or the community to attend as observers or consultants when and as required.

The Mental Health Taskforce will adopt the role of a formal consultative group.

Working Groups

Intersectoral national working groups to support policy development and legislation will be established and convened as required.

Terms of reference could include

- Using the media, NGOs, and international agencies for advocacy in relation to policies and legislation for mental health and development
- Strengthening the collaborative efforts between governments and NGOs for implementation of policy decisions and legislation
- Using PPHD and other partners for advocacy as well as for supporting and sustaining community actions
- Intensifying advocacy and IEC efforts for improvement of health and education services for all groups
- Encouraging local-level youth organizations to develop peer groups to plan, implement, and coordinate youth programs
- Mobilizing family and community resources for youth health concerns and development programs, together with the active participation of adolescents themselves.

Intersectoral/Sectoral Liaison

Intersectoral collaboration and liaison is required at both central and provincial levels. The MH&DRD will establish a communication plan and ensure intersectoral liaisons will address priority issues.

The MH&DRD will support the PPHDs to have included on the agenda of any provincial standing committees matters regarding the implementation of the NMHS.

IMPLEMENTATION

ACTION PLANS

NMHS implementation plans based on 5 year strategic plans will be produced at central and provincial levels. AOPs for will be produced each year to implement the strategic plan.

Plans will be costed out and funding sources will be identified.

The MH&DRD will combine provincial plans into a consolidated national mental health plan.

The MH&DRD will support PPHDs to implement national mental health priorities.

The MH&DRD will identify all known funding opportunities and allocate funds. PPHDs will advise the MH&DRD of local funding opportunities that support implementation.

MONITORING AND EVALUATION

The following strategic approaches will be applied for the monitoring:

1. Development of monitoring and evaluation tools
2. Development of monitoring and supervision check lists in coordination with the Monitoring and Evaluation Unit
3. Development of performance indicators
4. Development of monitoring and supervision guidelines
5. Development of a training manual on supervision skills.

POLICY

The National Mental Health Strategy will be monitored for indicators for NMHS target areas. The monitoring will be undertaken in conjunction with other national routine service monitoring exercises (HMIS, BSC) plus periodic surveys of consumers (household surveys, etc.) for outcome and impact. Additional quality improvement monitoring will be undertaken.

The following draft ** indicators have been developed.

Indicator	Measure where	Freq	Data Available
# of Schools with mental health program	P	Q	PPHD/NGO/NM H&DRD
Prop of BPHS Health Workers trained in mental health in HF (or Province)	P/HF	Q	PPHD/NGO
Prop of EPHS health workers trained in mental health in HF (or province)	P/HF	Q	PPHD/NGO/NM H&DRD
Strategy developed for private health providers	N		NMH&DRD
# treatment and rehab units established in Afghanistan for mental health patients	N	A	NMH&DRD
# of Mental Health Steering Committee Meetings to oversee national mental health strategy implementation	N	A	NMH&DRD
# of mental health researches	N	A	NMH&DRD
Availability of curriculum for specialized mental health training EPHS	N	A	NMH&DRD
# of psychiatrists trained for EPHS	N	A	NMH&DRD
# of NMHW staff appraised every 6 months	N	A	NMH&DRD

Overall strategy review mechanism and timing – The National Mental Health Strategy will provide the direction and form the basis of ongoing MOPH operational strategy. For this to be effective and on time, the following process is required:

- a timely review of the success of the strategy implementation process itself
- an evaluation of the NMHS per se

Key indicators will be developed to guide these processes with the review being organized and coordinated by the Mental Health Working Group drawing on appropriate expertise for the purpose.

The reviews will be undertaken after the completion of the 2nd full planning implementation cycle of MoPH, following the approval of this National Mental Health Strategy document.

