Editorial

MENTAL HEALTH CARE REFORM IN AFGHANISTAN

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The mental health situation in Afghanistan is characterized by a highly felt need and an extremely incapacitated mental health care system. The new Afghan government has identified mental health as one of five health priorities. Integration of mental health into the basic health care services of Afghanistan could substantially increase the effectiveness of mental health services. The Afghan government collaborates with non-governmental organisations to rapidly expand basic (mental) health services to underserved populations.

MENTAL HEALTH AND MENTAL HEALTH CARE IN AFGHANISTAN

Over two decades Afghanistan has been ravaged by conflict. External and internal migration of millions of Afghans has destroyed their social and family structures. Much of the infrastructure has been demolished and most qualified manpower and technical expertise fled the country. The governmental health care system is in an extremely poor condition [1, 2]. The remnants of the mental health care system are hospital oriented and of poor quality. The department of neuropsychiatry of the Nangarhar medical faculty has only a few beds, virtually no psychotropic drugs, and is heavily understaffed, with only one certified psychiatrist, and no psychiatric nurses. This is the only psychiatric treatment facility in East Afghanistan, presumed to serve a population of several million people. Two other cities in Afghanistan, Kabul and the northern town of Shebargan, have treatment facilities for mental health problems. According to published statistics the country would have eight psychiatrists, 18 psychiatric nurses and 20 psychologists [1]. While these figures are strikingly low for a population of 25 million the reality is even worse, since most of these trained mental health professionals have left. The vast majority of Afghans is thus deprived of any mental health care facilities.

The mental health situation of the population can be expected to be poor, but prevalence figures of mental disorders among Afghans are hardly available. One third of refugees settled in neighbouring Iran had high scores of psychopathology measured by the GHQ-28 (General Health Questionnaire) [2]. Recent data on the situation in Afghanistan itself is lacking. The available sources indicate that depression and anxiety disorders are extremely prevalent, particularly among women and children [3, 4]. In Afghanistan important contributing factors to the development of depressive and anxiety disorders in women are war related traumatic losses, sexual violence, and the culturally sanctioned social deprivation of women through a system of strict gender-segregation ('*purdah*') [5]. The high level of exposure to war-related violence has led to high figures of physical disability among men and can be expected to have profound effects on their mental health status. It is generally assumed that posttraumatic stress disorder is common, but exact figures are not yet available. Studies in other post-conflict settings give prevalence rates for PTSD ranging from 15.8% (Ethiopia) to 37.4% (Algeria)[6]. Data on severe neuro-psychiatric conditions such as schizophrenia and epilepsy is also not available. Based on results of surveys in other low income countries we estimate the prevalence of schizophrenia between 0.14 to 0.46% and epilepsy around 1% [7, 8]. Substance related disorders, in particular addiction to opium, are common in the poppy growing areas in the south and east of the country.

The existence of mental problems is widely recognized by both the health care personnel and the general population [9]. People report a high burden of mental disorders and seek refuge to traditional shrines or self medication with psychopharmacological drugs. A sample of pharmacies in Kabul and Jalalabad had a huge stock of benzodiazepines and the vendors mention high over-the-counter sales of these products.

In short, there is all reason to presume a huge morbidity of mental disorders in this war ravaged country with an extremely incapacitated mental health care system. Afghanistan faces an urgent need to establish effective and culturally appropriate mental health services.

RECENT DEVELOPMENTS IN AFGHANISTAN'S HEALTH CARE POLICY

The new Afghan government is faced with the huge task to rapidly expand health services to large numbers of people. The government, backed by major international donors, has decided to contract non-governmental organisations (NGOs) for health service delivery in the most underserved parts of the country. The Afghan Ministry of Public Health developed a 'basic package of services' (BPS) defining the medical interventions to be made available in all districts of the country [10]. This document drafts the necessary interventions in five priority areas: maternal and newborn health, child health and immunisation, public nutrition, communicable diseases, and mental health. It is a novelty for a low income country to give mental health such a high priority. The Afghan government justifies this step by pointing at the clearly felt need by its population after decades of war and internal conflicts. Besides, it mirrors developments in international health policy to increasingly pay attention to mental health [11]. The creation of available, accessible, affordable and acceptable mental health facilities in Afghanistan can only be accomplished through a major policy shift, breaking away from hospital based psychiatry towards integration of mental health into primary health care services.

