

WHO-AIMS

**WHO-AIMS REPORT ON
MENTAL HEALTH SYSTEM
IN AFGHANISTAN**



**World Health
Organization**



**MINISTRY OF
PUBLIC HEALTH
AFGHANISTAN**

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*A report of the assessment of the mental health system in Afghanistan using
the World Health Organization - Assessment Instrument for
Mental Health Systems (WHO-AIMS).*

Kabul, Afghanistan

2006



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Please refer to WHO-AIMS (WHO, 2005) for full information on the development of WHO-AIMS at the following website.

http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

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The WHO-AIMS project is coordinated by Shekhar Saxena. Developing guidelines and treatment protocols for different categories of health staff is important issue to address lack of knowledge and skills among health staff.

Involvement of community in planning and services provision in mental health is an important issue currently lacking. This could be done through support for mental health unit in MOPH and voluntary organizations.

Coordinated and sustained efforts are needed to strengthen the mental health system in Afghanistan.

Introduction

Afghanistan is a country with an approximate geographical area of 652,000 square kilometres and a population of 24.926 million people (WHO, 2005). The main languages used in the country are Pushto, Dari Persian and Turkic, and the main ethnic groups are Pushton, Tadjik, Hazara and Uzbeks. Religious groups include Muslims (Sunni and Shiaa) and a small group of Sikhs. The country is a lower middle-income group country based on World Bank 2004 criteria.

The proportion of the population under the age of 15 years is 43% (UNO, 2004), and the proportion of the population above the age of 60 years is 5% (WHO, 2004). Seventy-five percent of the population is rural. The life expectancy at birth is 41.9 years for males and 43.4 years for females (WHO, 2004). The healthy life expectancy at birth is 35 years for males and 36 years for females (WHO 2004). The literacy rate for men is 47% for men and 15% for women (UNESCO/MOPH, 2004).

The proportion of the health budget to GDP is 5.2% (WHO 2005). The per capita total expenditure on health was 34 international \$, 18 of which represented government expenditures (WHO 2004). There are 34 hospital beds per 100,000 population and 13 general practitioners per 100,000 populations. A small percentage of hospital beds are in the private sector. In terms of primary care, there are 3,900 physician-based primary health care clinics in the country (2,000 public and 1,900 private) and 3,100 non-physician based primary health care clinics (1,500 public and 1,600 private).

Data for this study was collected in 2005 and is based on the year 2004.

Executive Summary

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) was used to collect information on the mental health system in Afghanistan. The goal of collecting this information is to improve the mental health system and to provide a baseline for monitoring the change. This will enable Afghanistan to develop information-based mental health plans with clear base-line information and targets. It will also be useful to monitor progress in implementing reform policies, providing community services, and involving users, families and other stakeholders in mental health promotion, prevention, care and rehabilitation.

Afghanistan has had a national mental health plan, policy and legislation since 1987 which addresses the main mental health issues. A regular budget allocation does not exist for mental health. In 2004, 0.1 million USD (out of a 289.4 million USD total health budget) was directed for mental health. Although a national human rights body exists, only one review/inspection of human rights protection for a patient was carried out in 2004.

The majority of beds in the country are provided by inpatient units in general hospitals. The majority of users are treated in outpatient facilities and in inpatient units. Female users account for 47% of the population in all mental health facilities in the country. The proportion of female users is highest in day treatment and outpatient facilities while the percentage children and adolescents are generally low in all facilities. Schizophrenia and other disorders are most common in inpatient units, while in the mental hospital substance use disorders and schizophrenia are seen most frequently.

Less than one percent of training for medical doctors is devoted to mental health in comparison of 2% of nurses. Four percent of primary care doctors and 1% of nurses have received at least 2 days of refresher training in mental health in 2004. Psychiatric treatment protocols do not exist for primary care staff. Referrals for psychiatric care from physician based and non-physician based primary health care are 20% and 80% respectively. Only doctors can prescribe psychotropic medications in primary care settings.

There are only two psychiatrists (neither working in mental health facilities), 61 other doctors, 37 nurses and 40 other mental health workers in the mental health services in country. Last year 2.6 doctors and 2.4 nurses per 100,000 general populations graduated from training programs.

There is no coordination body on mental health to oversee publications and awareness campaigns. There is no financial or legislative support for people with psychiatric problems. Also, there are no formal collaborations with other government departments or agencies (e.g., Ministry of Education, department responsible for elder affairs, etc) in order to address the needs of patients.

Although no defined mental data collection exists in the ministry, 36% of outpatient facilities, 100% of inpatient units and the mental hospital transmit limited mental health data to the health department, including the number of patients, admissions and diagnoses.

The mental health unit, led by the Primary Health Care Directorate in the Ministry, was established recently. However, the current network of mental health facilities remains incomplete. The only mental hospital, in the capital city, houses 60 beds while community mental health facilities are yet to be developed in the country. Although there are few outpatient mental health facilities, these facilities are widely used if essential psychotropic medications are available. Almost all mental health outpatient facilities are located in major cities. In rural areas, primary healthcare staff have either limited training in mental health or mental health services are entirely unavailable. The utilization of services by poor people entirely depends on the availability of free medications in the facilities. In addition to revising the current mental health legislation, public awareness campaigns and the establishment of review/inspection boards would be potent

mechanisms for improving human rights of patients in Afghanistan. Although there have been efforts to promote equity of access to mental health service, these efforts have been inadequate. Limited resources are available for mental health and much of these resources are directed towards the mental hospital, leaving inpatient and outpatients facilities under funded. Most of the resources have been spent for training of primary care staff while no supervision and monitoring systems have been established.

The Ministry of Public Health supports a standard training program based on the “Basic Package for Health Services” or BPHS for primary care. However, no such module has been developed and the training for primary care staff is widely inadequate. Although an essential psychiatric medicines list is available in the country, these medications have not been available in primary health care facilities due to postponement of implementation of the mental health component of BPHS. Family and consumers associations do not exist in the country while links between the mental health sector and other sectors are very limited. The interaction between mental health providers and primary health care staff is limited to trainings conducted only occasionally. The Ministry of Public health is planning to update the mental health policy and legislation in 2006. The policy and plan will highlight grossly inadequate and unreliable mental health statistics in the country.

