International Medical Corps

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Rapid Mental Health and Psychosocial Support Needs Assessment in Haripur, Mansehra and Lower Dir Afghan Refugee Villages of Pakistan

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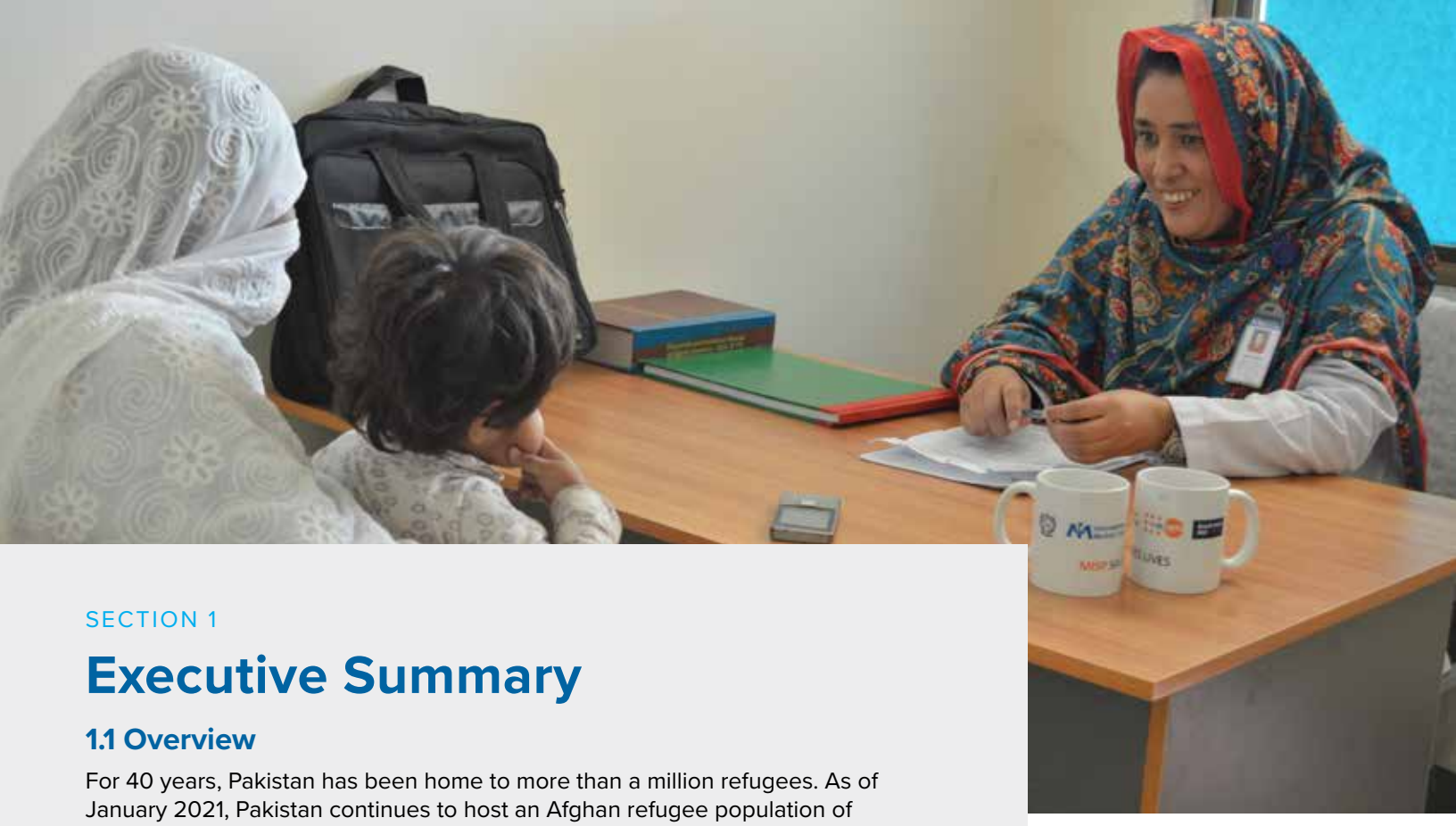
LIST OF ACRONYMS

