

# Psychiatry in Afghanistan

Peter Ventevogel,<sup>1</sup> Ruhullah Nassery,<sup>2</sup> Sayed Azimi<sup>3</sup>  
and Hafizullah Faiz<sup>4</sup>

<sup>1</sup>Technical Adviser Mental Health, HealthNet TPO, Kabul, Afghanistan, email [peterventevogel@yahoo.co.uk](mailto:peterventevogel@yahoo.co.uk)

<sup>2</sup>National Coordinator for Mental Health in Primary Health Care, Ministry of Public Health, Kabul, Afghanistan

<sup>3</sup>Mental Health Adviser, World Health Organization, Kabul, Afghanistan

<sup>4</sup>Project Coordinator Mental Health, HealthNet TPO, Jalalabad, Afghanistan

The country profiles section of *International Psychiatry* aims to inform readers of mental health experiences and experiments from around the world. We welcome potential contributors. Please contact Shekhar Saxena (email [saxenas@who.int](mailto:saxenas@who.int)).

Decades of war and violence are reflected in Afghanistan's health statistics, which are among the poorest in the world.

**A**fghanistan's historic strategic position between the great civilisations of India, Persia and Central Asia has made it from the very beginning both a crossroads for trade and cultural exchange and an almost continuous battlefield. In the years since the Soviet invasion in 1979 the country has become the stage of an ongoing complex humanitarian emergency. The period of Soviet occupation was characterised by massive human rights violations. The Soviet army and its allies were involved in indiscriminate bombardments and targeted executions, while the *mujahedeen* were involved in guerrilla warfare. The USSR was forced to withdraw in 1989 and the remnants of Afghanistan's communist regime were defeated in 1992.

Rivalry among the *mujahedeen* groups in the early 1990s led to the destruction of large parts of the capital, Kabul, and divided the country into different regions belonging to different ethnic groups.

The rise of the fundamentalist Islamic Taliban movement was accompanied by a period of harsh rule, in which individual freedom was curtailed and the rights of women were severely restricted. In November 2001 the Taliban were ousted from power by the former *mujahedeen*, supported by a US-led multinational coalition. The situation has stabilised since, but violence is not over yet, with continued insurgent activities targeting government officials, schools for girls, non-governmental organisations and United Nations agencies.

## Effects on health

The effects of 25 years of violence in Afghanistan on the physical and human infrastructure have been enormous. The war caused an estimated 1 million deaths (Human Rights Watch, 2003). At the height of the crisis, the total number of Afghan refugees in Iran and Pakistan reached 3.7 million, amounting to 15% of the total population of Afghanistan, which is estimated at between 21 and 28 million. Afghanistan is one of the countries most severely affected by mines and other types of unexploded ordnance (International Campaign to Ban Landmines, 2001).

Decades of war and violence are reflected in Afghanistan's health statistics, which are among the

poorest in the world. Life expectancy at birth is 43 years (World Bank, 2004), the mortality rate for children under 5 years of age is 257/1000 (fourth highest in the world) and the maternal mortality rate is 1900/100 000 (second highest in the world) (UNICEF, 2005).

## Mental health status

The few publications from the pre-war period about mental health and mental healthcare in Afghanistan give the impression that Afghanistan was not very different from any other developing country in the region (Waziri, 1973).

Little is known about the effects of the war on the mental health status of the Afghans during the Russian occupation and the armed resistance of the *mujahedeen*. In the refugee camps in Pakistan, clinicians reported that they saw many patients with anxiety and depressive symptoms (Dadfar, 1994).

The Taliban policy of extreme gender segregation and the denial of basic human rights to women led to increased rates of depression and anxiety. A study conducted in 2000 by the organisation Physicians for Human Rights compared the mental health of women living in a Taliban-controlled area with that of women living in a non-Taliban-controlled area, and found that major depression was far more prevalent among the women exposed to Taliban policies (Amowitz *et al*, 2003).

The fall of the Taliban regime has not resulted in dramatic improvements in the mental health status of the population. A nationwide survey (Lopes Cardozo *et al*, 2004) and an in-depth survey in Nangarhar province (Scholte *et al*, 2004) both found persistently high prevalence rates of depression and anxiety, in particular among women, with elevated scores on depression questionnaires in around two-thirds of all women (58.4% and 73.4% in the two studies respectively) and anxiety symptoms in four-fifths of all women (78.2% and 83.5%). The studies found a clear relationship between the number of traumatic events and the likelihood of developing psychopathology. The prevalence figures mentioned here must be interpreted with caution, since there are several possible sources for bias from the use of self-report questionnaires (Bolton & Betancourt, 2004).