There have not been major changes in the mental health system in Afghanistan since the collapse of the Taliban. This is most obvious when examining the development of mental health human resources and services. There has been a slight increase in number of beds and mental health outpatients all in major cities while services in rural areas are non-existent. Although a strategy paper for integration of mental health into primary health based on the Basic Package of Health Services (BPHS) care has been developed by the Ministry of Public Health, due to lack of funds to implement mental health components of BPHS the process of integration has been postponed until 2006. In early 2003 treatment protocols for common mental disorders were drafted but have not been finalized yet. Psychosocial interventions centres were established in 2005 by some international NGOs in the capital but they have not been implemented in rural areas.

Domain 1: Policy and Legislative Framework

Policy, plans, and legislation

Afghanistan's national mental health program has been used as mental health policy since it was enacted in 1987 and includes the following components: downsizing large mental hospitals, developing a mental health component in primary health care, human resources, equity of access to mental health services across different groups, advocacy and promotion, financing, quality improvement and monitoring systems. In addition, a list of essential medicines is present. These medicines include antipsychotics,

antidepressants, anxiolytics and antiepileptics. The last revision of the mental health plan was in 1987. This plan contains the following components:

- developing community mental health services
- downsizing large mental hospitals
- reforming hospitals to provide more comprehensive care
- developing a mental health component in primary care
- human resources; mental health advocacy and promotion
- equity of access to mental health services across different groups
- financing
- quality improvement and monitoring system

In addition, a timeframe and specific goals are identified in the last version of the mental health plan. There is no disaster/emergency preparedness plan for mental health. The last piece of mental health legislation was enacted in 1997, which focused on access to mental health care including:

- least restrictive care
- rights of mental health service consumers, family members, and other care givers
- competency, capacity, and guardianship issues for people with mental illness
- voluntary and involuntary treatment
- accreditation of professionals and facilities
- law enforcement and other judicial system issues for people with mental illness
- mechanisms to oversee involuntary admission and treatment practices
- mechanisms to implement the provisions of mental health legislation

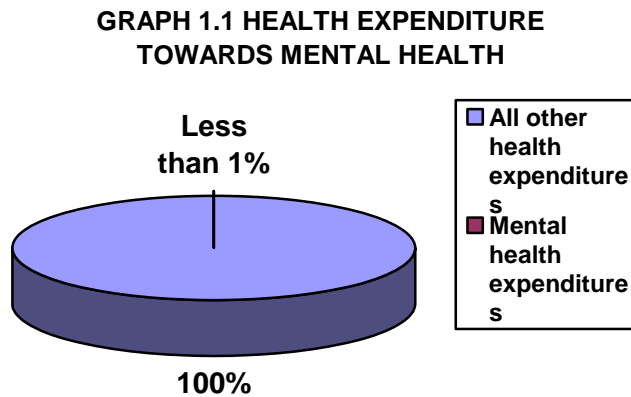
The ministry of Public Health is planning to revise the current mental health policy and legislation and to formulate a new national mental health program. The data was collected from Ministry of Public Health publications on mental health policy, mental health legislation and national mental health program. The Mental Health Unit, under the Primary Health Care Directorate, provided additional information on future plans and activities.

Financing of mental health services

100,000 US \$ was directed towards mental health in 2004. Of all the expenditures spent on mental health 50,000 US \$ is directed towards mental hospitals. The percentage of the population with free access to essential psychotropic medicines is less than 1% For those that pay out of pocket, the cost of antipsychotic medication is 6 Afghanis (12% of daily minimum wage) and antidepressant medication is 8 Afghanis (16% of daily minimum wage). Mental disorders are not covered by social insurance schemes.

The developmental budget for health in 2004 was 289.4 M \$ and 0.1 M \$ was targeted for mental health. Of the total developmental budget for health, the government paid 22.3 M and the rest was from international donor contribution. Some funds were from international NGOs running mental health projects in Afghanistan but are not recorded in Ministry documents. The data was obtained from the Developmental Budget Section, Policy and Planning Directorate of Ministry of Public Health (MOPH).

Graph 1.1: Expenditures on mental hospitals as a proportion of total mental health care spending



Human rights policies

A national human rights review body exists (Afghanistan's Independent Human Rights Commission -AIHRC) which has the authority to inspect human rights issues in mental health hospitals as well. Only one review/inspection of human rights protection of patients occurred in 2004. This review was in response to a family member complaint to the mental hospital. The data was obtained from the AIHRC office in Kabul and sub offices in the regions.

There was no training, meeting, or other type of working sessions on human rights protection of patients for the staff of mental hospitals, inpatient psychiatric units, or community residential facilities staff.

Domain 2: Mental Health Services

Organization of mental health services

A national mental health authority exists which provides advice to the government on mental health policies and legislation. The mental health authority is also involved in service planning, service management and co-ordination, monitoring and quality assessment of mental health services. Mental health services are not organized in terms of catchments/service areas.

The Mental Health Unit in the Ministry of Public Health was functional in January 2004. The Ministry of Public Health is planning to revise the organization of the Mental Health Services after revision of the Mental Health Policy and during formulation of new mental health plan for the country.

Mental health outpatient facilities

There are 11 outpatient mental health facilities available in the country but none are for children and adolescents. These facilities treat 234 users per 100,000 general populations. Of all users treated in mental health outpatient facilities, 48% are female and 25% are children or adolescents. The users treated in outpatient facilities are primarily diagnosed with mood (affective) disorders (36%) and neurotic, stress related and somatoform disorders (20%). The average number of contacts per user is unknown. Two of the outpatient facilities provide follow-up care in the community, while none have mental health mobile teams. In terms of available treatments, 21-50% of the outpatient facilities offer psychosocial treatments. Eighty-two percent of mental health outpatient facilities had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptics) available in the facility or a near-by pharmacy all year round.

The mental health outpatient facilities are scattered throughout the country and are not linked with the Mental Health Unit in the ministry. Since no standard reporting system for mental health has been established, the current data was estimated based on the available data in the facilities. Reporting records show only the number and gender of the cases seen. Most records revealed the diagnosis the patient received but treatment data was incomplete or missing. In most cases the gender of the patient was determined according the name entered in the register book. Data on psychotropic medicine and follow-up for each patient were not available.