ACC	Afghan Citizen Card
BHU	Basic Health Unit
BPRM	United States Bureau for Population Refugee and Migration
DA	District Administrator
DFID	Department for International Development
ECHO	European Civil Protection and Humanitarian Aid Operations
FATA	Federally Administered Tribal Areas
FGD	Focus Group Discussions
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GSGs	Gender Support Groups
KII	Key Informant Interviews
KP	Khyber Pakhtunkhwa
LHV	Lady Health Visitor
LMIC	Low and Middle Income Countries
MEAL	Monitoring Evaluation Accountability and Learning
MH	Mental Health
mhGAP	Mental Health Gap Action Program
MHO	Mental Health Ordinance
MHPSS	Mental Health and Psychosocial Support
MISP	Minimum Initial Service Package
MNS	Mental, Neurological and Substance Use
NFI	Non-Food Items
NGO	Non-Governmental Organization
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
OFDA	Office of U.S. Foreign Disaster Assistance
OPD	Outpatient Department
POR	Proof of Registration
PHC	Primary Heath Care
RH	Reproductive Health
RVA	Refugee Village Administrator
RV	Refugee Village
SHARP	Society for Human Rights and Prisoners' Aid
THQ	Tehsil Head Quarter
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
USAID	United States Agency for International Development
WFP	World Food Program
WHO	World Health Organization
YEP	Youth Empowerment Program



SECTION 1

Executive Summary

1.1 Overview

For 40 years, Pakistan has been home to more than a million refugees. As of January 2021, Pakistan continues to host an Afghan refugee population of 1.4 million registered individuals, in addition to approximately 1 million more unregistered refugees, largely as a result of protracted conflict—spanning three decades—within Afghanistan. Out of this population, 32% (448,652) reside inside refugee villages (RVs) while 68% (953,327) reside outside RVs, and more than 58% (816,345) of total refugees reside in the Khyber Pakhtunkhwa province of Pakistan. In 46% (20/43) of the RVs in Khyber Pakhtunkhwa, International Medical Corps has been the provider of health and gender-based violence (GBV) prevention and response services for three decades. International Medical Corps' current mental health and psychosocial support (MHPSS) and GBV prevention and response programs target 107,504 refugees living in nine RVs within three districts (Haripur, Mansehra and Lower Dir). Of these, 51% are female and 49% male.

International Medical Corps Pakistan has initiated a program on "Expanding MHPSS and Strengthening GBV Prevention and Response for Afghan Refugees in KP Province" with the financial support of BPRM in three districts—Haripur, Mansehra and Lower Dir—working in seven Afghan RVs in Khyber Pakhtunkhwa.

The purpose of this assessment is to identify MHPSS needs (resources, services, skilled personnel, appropriate training, psychotropic medication) in the targeted primary, secondary and tertiary level of health facilities in Haripur, Mansehra and Lower Dir districts. Moreover, the assessment aims to identify the main MHPSS issues affecting the target communities and to analyze the capacity of the target community to address key MHPSS issues.

According to the responses from the survey, community members are experiencing a variety of mental, neurological and substance use (MNS) conditions, with depression, anxiety and drug misuse being the most commonly reported by members of the community as negatively affecting their routine daily lives. Women in the community also reported experiencing GBV and inequality issues.

Moreover, the community also faces broader concerns that impact their mental health, such as:

- lack of education and health services, employment opportunities and acquiring professional skills;
- poverty;
- poor infrastructure and housing, including lack of access to proper sanitation and drinking water;
- poor security, including the uncertainty about their stay as refugees in Pakistan; and
- no access to formal documentation, specifically passports and proof-of-registration (POR) cards.

