Report

Mental health manpower development in Afghanistan: a report on a training course for primary health care physicians

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Introduction

Afghanistan is a multiethnic and multilingual country that has been in a state of war since 1979. This has resulted in large-scale migration and internal dislocation of different ethnic groups fleeing violence and hunger in the wake of war. Alongside the loss of life, fragmentation of families and disruption of social and economic institutions have taken place. According to the United Nations Children's Fund (UNICEF), Afghanistan ranks fourth highest in the world for mortality rates of children under 5 years of age, and is among the least advantaged in terms of life expectancy and basic immunization rates [*1*]. The under-5 mortality rate is 257 per 1000, infant mortality is 165 per 1000 and life expectancy at birth is 45 years. The level of diphtheria/polio/tetanus immunization is 31%, and immunization of pregnant women against tetanus, 37%.

There are no reliable epidemiological data available on the prevalence of mental disorders in Afghanistan. According to the World Health Organization (WHO), globally the percentage of the population suffering from severe mental disorders at any time is 1%, while 10%–15% suffer from minor psychiatric disorders. In countries at war or with high rates of internal displacement, the rates of mental ill-health are likely to be higher than in more stable environments. A recent study showed that 55% of Cambodian refugees fleeing the Khymer Rouge were assessed as fulfilling the criteria for depressive illness, and 15% for post-traumatic stress disorder (PTSD) [*2*]. Similar studies carried out in Lebanon [*3*] and Nicaragua [*4*] showed PTSD prevalence rates

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of 27% in children and 50% in women. This differential effect is not restricted to PTSD: crude death rates among the internally displaced and refugees rise 3–50 times the base rates, particularly affecting younger children [*5,6*].

Rates of mental retardation in developing countries are estimated to be 2–8 times those of industrialized countries, while epilepsy is estimated to be 3–5 times more prevalent [*7,8*]. In developing countries, the prevalence of childhood psychiatric disorders is estimated to be between 8% and 13% [*9,10*]. In women, studies show a rate 2–3 times higher, particularly for major depression [*11–13*]. Factors such as nutrition, sexual and domestic violence and discrimination at work have been identified as possible contributory factors [*14–17*]. In Afghanistan, problems of drug abuse and antisocial behaviour have been identified among adolescents and youths exposed to low-intensity war.

The number of psychiatrists in Afghanistan (including those who have only received 3 months in-service psychiatric training) is less than 35. There are 40 community health workers (similar to so-called *felchers*) and 70 primary health care and school health staff who have been trained to identify and manage common mental disorders. In the whole of Afghanistan, less than 100 psychiatric beds are available. There is an obvious gap between need and the availability of services. The Afghanistan national mental health programme advocates the development of a nucleus of trained mental health professionals to act as "master trainers" for primary health care physicians and health workers in their respective provinces in order to ensure at least a minimum provision of mental health services.

Course development

A 3-month residential training course was developed by the WHO Regional Office for the Eastern Mediterranean in consultation with the WHO representative for Afghanistan and the Afghan health authorities. The curriculum consisted of history-taking, diagnosis in psychiatry, major psychiatric illnesses, child psychiatry, stress and disasters, psychopharmacology, doctor–patient relationships/communication, interview techniques, simple techniques of supportive therapy and counselling, prevention of mental illness, research methods and evaluation, and intersectoral collaboration.

Ten general physicians with previous training in psychiatry, from all parts of the country, were nominated for the course. The director of the mental health centre at Shebergan was the local focal point. The previous medical experience of the physicians ranged from 3 years to more than 25 years. Eight participants were from the northern provinces and two from Nangarhar province. Four trainers were recruited from Pakistan and the Islamic Republic of Iran. One of the trainers, with expertise in both psychiatry and public health, who had previously visited Afghanistan, was involved in the selection of nominees. He remained with the course throughout its full duration (3 months). The other three trainers provided various other expertise in community mental health (duration of involvement, 3 weeks), child mental health (2 weeks), general adult psychiatry and research methods and evaluation (2 weeks). The variation in the amount of time spent on the course by the trainers was in response to the training needs of the participants.

The course was carried out against a backdrop of long-term low-intensity war.

Table 1 **Results of pre-course and post-course assessment: mental health training course for general physicians, Afghanistan**

Target areas	Percentage of total mark	Maximum possible mark	Pre-course Mean (range)	Post-course Mean (range)	*P*-value
Knowledge	30	90	57 (51–62)	70 (68–71)	< 0.001
Problem-solving	40	120	60 (54–66)	73 (66–80)	< 0.001
Research	10	30	11 (8–14)	19 (17–20)	< 0.001
Interview skills	20	60	31 (28–34)	33 (31–35)	Non-significant
Total	100	300	158 (142–174)	195 (185–205)	< 0.001

There was very limited logistic support, particularly relating to the quality of board and lodgings available to participants. The only food available was rice and broth. There was a continuous military presence, with the potential to distract the focus of the training programme at any time.

The course began with a pretraining evaluation as the participants arrived, after which participants were given feedback on their strengths and on the areas needing improvement. Classroom training included lectures, seminars, case demonstrations, video feedback on interview skills and weekly full-day research workshops. Each participant was supervised daily in the assessment and management of patients attending the outpatients clinic. A post-course evaluation was also provided.

Evaluation

The instruments for the pre- and post-course evaluations were developed to test for:

- knowledge — 31 multiple choice questions;
- problem-solving — 10 short written cases with short answer questions covering the major diagnoses;
- research — 10 multiple choice questions;
- interview skills — an independently rated video of the participant interviewing a patient.

The evaluation instruments were based on the course curriculum and developed in consultation with medical faculty members of Balkh University. They were prepared in English and translated into Dari (the language of the northern regions of Afghanistan). The evaluation was trialed on four experienced general physicians, and their feedback incorporated into the final version.

All 10 participants completed the evaluations (Table 1). Overall there was a significant improvement in scores, and each participant scored higher on the post-course than the pre-course assessment. The pre-course scores were more widely spread than the post-course scores, which clustered around the mean. The greatest improvement was seen in research and

knowledge. There was also a highly significant improvement in problem-solving skills. There was no change in interview skills ratings.

The course achieved its aim of improving the knowledge, problem-solving skills and research knowledge of the participants, although interview skills did not improve. The resources for knowledge acquisition were readily available in the form of textbooks in the local language and two trainers were on site at all times. By contrast, the opportunities for video feedback were limited because there was only one video camera in the province, which was being used at the television station most of the time. The participants were each only able to make a recording of two interviews that were used in group feedback. Acquisition of new skills and changes in behavioural practice are difficult to achieve, and greater access to video equipment might have helped improve interview skills. The use of video feedback for interview-skills training has been shown to be an effective method elsewhere [*18*].

The participants were generally very satisfied with the course. Reviewing the course with the trainers, they identified law and mental health, health systems research, information systems development and the integration of mental health into primary care as four areas requiring more attention.

Conclusion

The development of the course followed the identification of a public health need for the provision of mental health services in Afghanistan. Prior to the course, the participants had very limited experience or training in mental health. The course assessments demonstrated that in the relatively short period of 3 months, despite adverse circumstances, the doctors showed significant improvement in three out of the four target areas. Further improvements in the course could be achieved by ensuring that training resources are available, including free availability of books in the local language and video facilities.

There has been no further evaluation to examine whether the practice of the doctors in relation to mental health problems has improved, or whether improvements have been sustained over a period of time. Research elsewhere suggests that there is a need for ongoing support to sustain the gains made in the initial training (S. Regmi et al., unpublished findings, 1998).

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