Day treatment facilities

There is only one-day treatment facility available in the country. This facility treats 8 users per 100,000 general populations. Fifty-four percent of users treated are female and 6% are children or adolescents. On average, users spend 9 days per year in day treatment facilities.

Although there is no day treatment facility available for children and adolescents, youth can be treated at the day treatment centre. The data was obtained from the day hospital in the Kabul Psychiatric Hospital although there are no regular recordings of the cases seen. Data was estimated according to the available data in the centre.

Community-based psychiatric inpatient units

There are 5 community-based inpatient units available in the country for a total of 0.28 beds per 100,000 populations. None of these beds in community-based inpatient units are reserved for children and adolescents. Twenty-seven percent of admissions to community-based psychiatric inpatient units are female and there have been only 13 cases of children/adolescents. The admitting diagnoses belonged primarily to the following two diagnostic groups: schizophrenia (45%) and mood disorder (21%). The average length of admission is unknown. Fifty percent of patients in community-based psychiatric inpatient units received psychosocial interventions in the last year. Twenty percent of the community-based psychiatric inpatient units had at least one psychotropic

medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptics) available in the facility or a nearby pharmacy.

The data was obtained directly from inpatient psychiatric units in the capital and regions based on incomplete records available, which were reported to the Ministry. Data on days spent in the hospital and readmission was not available. Involuntary admissions and restraining was estimated after discussions with doctors in charge of in the units.

Community residential facilities

There are no community residential facilities available in the country.

Mental hospitals

There is one mental hospital in the country for a total of 0.24 beds per 100,000 populations. This facility is organizationally integrated with the mental health outpatient facilities. None of the beds in the mental hospital are reserved for children or adolescents. The number of beds has increased by 50% in the last five years. Eighteen percent of users are female.

The patients admitted to mental hospitals belong primarily to the following two diagnostic groups: psychoactive substance use (58%) and schizophrenia (24%). In 2004, the number of patients treated in mental hospitals was 1514 (6 per 100,000 populations). The average number of days spent in the mental hospital is unknown. There are no long stay patients (more than a year) in the mental hospital. Up to 20% of patients in the mental hospital received one or more psychosocial intervention in the last year. The mental hospital had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic).

The data was collected from Kabul Psychiatric Hospital. No data was available on duration of stay, readmission and follow-up. Involuntary admission and restraint rates were estimated after discussion with doctors in the hospital. Some long stay homeless patients reside in Marastoons which are available in major cities. The number of chronic patients staying in Marastoons (Supported by Afghans Red Crescent Society) in the country is 244 (211 male and 33 female). Most of them are there for more than 5 years without any psychiatric care. While some Marastoons have vocational training, it is not available for psychiatric patients. In the Galabad Marastoon patients are cared for by doctors from the Nangarhar Health Directorate and Health Net International, an international NGO that supplies medicines. The data for Marastoon was collected from Marastoon authorities in the Capital and regions. In 2005, three private mental hospitals each with 20 beds (total 60) were established but no records were available in MOPH.

Forensic and other residential facilities

There are no forensic inpatient units available in the country but any cases referred for treatment by police, courts or from prison are kept on the ward while a police officer guards the ward. Due to security problems, these patients are usually not admitted.

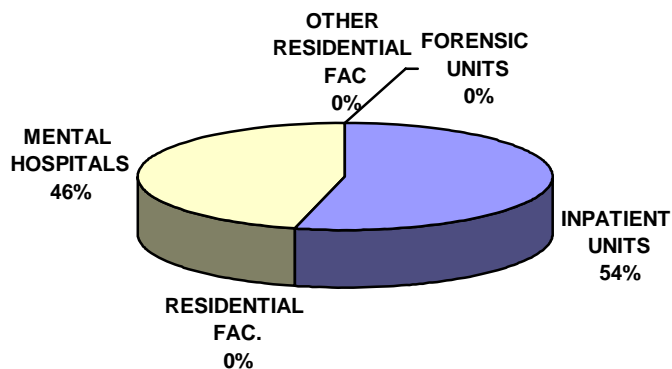
Human rights and equity

Twenty-five percent of all admissions to community-based inpatient psychiatric units and 40% of all admissions to mental hospitals are involuntary. Over twenty percent of patients were restrained or secluded at least once within the last year in community-based psychiatric inpatient units and in mental hospitals. All psychiatry beds in the country are located in or near the largest city. Such a distribution of beds prevents access for rural users. Inequity of access to mental health services for other minority users (e.g. linguistic, ethnic, religious minorities) is not an issue in the country.

Hospitals do not report involuntary admissions, restraining of patients and duration of stay. The data was estimated after discussion with mental hospital and general hospital authorities.