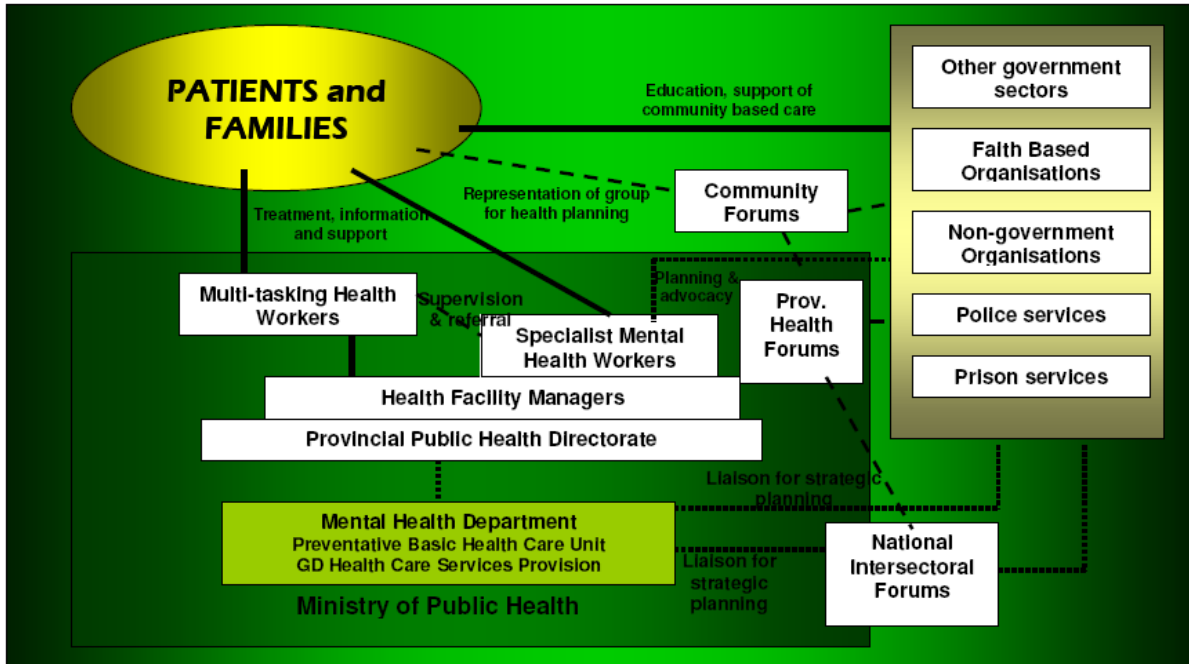
MOPH CONTACTS

Contact details – the service directorate with the mandate of strategy oversight

APPENDIXES

APPENDIX1:

Proposed MOPH structure for mental health interventions and services



APPENDIX 2:

Mental Health Department mandate

To ensure the continuing relevance, dissemination, implementation, and monitoring of the National Mental Health Strategy.

Aims of the central Mental Health Department:

General Aim:

Within the scope and constraints of the MOPH, to ensure that the GOA/MOPH response to the mental health of the Afghanistan population is clearly identified in policy and strategy and addressed through medium and short term plans, protocols, and practices.

Specific Aims:

1. Sound National Mental Health Policy and Strategy developed and maintained
2. Mental Health strategy implemented
3. Implementation monitored for efficacy and efficiency
4. Mental health needs identified through research and training is provided to support provision of interventions and services
5. Intersectoral collaboration with other Ministries to ensure a collaborative approach to interventions
6. Internal linkages with other departments within MoPH to ensure the integration of mental health initiatives into all health priority streams and interventions
7. Support and guidance for the PPHD and other provincial stakeholders for the implementation of the national strategies
8. Inform stakeholders through reporting to ensure that executive decision makers and implementing partners are aware of the progress in achieving positive impacts in mental health
9. Sufficient resources available, including funding, to implement mental health interventions and services
10. Systems in place and capacity of Mental Health Department sufficient to provide leadership and stewardship for implementation of the Mental Health Strategy and strategic plans
11. Openness and transparency achieved in all functioning of mental health departments and offices relating to the provision of mental health initiatives

Objectives:

Develop a sound, sustainable and meaningful Mental Health Program to reach these aims
Put systems in place to make sure that the program is implemented and functions within the overall framework of ANDS and HNSS (Health & Nutrition Sector Strategy) in an integrated manner with other departments and sectors

The objectives of the provincial mental health departments will be viewed and implemented within the following grouped areas:

1. Governance and maintenance of the Mental Health Strategy
2. Technical implementation of the focal point
3. Training and research
4. Internal and external coordination
5. Finance and funding

The Mental Health Department organizational structure will reflect these grouping of responsibility.