## Use of opiates and other drugs

Afghanistan is the largest producer of opiates in the world. Despite efforts to control poppy cultivation, in 2004 the country produced 87% of the world's opium (Todd *et al*, 2005). No reliable epidemiological data about the prevalence of opiate misuse among the Afghan population are available. The use of all intoxicants (*nasha-i-mawad*) in Islam is forbidden (*haram*), and in Afghanistan the Taliban have left a legacy of severe punitive measures for drug users (UNODC, 2003). None the less, it is estimated that Kabul alone has at least several tens of thousands of opiate users. Injection drug use appears to be a relatively new phenomenon and is thought to be on the increase, in particular among former refugees from neighbouring countries. Afghanistan has a Ministry of Counter Narcotics, which has drafted a national strategy for narcotics (2003, revised in 2005), a demand reduction policy (2003) and a harm reduction policy (2005). At present, harm reduction and drug treatment programmes are available only on a small scale. In Kabul the psychiatric hospital has a maximum of 20 beds for patients with substance misuse. Some Afghan non-governmental organisations (NGOs) have limited treatment facilities (10–20 beds) for heroin users in Kabul and provinces such as Kandahar and Paktya.

The prevalence of cannabis use is significant, especially in rural areas of the country, where it is not considered harmful. No data are available on the use of alcohol.

## Mental healthcare facilities

In the 1980s the Department for Mental Healthcare in the Ministry of Public Health attempted to decentralise mental healthcare and develop community mental health services. This resulted in four community mental health centres being established in Kabul, but the process was halted in other parts of the country by the rising civil war. Much of the qualified workforce and technical expertise have left the country. Currently, a mental healthcare system hardly exists outside Kabul. The mental health hospital in Kabul was so severely damaged in the course of fighting in the capital that the building was eventually demolished. A newly built psychiatric hospital in Kabul with a total of 60 beds opened in 2004. Small in-patient facilities for psychiatric patients exist in Jalalabad and Mazar i Sharif. A few provincial capitals have asylums (*marastoon*), whose main function is to provide shelter and food for homeless people, drug addicts and psychiatric patients with severe behavioural disturbances who have no family support.

Many people with mental disorders medicate themselves with psychopharmacological drugs or seek refuge in traditional religious shrines (van de Put, 2002).

## Mental health in primary care

The new health authorities have declared mental health a priority (Fatimi, 2004). In 2005 a department

for mental healthcare within the Ministry of Public Health started to function again, and a beginning was made to integrate mental health into general health policies. The government, backed by major international donors, has decided to contract NGOs for health service delivery in the most underserved parts of the country.

The Ministry of Public Health has developed a 'Basic Package of Health Services' (BPHS) that defines the medical interventions to be made available in all districts of the country (Government of Afghanistan, 2003). The BPHS drafts the necessary interventions in seven priority areas: maternal and newborn health, child health and immunisation, public nutrition, communicable diseases, disability, essential drugs, 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 by pointing at the clearly felt need for mental healthcare by its population after decades of war and internal conflict. Besides, this mirrors developments in international health policy.

The creation of available, accessible, affordable and acceptable mental health facilities in Afghanistan can be accomplished only through a major policy shift away from hospital-based psychiatry and towards integration of mental health into primary care services (Ventevogel *et al*, 2002). In the past few years the government, with the assistance of NGOs, the World Health Organization (WHO) and donors, has started to integrate mental health into primary care (Ventevogel & Kortmann, 2004).

## Psychosocial assistance

The need for psychosocial programmes is obvious (Baingana *et al*, 2005; Bolton & Betancourt, 2004). Several NGOs have developed focused psychosocial programmes for children (De Berry, 2004) and for women who have been subjected to violence. Others offer psychological assistance through counselling centres in different parts of Kabul or through community-based psychosocial services linked to the primary care system.

## Specialist education

Recent data collected by the WHO and Ministry of Public Health for the Assessment Instrument for Mental Health Systems (AIMS) demonstrated once more the paucity of human resources. The country has only two trained psychiatrists, one working in the WHO and the other in private practice. About 60 doctors work in mental healthcare but their training varies from almost nothing to some in-service training or short courses in institutes abroad. In 1999 a 3-month diploma course was held in northern Afghanistan to train 20 doctors in psychiatry (Mohit *et al*, 1999). Because of ongoing violence this initiative could not be followed up.

Afghanistan is the largest producer of opiates in the world. Despite efforts to control poppy cultivation, in 2004 the country produced 87% of the world's opium.

The prevalence of cannabis use is significant, in particular in rural areas of the country, where it is not considered harmful. No data are available on the use of alcohol.

The unmet mental health needs of the Afghan people are enormous. The challenge to increase the capacity of the mental health sector will remain huge over the coming years.

There is no postgraduate training in psychiatry and mental health is hardly represented in the undergraduate curricula for medical doctors, nurses or midwives. Psychologists at Kabul University are trained but there are no training institutes for clinical psychology, psychiatric nursing or social work.

## Conclusion

The unmet mental health needs of the Afghan people are enormous. The challenge to increase the capacity of the mental health sector will remain huge over the coming years. Sustained efforts of government, NGOs, institutional donors and United Nations bodies are needed to expand the coverage of basic mental healthcare and psychosocial services to the whole population of Afghanistan.