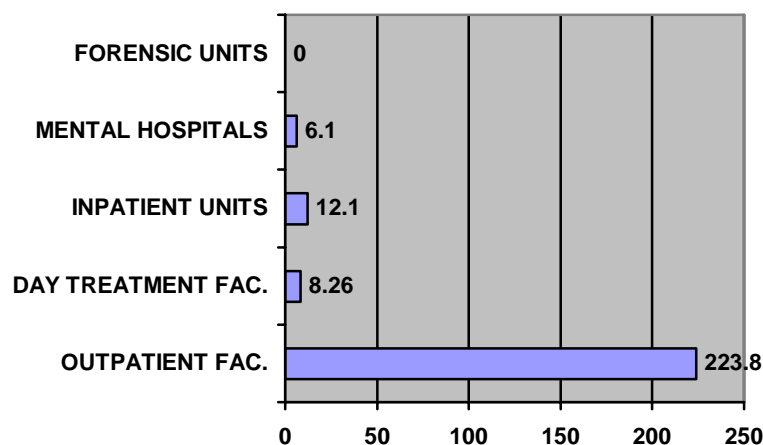
Summary Charts

**GRAPH 2.1 - BEDS IN MENTAL HEALTH FACILITIES
AND OTHER RESIDENTIAL FACILITIES**



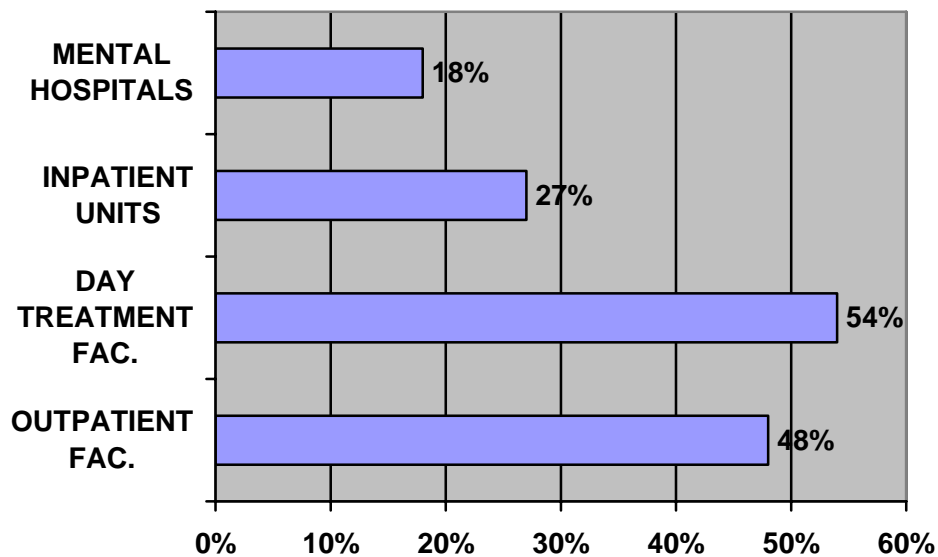
The majority of psychiatric beds in the country are provided by inpatient units in general hospitals, followed by the mental hospital.

**GRAPH 2.2 - PATIENTS TREATED IN MENTAL HEALTH
FACILITIES (rate per 100.000 population)**



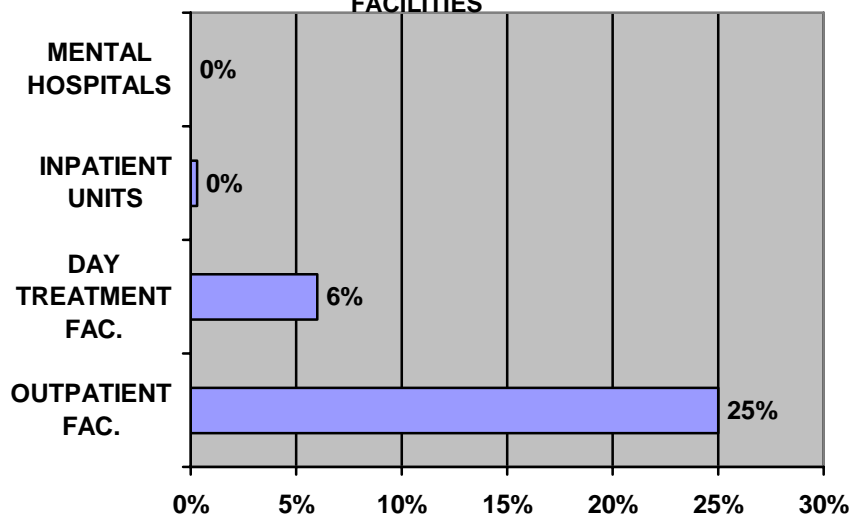
The majority of the users are treated in outpatient facilities and in inpatient units, while the rate of users treated in day treatment facilities and mental hospital is lower.

**GRAPH 2.3 - PERCENTAGE OF FEMALE USERS TREATED
IN MENTAL HEALTH FACILITIES**



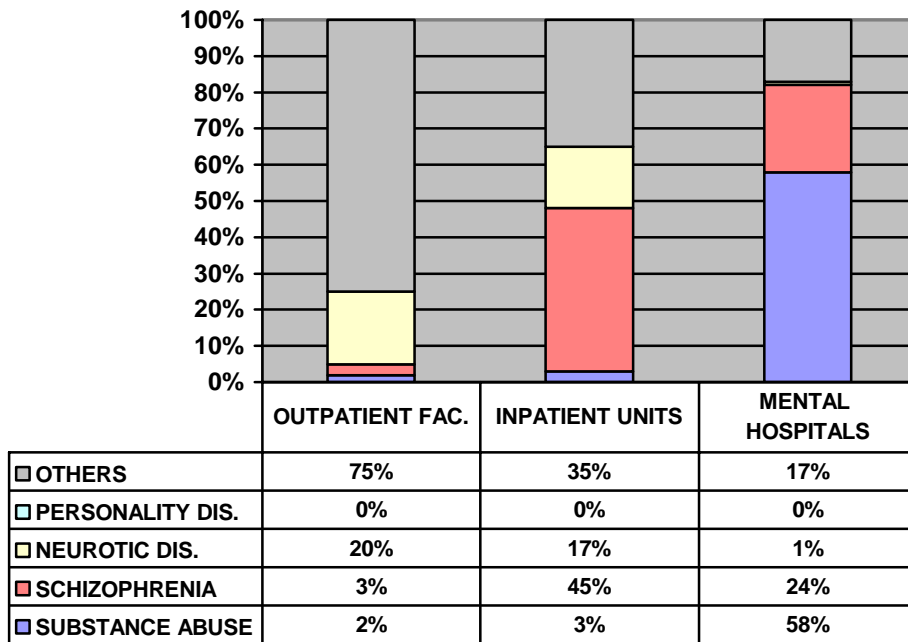
Female users account for just under 50% of the population in all mental health facilities in the country. The proportion of female users is highest in day treatment and outpatient facilities and lowest in mental hospital and inpatient units.