Involvement of others

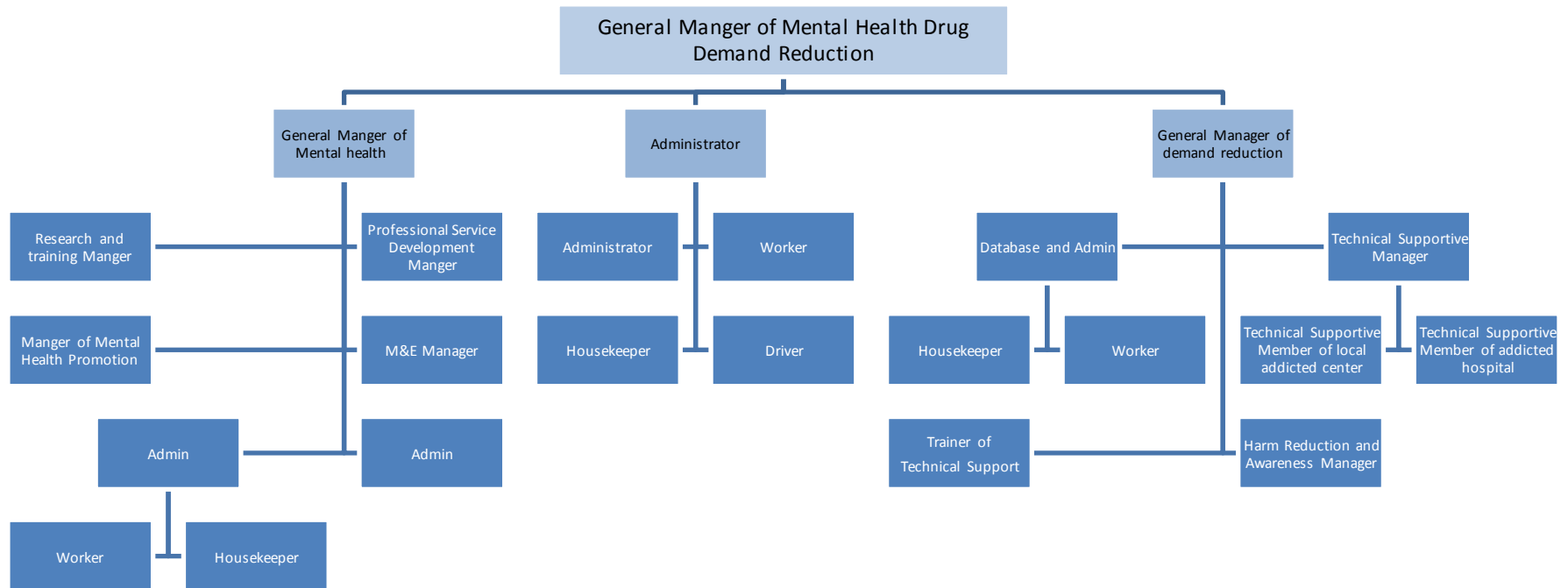
Partnerships within the MoPH - The MH&DRD will ensure a collaborative environment exists between itself and other relevant departments or units of the MOPH. Strong collaboration will focus on maternal and child health, private facilities unit, BPHS and EPHS department, prison health, nomadic health, school health, drug demand reduction unit, HIV/AIDS unit, adolescent health, diabetes, disability and rehabilitation, health behavior, and emergency preparedness and response as required. The MH&DRD will liaise and collaborate with service support departments including drug planning, human resource management, planning public relations, plus others involved in general administration.

Other Ministries – The MH&DRD will work in a collaborative manner with ministries that either provide gatekeeper functions (monitoring and referral) including education, justice, and interior. The MH&DRD will liaise closely with the Ministry of Higher Education for graduate and postgraduate training opportunities to ensure a required mental health workforce is available for service delivery.

Other partners – Development of the national mental health program will involve other key stakeholders as partners. These partners will include national and international NGOs, representatives of professional groups, and mental health service consumers. Technical support agencies will include WHO and other UN agencies, external government support agencies and specialized NGOs, and existing and potential donor partners, including USAID, WB, and EC. Other partners may include those engaged in specific project work, research, contracted implementing agencies, and private providers.