1.2 Recommendations

Based on the results of this assessment, International Medical Corps strongly endorses the following recommendations:

- Advocate through different platforms for the strengthening of the national mental health system and for the allocation of adequate resources at the provincial level to support the implementation of MH legislation.
- Use evidence-based protocols and brief psychological interventions to enable non-specialist staff to respond effectively to immediate mental health needs.
- Provide capacity building in scalable mental health interventions for humanitarian staff, including but not limited to healthcare staff and community workers.
- Establish preventative mental health services for children and youth, including youth empowerment programs (YEPs).
- Prioritize community awareness-raising on wellbeing, emotional distress and mental health conditions to promote community knowledge and address stigma, including engagement with local leaders, religious figures and traditional healers.
- Develop and disseminate MHPSS-related information, education and communication materials, such as materials on stress responses following distressing events, as well as on positive coping mechanisms.

1.3 General objectives

The main goals of this rapid assessment of MHPSS needs are to:

- learn more about existing services, weaknesses and strengths in the MHPSS service sector and to identify needs; and
- generate results that will serve as a baseline and to inform the design of future service provision to fill existing gaps in health services and community support.

1.4 Specific objectives

1. Identify MHPSS needs (resources, services, skilled personnel, appropriate training, psychotropic medication) in the targeted primary, secondary and tertiary level of health facilities in Haripur, Mansehra and Lower Dir districts.
2. Identify the main MHPSS issues affecting the target communities.
3. Analyze the capacity of the target community to address key MHPSS issues.

SECTION 2

Context

2.1 Socio-political context

Pakistan is a country with an approximate geographical area of 803,940 square kilometers and a population of 207,774,520, according to the 2017 Census of Pakistan. The main languages used in the country are Punjabi, Sindhi, Siraiki, Pashtu and Urdu. The main ethnic group is Punjabi and the others are Sindhi, Siraiki, Pashtun and Muhajir. The largest religious group is Muslim; in addition, there are small Hindu and Christian populations. The country is a low-income group country, based on World Bank 2004 criteria. Forty-three percent of the population is under the age of 15 and 7% percent of the population are over the age of 60. Sixty-eight percent of the population live in rural areas. The life expectancy at birth is 62 for males and 63 for females. The healthy-life expectancy at birth is 54 for males and 52 for females. The literacy rate is 62% for men and 37.5% for women. The proportion of the health budget to GDP is 3.9%. There is less than one hospital bed and 85 general practitioners per 100,000 population.[1]

Pakistan is the world's fifth most-populous country. During the period of 1950–2012, Pakistan's urban population expanded more than sevenfold while the total population increased by more than fourfold. In the past, the country's population had a relatively high growth rate, which has been changed recently by moderate birth rates. Between 1998–2017, the average population growth rate stood at 2.4%.

Pakistan has a semi-industrialized economy with a well-integrated agriculture sector and a growing services sector. It is ranked among the emerging and growth-leading economies of the world, and is backed by one of the world's largest and fastest-growing middle classes. Pakistan's political history since independence has been characterized by periods of military rule, political instability and conflicts with India. The country continues to face challenging problems, including overpopulation, terrorism, poverty, illiteracy and corruption.[2]

During the 1980s Soviet-Afghan War, many Afghans left their country. As a result of political unrest, mass arrests, executions and other human rights violations and civil war, about 3 million Afghan refugees escaped to Pakistan, and about 2 million to Iran. The migration began in December 1979 and continued throughout the 1980s.

By the end of 2001, as a consequence of the September 11 attacks in the United States, the Taliban were ousted by a US-led military operation. The toppling of the Taliban regime in 2001 marked the beginning of a massive wave of people returning to Afghanistan. More than 1.5 million

1 WHO-AIMS., (2009) Report on mental health system in Pakistan online. [Viewed 30 March 2020]. Available from: https://www.who.int/mental_health/pakistan_who_aims_report.pdf

2 Wikipedia., (2020) Pakistan Socio-Political Context (online). [Viewed 30 March 2020]. Available from: https://en.wikipedia.org/wiki/Economic_history_of_Pakistan

Afghan refugees returned from Pakistan in 2002 alone; the numbers range from 300,000 to 400,000 per year over the following years.[3]

For 40 years, Pakistan has been home to more than a million refugees. As of March 1, 2019, Pakistan continued to host an Afghan refugee population of 1,401,952[4] registered individuals in addition to approximately 1 million additional unregistered refugees,[5] largely as a result of the protracted conflict, spanning three decades, within Afghanistan.