**GRAPH 2.4 - PERCENTAGES OF CHILDREN AND
ADOLESCENTS TREATED IN MENTAL HEALTH
FACILITIES**



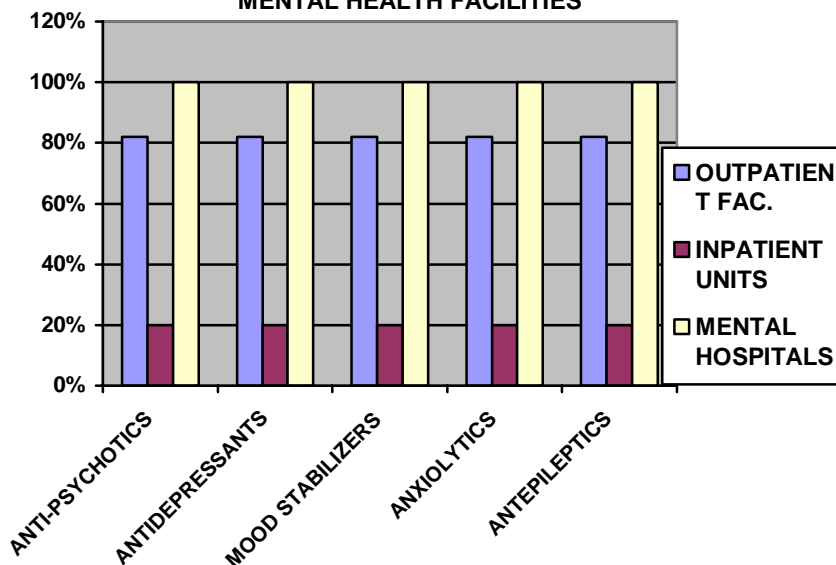
The percentage of users that are children and/or adolescents varies substantially from facility to facility and generally is low. The proportion of children users is highest in mental health outpatient facilities and lowest in mental hospitals.

GRAPH 2.5 - PATIENTS TREATED IN MENTAL HEALTH FACILITIES BY DIAGNOSIS



The distribution of diagnoses varies across facilities: in outpatients facilities neurotic disorders and other disorders are most prevalent, within inpatient units schizophrenia and other disorders diagnoses are most common, and in mental hospitals schizophrenia and substance abuse are most frequent.

GRAPH 2.7 - AVAILABILITY OF PSYCOTROPIC DRUGS IN MENTAL HEALTH FACILITIES



Psychotropic drugs are most widely available in mental hospitals, followed by inpatient units, and then outpatient mental health facilities.

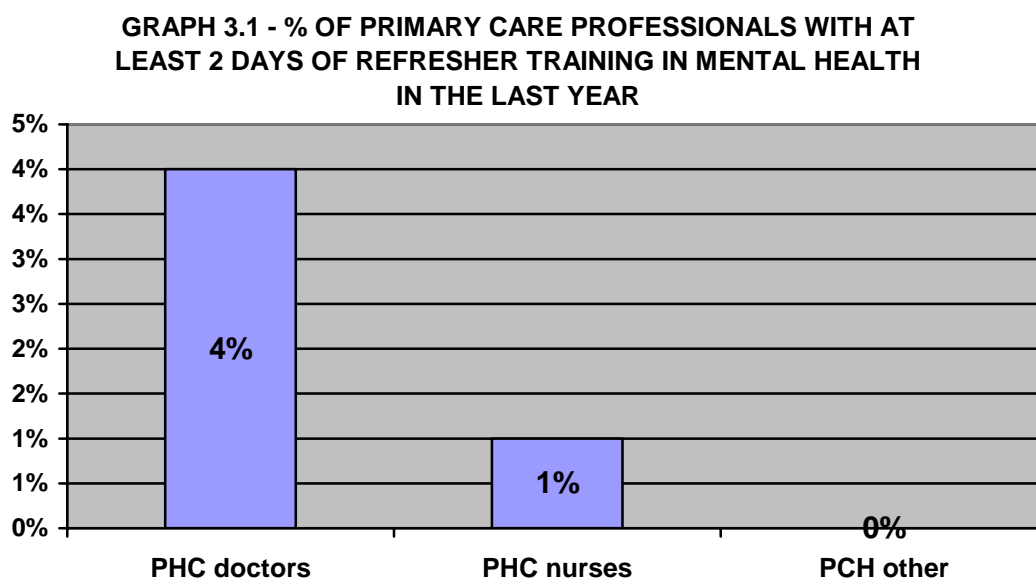
DOMAIN 3: MENTAL HEALTH IN PRIMARY HEALTH CARE

Training in mental health care for primary care staff

Less than 1% of the training for medical doctors is devoted to mental health, in comparison to 2% for nurses and non-doctor/non-nurse primary health care workers. In terms of refresher training, 4% of primary health care doctors have received at least two days of refresher training in mental health, while 1% of nurses and less than 1% of non-doctor/non-nurse primary health care workers have received such training.

The data on number of health staff in primary care was collected from Ministry of Public Health (Policy and Planning Dept e.g. Human Resources and Health and Management Information System offices). While data on Mental Health training was obtained from mental hospital and Mental Health Unit in MOPH. Number of health staff is approximate due to frequent transfers and recruitment of returnees from neighbouring countries.

Graph 3.1: Percent of primary health care professionals with at least two days of refresher training in mental health in the last year

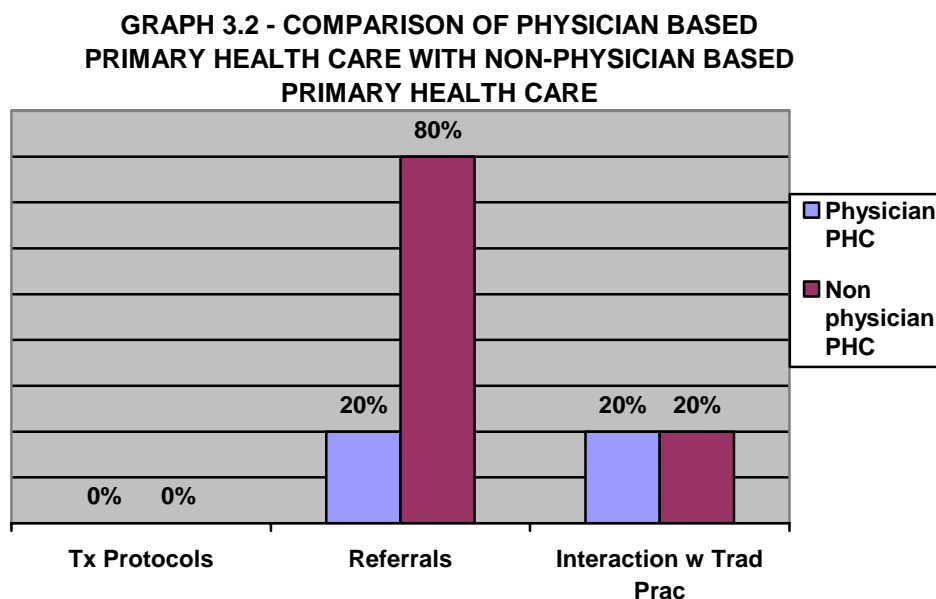


Mental health in primary health care

Both physician based primary health care (PHC) and non-physician based PHC clinics are present in the country. Neither physician-based nor non-physician-based primary health care clinics have assessment and treatment protocols for key mental health conditions. 1-20% of physician-based primary health care clinics make on average at

least one or more referrals per month to a mental health professional. 51-80% of non-physician based primary health care clinics make a psychiatric referral to a higher level of care. As for professional interaction between primary health care staff and other care providers, no primary care doctor has interacted with a mental health professional at least once in the last year. 1-20% of physician-based and non-physician-based PHC facilities have had interaction with a complimentary/alternative/traditional practitioner while no mental health facilities have had such an interaction. No recorded data is available. Current data was obtained through direct contact with authorities in Ministry of Public Health.