INTEGRATION OF MENTAL HEALTH IN PRIMARY HEALTH CARE

The need to integrate mental health in primary health care in low income countries is urgent, for several reasons. Mental disorders are among the most common and most disabling conditions [12]. Workers in primary care frequently do not recognize these disorders, and prescribe non-specific treatments such as analgesics, vitamins, and hypnotics [13]. Mental health care is usually only available for a small proportion of urban populations since the number of trained mental health professionals in low-income countries is low. Effective and relatively cheap treatment methods for mental disorders do exist. Training primary care workers can lead to a significant improvement of treatment for patients with disorders such as depression and epilepsy [14, 15]. Integration of mental health care into primary care reduces stigmatisation and facilitates the use of the social support system (family and community) as an important resource for healing and rehabilitation of mentally ill patients.

Since the 1980s the World Health Organization has been vigorously advocating integration of mental health care components in the national basic health care structures of developing countries, but the actual implementation of this policy is fairly limited. In the 1980s Afghanistan made an early attempt, establishing several community mental health centres in Kabul, but due to the decreasing security, the project ended prematurely and could never expand to other parts of the country. A few years ago the WHO tried to tackle the shortage of qualified personnel by organizing a mental health training for primary health care physicians in Northern Afghanistan [17]. The results were satisfying and some of the trained doctors are still practicing. Unfortunately this initiative has not been followed up, due to the political instability in the country and the unwillingness of the Taliban regime to invest in health care.

In Afghanistan's neighbouring countries recent experiences with the integration of mental health care in primary care yielded promising results. In Pakistan a community mental health project produced a sustained increase in the detection and treatment of common mental disorders in primary care [18]. The Iranian national mental health programme has been able to integrate some mental health services in about half of the countries rural districts [19].

WHAT NEEDS TO BE DONE?

The construction of a national public mental health system requires collaborative efforts of government, international donors and nongovernmental organisations to set the following objectives:

1) To initiate research to facilitate policymaking.

In the critical situation of Afghan health care the outcomes of research could be instrumental in developing a new mental health policy. Culturally informed psychiatric epidemiological and anthropological studies could provide us with baseline epidemiologic data, prevalence figures in primary care attenders, and help-seeking patterns [20]. A nationwide survey presently conducted by UNICEF is a first step in this direction.

2) To develop methodologies and models for integration of mental health into the Afghan basic health care system. Presently this is carried out in relatively small geographical areas by two NGOs in the western province of Herat and the eastern province of Nangarhar. These programmes include sensitizing the medical staff in the region with regards to mental health issues, installing a system of mental health supervision, maintaining regular supply of essential mental health drugs, and training courses for Afghan primary health care doctors, nurses and midwifes in basic mental health issues including prevention, diagnosis, and evidence based treatment. Shorter courses are organized for Village Health Volunteers and Traditional Birth Attendants to enable them to identify persons with a mental health problem in their communities and refer them to the basic health centres, and to follow-up of patients with a chronic mental illness, based upon medical instructions.

3) To use innovative methods for a rapid build-up of mental health capacity.
The World Health Organization is organizing upgrading courses for personnel of mental institutions. Through a ´Training of Trainer approach´ large numbers of mental health workers can be trained and supervised, as has been demonstrated in psychosocial and mental health programmes elsewhere in the developing world [21].

4) To carefully monitor and evaluate each intervention programme with clear outcome measures so that effectiveness - or lack of it - can be recognized [22]. After establishing various programmes the cost-effectiveness needs to be studied and compared. A recent study in Pakistan and India proves that also in low income countries cost-effectiveness-studies of primary mental health interventions are feasible[1].

5) To reform the curricula in medical faculties and nursing schools which presently do not properly address mental health issues and need to be revised and shifted toward a public mental health approach. Academic links with institutions in the other parts of world can facilitate this process[2].

CONCLUSION

The current worrisome mental health situation of the Afghans could be substantially improved when the right steps are taken. All ingredients for a successful mental health care reform seem to be in place: A strongly felt need for mental health care in the population, a clear political will to give priority to mental health, and availability of international funding agencies for significant investments in restructuring the health care system. The Afghan context offers opportunities to do what should have been done long before in many developing countries: a rigorous break with the asylum-based urban psychiatry of the past, and the development of integrated mental health services within the basic health care system.

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