## References

- Amowitz, L. L., Heisler, M. & Iacopino, V. (2003) A population-based assessment of women's mental health and attitudes toward women's human rights in Afghanistan. *Journal of Women's Health*, **12**, 577–587.
- Baingana, F., Bannon, I. & Thomas, R. (2005) *Mental Health and Conflicts: Conceptual Framework and Approaches*. Washington, DC: World Bank.
- Bolton, P. & Betancourt, T. S. (2004) Mental health in postwar Afghanistan. *Journal of the American Medical Association*, **292**, 626–628.
- Dadfar, A. (1994) The Afghans: bearing the scars of a forgotten war. In *Amidst Peril and Pain. The Mental Health and Well-being of the World's Refugees* (eds A. J. Marsella et al), pp. 125–139. Washington, DC: American Psychological Association.

- De Berry, J. (2004) Community psychosocial support in Afghanistan. *Intervention*, **2**, 143–151.
- Fatimi, M. A. (2004) Health priorities in the coming five years. Statement by the Minister of Public Health. Kabul: Ministry of Public Health.
- Government of Afghanistan (2003) *Basic Package of Health Services*. Kabul: Ministry of Public Health.
- Human Rights Watch (2003) *Killing You Is a Very Easy Thing For Us. Human Rights Abuses in Southeast Afghanistan*. New York: HRW.
- International Campaign to Ban Landmines (2001) *Landmine Monitor Report 2001*. Available at <http://www.icbl.org/lm/2001/report>
- Lopes Cardozo, B., Bilukha, O. O., Crawford, C. A., et al (2004) Mental health, social functioning, and disability in postwar Afghanistan. *JAMA*, **292**, 575–584.
- Mohit, A., Saeed, K., Shahmohammadi, D., et al (1999) Mental health manpower development in Afghanistan. A report on a training course for primary health care physicians. *Eastern Mediterranean Health Journal*, **5**, 373–377.
- Scholte, W. F., Olf, M., Ventevogel, P., et al (2004) Mental health problems following war and repression in eastern Afghanistan. *Journal of the American Medical Association*, **292**, 585–593.
- Todd, C. S., Safi, N. & Strathdee, S. A. (2005) Drug use and harm reduction in Afghanistan. *Harm Reduction Journal*, **2**, 13. Available from <http://www.harmreductionjournal.com/content/2/1/13>
- UNICEF (2005) *State of the World's Children 2005*. New York: United Nations Children's Fund.
- UNODC (2003) *Community Drug Profile 5: An Assessment of Problem Drug Use in Kabul City*. Kabul: United Nations Office for Drugs Control. Available at [http://www.unodc.org/pdf/afg/report\\_2003-07-31\\_1.pdf](http://www.unodc.org/pdf/afg/report_2003-07-31_1.pdf)
- van de Put, W. (2002) Addressing mental health in Afghanistan. *Lancet*, **360** (suppl.), S41–S42.
- Ventevogel, P. & Kortmann, F. (2004) Developing basic mental health modules for health care workers in Afghanistan. *Intervention*, **2**, 43–54.
- Ventevogel, P., Azimi, S., Jalal, S., et al (2002) Mental health care reform in Afghanistan. *Journal of Ayub Medical College, Abbottabad*, **14** (October–December), 1–3.
- Waziri, R. (1973) Symptomatology of depressive illness in Afghanistan. *American Journal of Psychiatry*, **130**, 213–217.
- World Bank (2004) *World Development Report*. New York: Oxford University Press.

## COUNTRY PROFILE

# Psychiatry in Ukraine

Semyon Gluzman<sup>1</sup> and Stanislav Kostyuchenko<sup>2</sup>

<sup>1</sup>Executive Secretary, Ukrainian Psychiatric Association, Kiev, Ukraine, email [upa2@i.com.ua](mailto:upa2@i.com.ua)

<sup>2</sup>Lecturer, Psychiatry Department, Kiev Medical Academy of Postgraduate Training, Ukraine

**Ukraine, at 603 700 km<sup>2</sup>, has the second largest landmass in Europe. It has a population of about 47.4 million. Ukraine is a lower-middle-income country with a gross national income per capita of US\$1 260 (World Bank, 2002).**

## Healthcare

The health and well-being of the Ukrainian population, as in other former Soviet countries, are generally very poor. Life expectancy at birth is 69.7 years (64.4 years for men and 75.3 years for women). Overwhelmingly the most important reason for this is the combination of poverty, poor diet and living conditions, and lifestyle factors such as tobacco and alcohol use. Cardiovascular disease and trauma (accidents and poisonings) are the two most common causes of death, followed by cancer (UNDP & UNICEF, 2002).

Healthcare expenditure amounts to 3.5% of gross domestic product. In-patient care accounts for two-thirds of total healthcare expenditure. The number of physicians per 100 000 is 229; hospital bed provision is 903.2 per 100 000 (1998 figure), much in line with the average of 812.0 per 100 000 across Europe.

During the past 10–15 years government programmes have sought to strengthen primary healthcare on the basis of family medical practice, to develop a system of health insurance, and to create the conditions for private medical practice. A key feature of the current situation in Ukraine is the low level of remuneration for doctors and other healthcare staff (International Labour Office, 2001).

## Mental health services

In-patient psychiatric care is delivered in 89 psychiatric hospitals. Of a total of 44 812 psychiatric beds, only

In-patient psychiatric care is delivered in 89 psychiatric hospitals. Of a total of 44 812 psychiatric beds, only 1468 are in general hospitals.