Graph 3.2: Comparison of physician-based primary health care with non-physician based primary health care



Prescription in primary health care

Nurses and non-doctor/non-nurse primary health care workers are not allowed to prescribe psychotropic medications. Primary care doctors and all other doctors are allowed to prescribe psychotropic medications without restrictions. As for availability of psychotropic medicines, 1-20% of physician-based PHC clinics have at least one psychotropic medicine of each therapeutic category while no non-physician-based PHC clinics have these medications. In the majority of PHC clinics, essential psychotropic medications are not available free of charge but some of these medications can be purchased at nearby local pharmacies in cash.

Data was estimated after discussion with health authorities in MOPH and regional health directorates. Data on the type and strength of medicine was not available. The prices of psychotropic medicine in local markets were varied across pharmacies also in some provinces. Moreover, some doctors questioned the quality of available psychotropic medicine in the markets.

DOMAIN 4: HUMAN RESOURCES

Number of human resources in mental health care

The total number of human resources working in mental health facilities or private practice per 100,000 populations is 0.5. The breakdown according to profession is as follows: 0.008 psychiatrists, 0.24 other medical doctors (not specialized in psychiatry), 0.14 nurses, 0.16 other mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counselors). No psychiatrist works solely for government administered mental health facilities, one works only for NGOs, and one works for both the sectors. Eighty-four percent of psychologists, social workers, nurses and occupational therapists work only for government administered mental health facilities; 9% work only for NGOs, for profit mental health facilities and private practice; and 6% work for both the sectors.

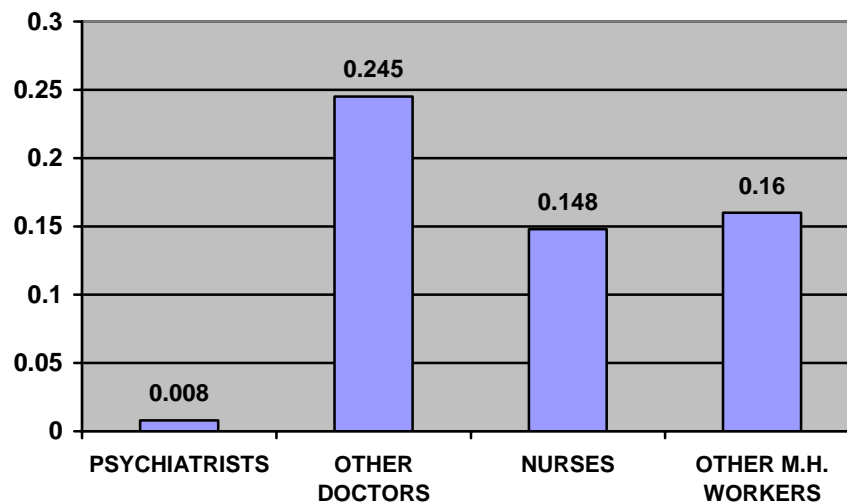
Regarding the workplace, there are no psychiatrists working in outpatient facilities, community-based psychiatric inpatient units, or in the mental hospital. Ten other medical doctors, not specialized in mental health, work in outpatient facilities, 30 in community-based psychiatric inpatient units, and 20 in the mental hospital. Regarding nurses, 17 work in outpatient facilities, 21 in community-based psychiatric inpatient units, and 15 in the mental hospital. No psychologists, social workers or occupational therapists work in outpatient facilities, community-based psychiatric inpatient units or in the mental hospital. With regards to other health or mental health workers, 8 work in outpatient facilities, 0 in community-based psychiatric inpatient units and 40 in mental hospitals.

In terms of nurse staffing, there are 0.3 nurses per bed in community-based psychiatric inpatient units and 0.25 per bed in the mental hospital. Finally, for other mental health care staff (e.g., psychologists, social workers, occupational therapists, other health or mental health workers), there are no staff per bed for community-based psychiatric inpatient units, and 0.67 per bed in the mental hospital. The distribution of human resources between urban and rural areas is unfair: all nurses work in or near the largest city,

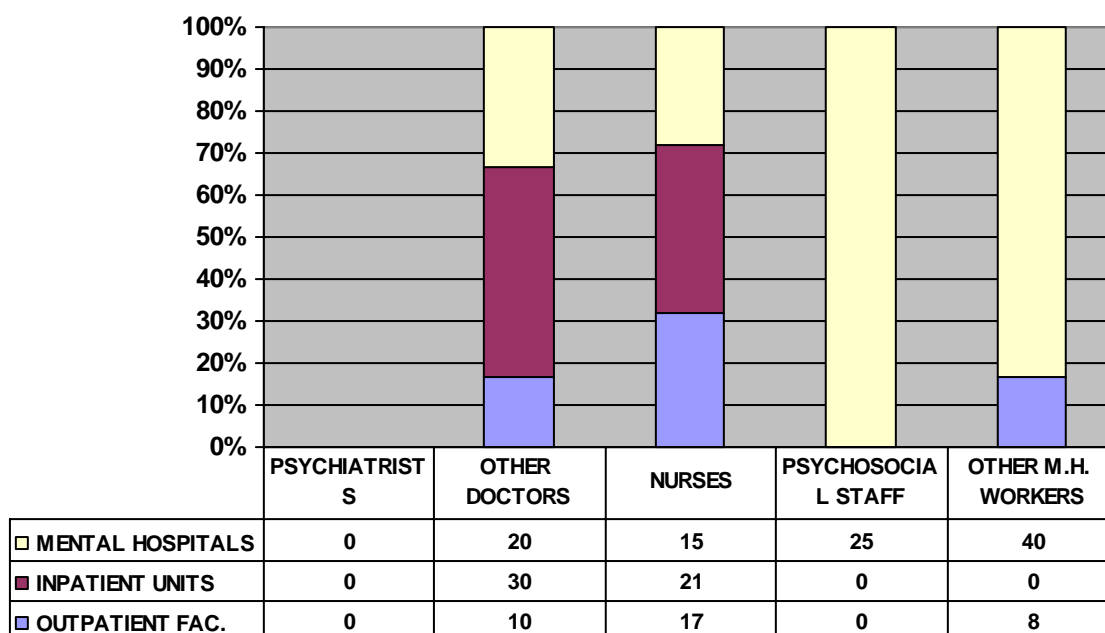
The data was collected from Human Resources Dept in MOPH and Kabul Psychiatric Hospital. According to the Human Resources dept in the MOPH, the distribution of health care staff in the country is 60% urban and 40% rural. In contrast, all mental health care staff work in large cities.

