# Afghanistan case study

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| Title of the case study |
| Name of person completing the form |
| Dr Bashir Ahmad Sarwari |
| Contact details for more information about the case study |
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| DESCRIPTION |
| Briefly describe the organization of the health system in your country: governance mechanisms/structures (health policies/strategies/plans, legislation, etc.), financing mechanisms, human resources (density, distribution), availability of service delivery packages (what are the preventive, curative and rehabilitative/palliative services included in the package), information system organization (core set of indicators, standard collection, collation, analysis and reporting mechanisms).  A mental health strategy for the years 2011−2016 has been developed and a related action plan and costing completed. The Ministry of Public Health has a stewardship role for service provision and in almost all the 29 provinces (except three), services are provided through contract by nongovernmental organizations. Primary health care (PHC) services are funded by donors at a cost of almost US$ 4.25/per capita/per year. Standard training curricula and a manual have been developed for doctors, nurses, midwives (MWs), community health supervisors and community health workers. A new category of psychosocial counsellor has been defined, trained and deployed to all comprehensive health centres (CHCs) (1 year: 3 months intensive in class and 9 months on-the-job).  Currently: 380 CHCs out of 400 have at least one psychosocial counsellor; basic psychotropic medication is available in almost all PHC settings; MWs are providing basic counselling in basic health centres (BHCs) with 15 000−3000 population; there are referrals between health facility and secondary care (hospital sector); of the three kinds of hospital (district with up to 40 beds, provincial with up to 100 beds and regional with up to 400 beds), mental health services are weak in district hospitals, in provincial hospitals there is a doctor providing an out-patient department (OPD) and two psychosocial counsellors providing psychosocial counselling services, and in regional hospitals there are mental health wards with up to 20−40 beds with an OPD and in-patient department (IPD), including a residency programmes for psychiatrists; during eight years almost 102 psychiatrists have graduated from residency programmes; a suicide prevention strategy has been developed and some part of it has already begun to be implemented; a standard a package of emergency counselling and psychological first aid has been developed and two psychosocial counsellors trained in every province; later on these counsellors will provide EC training for med levels and psychological first aid for community gatekeepers in the most vulnerable provinces; there are eight deliverables in the health management information system (HMIS) system and all implementing partners provide monthly reports to the HMIS/Ministry of Public Health and every quarter the data are analysed by department:  1. Common mental disorders: depression, anxiety, post-traumatic stress disorder (PTSD)  2. Severe mental disorder diagnosed and referred  3. Epilepsy  4. Number of health facilities with IEC (mental health) materials  5. Number of health facilities providing detoxification of substance abuse services (narcotics)  6. Availability of psychosocial counselling services in health facilities  7. Number of clients received psychosocial counselling  8. Stock out report on fluoxetine and amitriptyline.  The 1987 Mental Health Act was revised in 2016 and is with the Ministry of Justice to be approved; a new code of practice has been developed to implement the Act and a new strategy for the years 2017−2022 is being developed. The WHO QualityRights toolkit has been implemented in Kabul mental health hospital. |
| Briefly describe the process of Integration of mental health in general health care/PHC in your country. Please indicate the proportion of PHC facilities which are providing integrated services and provide information about the governance mechanisms/structures put into place to facilitate integration, financing mechanisms, human resource development strategies (including training, deployment and continued development), package of mental health interventions being delivered in an integrated manner, monitoring and evaluation mechanisms put in place to support the process of integration, including integrating a mental health component in the national health information system (core set of indicators, standard collection, collation, analysis and reporting mechanisms)  Since 2005, mental health has been integrated in PHC and in the hospital sector. Priority conditions are common mental disorders such as depression (mild and moderate), anxiety disorder (GAD, PTSD, phobia, panic, OCD), unexplained somatic complaints, conversion disorders, learning problems, mental retardation and epilepsy, and severe mental disorders such as mania, severe and psychotic depression, including post-partum depression, and schizophrenia. The approach to deal with