APPENDIX 3:

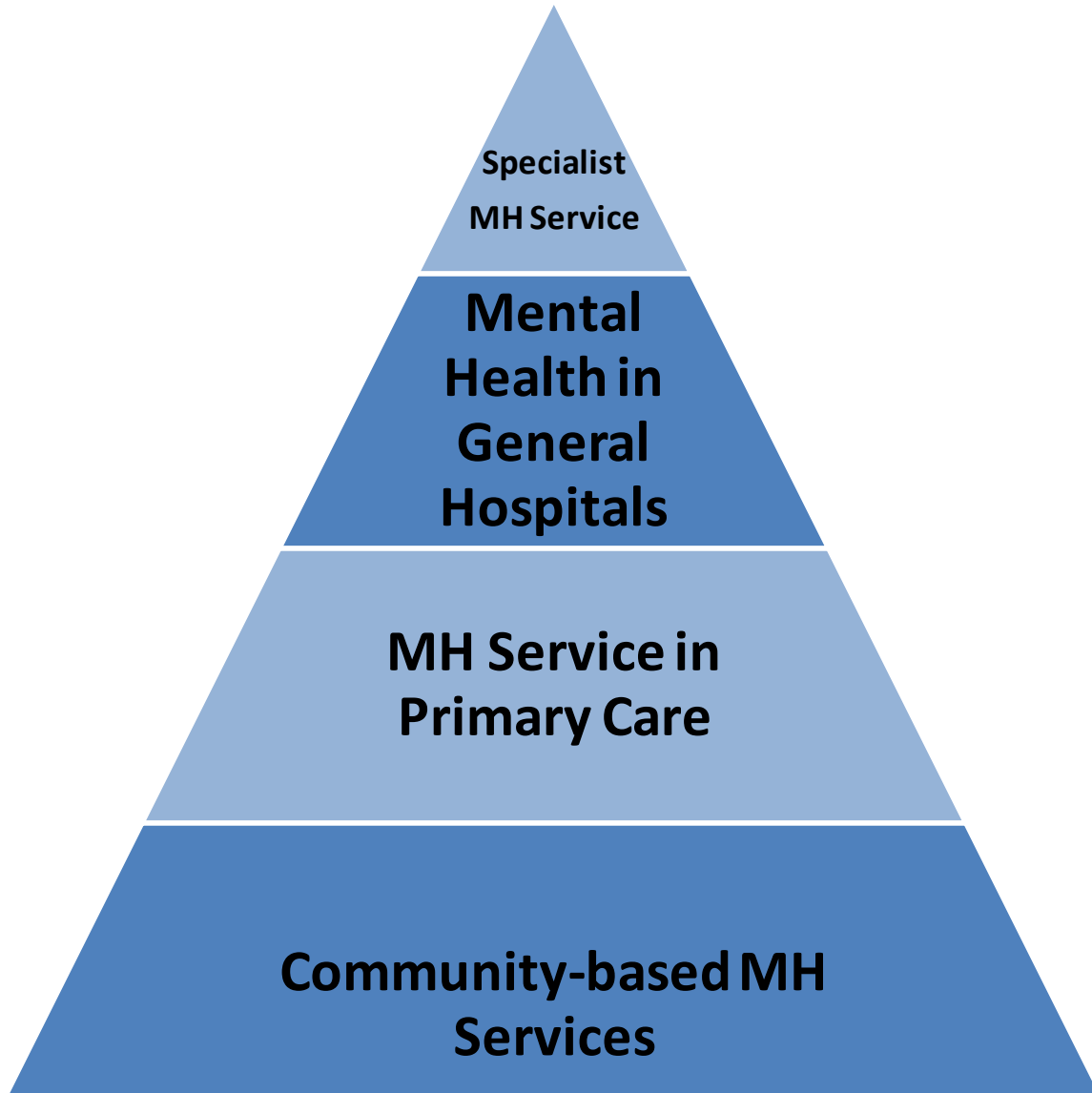
Mental Health Dept Organogram:



APPENDIX 4:

MH care hierarchy

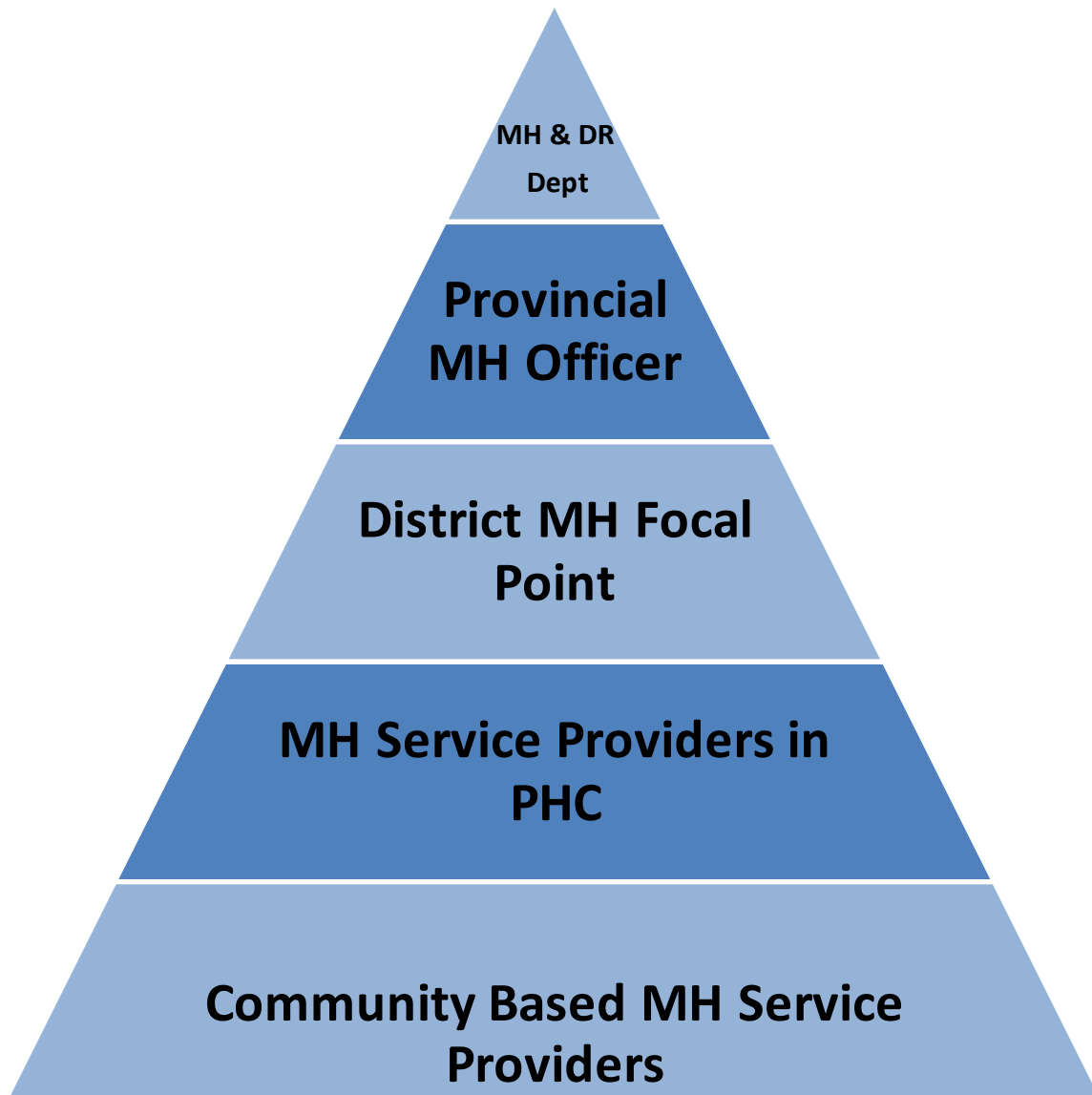
Alternative/Traditional Care



APPENDIX 5:

Organ gram diagram of Mental Health and Drug Demand Reduction Department, Preventive medicine Directorate MOPH (1389)

Self Care/Personal Care





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