In 2005 there were trainings for psychosocial counselors in the capital city by NGOs. The psychosocial counselor is a new category of mental health staff; this category has not been identified in MOPH Human Resource Dept as health staff yet. Fifteen counseling centers (with 33 psychosocial counselors) have been established in the capital during 2005 by Caritas Germany. A center in Kabul's Women's Garden, supported by Medica Mondiale has provided psychosocial support for women for more than two years.

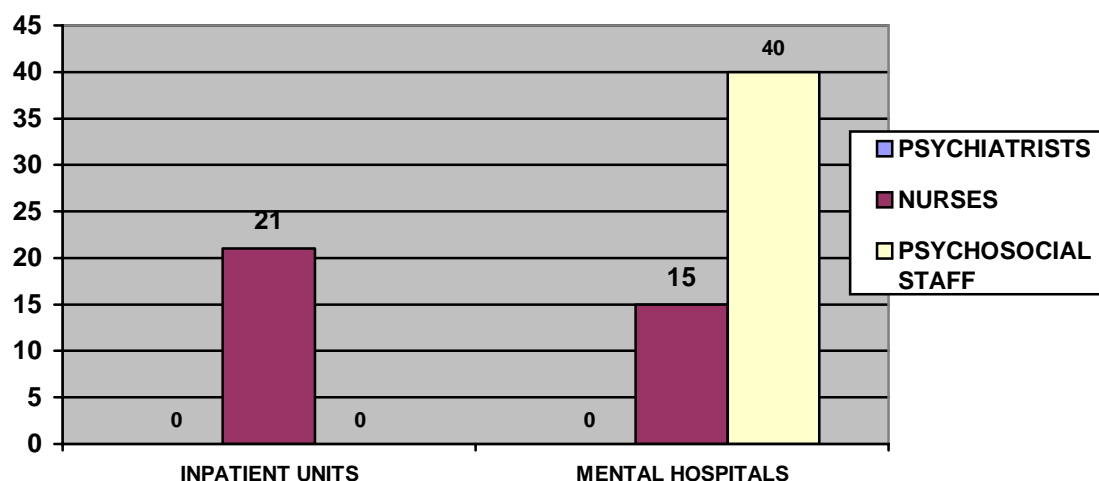
GRAPH 4.1 - HUMAN RESOURCES IN MENTAL HEALTH
(rate per 100.000 population)



GRAPH 4.2 - STAFF WORKING IN MENTAL HEALTH FACILITIES
(percentage in the graph, number in the table)



GRAPH 4.3 - RATIO HUMAN RESOURCES/BEDS

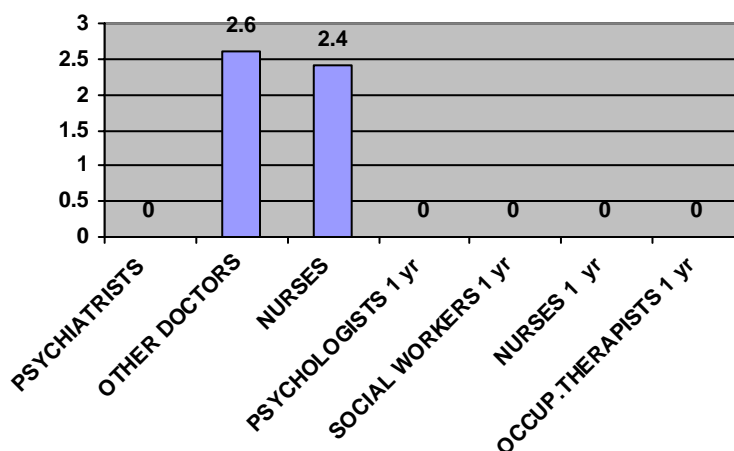


Training professionals in mental health

The number of professionals graduated last year in academic and educational institutions per 100,000 is as follows: no psychiatrists, 2.6 other medical doctors (not specialized in psychiatry), 2.4 nurses, no psychologists, social workers, occupational therapists, or other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counselors). The number of psychiatrists who emigrated from Afghanistan within five years of their training is unknown. The graph 4.5 shows the percentage of mental health care staff with at least two days of refresher training in the rational use of drugs, psychosocial interventions, and child/adolescent mental health issues.

The MOPH has promoted some general practitioners working in the mental hospital or inpatient units as psychiatrists; however, formal psychiatric academic training does not exist. So, all doctors were put in the “other doctors” category.

GRAPH 4.4 - PROFESSIONALS GRADUATED IN MENTAL HEALTH (rate per 100.000 population)



Consumer and family associations

There are no users/consumers or family associations. There are some NGOs in the country involved in individual assistance activities such as counselling or support groups.

DOMAIN 5: PUBLIC EDUCATION AND LINKS WITH OTHER SECTORS

Public education and awareness campaigns on mental health

There is no coordinating body to oversee publication and awareness campaigns. It is unknown if government agencies or international organizations have promoted public education and awareness campaigns in the last five years.

Legislative and financial provisions for persons with mental disorders

At the present time, there is no legislative or financial support for persons with mental disorders for the following: provisions for employment, provisions against discrimination at work, or provisions for housing.