mental disorders and psychosocial problems is bio-psychosocial,  Below are the types of health facility in the health system:   * more than 15 175 health posts run by two CHWs each covering 3000 population, providing awareness, identification of cases and follow up of patients; * 579 subcentres run by nurse, MW and medical doctors providing bio-psychosocial services through medication/basic psychosocial counselling located in areas up to two hours away by foot; * 147 mobile health team providing basic counselling and medication for mentally ill patients; * more than 834 BHCs covering 15 000−30 000 area providing basic counselling by MWs and medication by trained medical doctors, including supervision and documentation; * more than 405 CHCs which covering 30 000-60 000 population, providing advanced psychosocial counselling services by trained psychosocial counsellors and medication by trained medical doctors, including supervision and documentation and monitoring * more than 80 district hospitals: currently there is basic counselling by nurses and MWs plus medication by trained medical doctors and this is a bottleneck for mental health; * 28 provincial hospitals covering 100 000 population with IPD and OPD services and equipped with two psychosocial counsellors to provide counselling services and short stay IPD services for severe cases of mental health; * six regional hospitals providing an IPD and OPD and also psychosocial counselling plus residency programmes for psychiatrists; * one mental health hospital is a tertiary hospital with 100 beds (40 for drug users and 60 for mental health patients), with a residency programme and also services for forensic and child psychiatry; * there are many programmes at community level to provide awareness and referral such as in women’s prisons, juvenile centres, women’s gathering places, mosques, schools and universities, with mental health prevention and promotion interventions such as life skills education. |
| What challenges did you face?  Low resources: The European Union is the only donor for mental health. Stigma exists at different levels. Low community awareness. Insecurity. Limited public mental health expertise, with only one psychosocial counsellor at every CHC, which is difficult in the Afghan context due to sociocultural issues. |
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| What are your future plans for the intervention/action?  Adding one more psychosocial counsellor in CHCs for a female/male balance; implementation of the Mental Health Act and related code of practice; finalization of new mental health strategy for the years 2017−2022; revision of the basic package of health services (BPHS) and essential package of health services (EPHS) (hospital package) to strengthen mental health services in district and regional hospitals; functional referral between BPHS and EPHS; establishing more reliable indicators in the HMIS system, including a monitoring and evaluation check list; continuing to implement the suicide prevention strategy 2017−2021; strengthening community approaches for prevention and promotion; strengthening supervision and monitoring of mental health services; improving the quality of mental health services throughout the health system; improving the human rights of patients with mental disorders and reducing the violation of human rights in health facilities; removing patient from *marastoons* (detention centres for the mentally disabled currently run by the Afghan Red Crescent Society), through community integration, training and reintegration of patients in their families; a counsellor trained in the emergency package will provide EC training for med levels and PFA for community gatekeepers in the most vulnerable provinces; establishing a mental health social work department at the Ghazanfar Institute for Health Sciences to graduate psychosocial counsellors and social workers. |
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| IMPACT OF INTERVENTION/ACTION |
| Any studies conducted to evaluate the process and impact of integration of mental health in PHC? |
| Under process and will be complete up to the end of 2018 |
| What impact has the integration had (e.g. number of people treated, impact on patient outcomes, or reduction in stigma)? |
| More than 1 million patients visited health facilities in 2016 and received mental health and psychosocial counselling services |
| Are there any published studies/reports? Please provide references |
| WHO’s *Building back better* (2013) |
| ADDITIONAL INFORMATION |
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| Key references/documents (we can link electronically to these) |
| http://www.who.int/mental\_health/emergencies/building\_back\_better/en/ |
| Do you have any documents that you would be willing to share to be adapted and implemented in other settings, such as training manuals or intervention manuals? |
| Yes, package for doctors, med levels, psychosocial counsellors, gender-based violence psychosocial counsellors, emergency counselling and psychological first aid, basic counselling, code of practice and many tools (check lists procedures, standards and guidelines) |