There is a unit for identification and grading of physical disability in the MOPH according to the Disability Benefit Act from the 1980s. For 100% disability, the government pays 6 \$ per month and for 50-80% it pays 3 \$ per month. Psychiatric disorders are not included in the benefits; however, dementia and epilepsy are included under neurological conditions.

Links with other sectors

There are no formal collaborations with the departments/agencies responsible to address the needs of patients. In terms of support for child and adolescent health, none of the primary or secondary schools has either a part-time or full-time mental health professional or school-based activities to promote mental health and prevent mental disorders. The percentage of prisoners with psychosis and/or mental retardation is unknown. Regarding mental health activities in the criminal justice system, an unknown number of prisons have regular contact with a mental health professional. As for training, no police officers, judges, or lawyers have participated in educational activities on mental health in the last five years. In terms of financial support for users, no mental health facilities have access to programs that provide outside employment for users with severe mental disorders. Finally, none of the people who receive social welfare benefits do so for a mental disability.

Some police officers and judges have been trained on drug abuse but no other educational activities on mental health have been conducted in the last five years.

DOMAIN 6: MONITORING AND RESEARCH

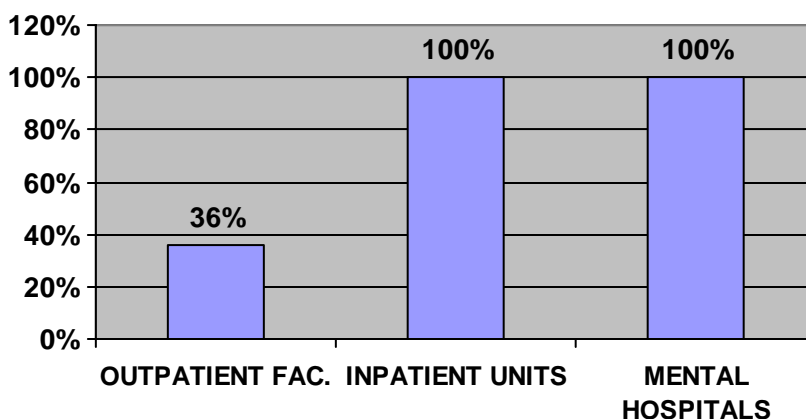
There is no formally defined minimum data set of items. As shown in the graph 6.1, the extent of data collection is consistent among mental health facilities. The government health department received data from the mental hospital; all community based psychiatric inpatient units, and 36% of mental health outpatient facilities.

However, no report was produced on the data transmitted to the government health department. In terms of research, 46% of all health publications in the country were on mental health. The research focused on Epidemiological studies in community samples. Details of research were not available.

Table 6.1 - Percentage of mental health facilities collecting and compiling data by type of information

	MENTAL HOSPITALS	INPATIENT UNITS	OUTPATIENT FAC.
N° of beds	0	0	
N° inpatient admissions/users treated in outpatient fac.	100%	100%	100%
N° of days spent/user contacts in outpatient fac.	0	0	0
N° of involuntary admissions	0	0	
N° of users restrained	0	0	
Diagnoses	100%	100%	100%

GRAPH 6.1 - PERCENTAGE OF MENTAL HEALTH FACILITIES TRANSMITTING DATA TO HEALTH DEPARTMENT



Next Steps in Strengthening Mental Health System

The initial steps for improving mental health services in Afghanistan are to develop services in rural areas starting with the implementation of mental health component of BPHS and to increase the number of mental health human resources through short-term training courses or psychiatry residency training abroad. Formulating a new National Mental Health Plan and policy will open the way for future initiatives in the field. To address these issues, workshops with all stakeholders must be organized to exchange information and to do needs assessments.

Followings are the possible areas where WHO-AIMS data could be used to plan actions in consultation with the Ministry of Public Health and WHO:

National Mental health policy and Plan can be formulated based on WHO-AIMS information.

Mental Health Information system and integration of services in 40 % of primary health care facilities (including training of PHC staff) together with public education on mental health and patients' human right could help to increase access to mental health services in the country.

Co-ordinated and sustained efforts are needed to strengthen the mental health system in Afghanistan.

Ideas for planning

Followings are possible areas where WHO-AIMS data could be used to plan actions in consultation with the Ministry of Public Health and WHO:

National Mental health policy and Plan could be formulated in 6 months.

Mental Health Information system and integration of services in 40 % of primary health care facilities (including training of PHC staff) together with public education on mental health and patients' human right could help to increase access to mental health services in the country.

Public Mental Health awareness through available means in MOPH, Information and Education Unit (IEU) to enhance greater understanding of mental health in community. This could be done via establishing a mental health awareness coordination body in MOPH and development of education materials for public awareness.

Implementation of mental health act in psychiatric facilities and raising awareness on human rights of patients through trainings and awareness campaigns should be addressed regularly.

Developing guidelines and treatment protocols for different categories of health staff is important issue to address lack of knowledge and skills among health staff.

Involvement of community in planning and services provision in mental health is an important issue currently lacking. This could be done through support for mental health unit in MOPH and voluntary organizations.

Coordinated and sustained efforts are needed to strengthen the mental health system in Afghanistan.

Mental Health System in Afghanistan

Afghanistan has had a National Mental Health Plan, Policy and Legislation since 1987 which addresses the main mental health issues. A regular budget allocation does not exist for mental health. In 2004, 0.1 million USD (out of a 289.4 million USD total health budget) was directed for mental health. There is a national human rights body; only one review/inspection of human rights protection for a patient was carried out in 2004. There is no coordination body on mental health to oversee publications and awareness campaigns. There is no financial or legislative support for people with psychiatric problems.

There are only two psychiatrists (neither working in mental health facilities), 61 other doctors, 37 nurses and 40 other mental health workers in the mental health services in country.

The only mental hospital, in the capital city, houses 60 beds while community mental health facilities are yet to be developed in the country. No defined mental data collection exists in the ministry. Limited resources are available for mental health and much of these resources are directed towards the mental hospital, leaving inpatient and outpatients facilities under funded.

Almost all mental health outpatient facilities are located in major cities. In rural areas, primary healthcare staff have either limited training in mental health or mental health services are entirely unavailable. The utilization of services by poor people entirely depends on the availability of free medications in the facilities.

Coordinated and sustained efforts are needed to strengthen the mental health system in Afghanistan.