International Medical Corps has been providing humanitarian assistance in Pakistan since 1984, initially providing basic paramedical training to Afghan refugees who then returned home to treat neglected local populations.

International Medical Corps' assistance extended in 1999 to the local Pakistani population in volatile frontier areas. Since then, International Medical Corps has been at the forefront of the response to all major emergencies in Pakistan, including the 2005 earthquake in Khyber Pakhtunkhwa; helping internally displaced persons (IDPs) affected by conflict; and helping those affected by devastating floods in 2011 and 2012 and an earthquake in 2014. This assistance has included the following sectors: health; MHPSS; GBV; nutrition; water, sanitation and hygiene (WASH); non-food items (NFI); literacy trainings; and livelihood and skills development. Major donors included PRM, USAID, OFDA, UNICEF, UNHCR, UNOCHA, WHO, UNFPA, DFID, ECHO, WFP and Qatar Charity in four provinces: Khyber Pakhtunkhwa, Sindh, Punjab and Baluchistan, including formerly Federally Administered Tribal Areas (FATA).

International Medical Corps has been addressing GBV in Pakistan since 2008, approaching this humanitarian issue with a comprehensive community-based strategy in refugee villages in Khyber Pakhtunkhwa. Currently, International Medical Corps is implementing a program providing MHPSS and GBV services with the financial support of BPRM in three districts—Haripur, Mansehra and Lower Dir—working in seven Afghan RVs in Khyber Pakhtunkhwa. International Medical Corps has been providing health and GBV prevention and response services for three decades in 46% (20/43) of the RVs in Khyber Pakhtunkhwa. International Medical Corps' current MHPSS and GBV prevention and response program is targeting 107,504[6] members of the refugee population living in nine RVs within three districts. Of these refugees, 51% are female and 49% male.

Since April 2019, International Medical Corps has also been implementing a project called "Minimum Initial Service Package (MISP) for Reproductive Health (RH)," with the support of UNFPA, in three health facilities of Khyber District and two Afghan RVs in Peshawar district.

2.2 Mental health systems in Pakistan

When Pakistan was created by the partition of the Indian subcontinent in 1947, the new state continued to implement the Lunacy Act of 1912, which had been in place in British India. The focus of the act was more on detention of those with chronic and severe mental health conditions than on treatment and with advances in psychiatric treatment, especially the introduction of psychotropic medication, updated legislation was needed. In the 1970s and onwards, advocates for reform of this legislation were active. The government of Pakistan proposed a new mental health act in 1992 and circulated a draft among psychiatrists for their comments (Rehman, 1994) but it was not until 2001 that the Lunacy Act of 1912 was replaced by the Mental Health Ordinance (MHO) of 2001.[7] The MHO, in the form of a presidential order, set out to "amend the law relating to the treatment and care of mentally disordered persons, to make better provision for their care, treatment, management of properties and affairs and to encourage community care and further to provide for promotion of mental health and prevention of mental disorder."

A federal Mental Health Authority was established in 2001 under the MHO, to develop national standards for inpatient care and to work toward a code of practice for mental health care providers. However, the Authority lapsed in 2010 without achieving any significant progress.

After passage of the 18th Amendment to Pakistani Constitution, which increased power of the country's parliament, the health became a provincial responsibility in Pakistan. The Sindh Provincial Assembly took the lead and passed the Mental Health Act in 2013, with the aim of improving the delivery of mental health care and protecting the rights of those diagnosed with mental health conditions. The Punjab government enacted the Punjab Mental Health Act in 2014, without any consultations with mental health professionals or advocacy groups.[8] The Khyber Pakhtunkhwa government enacted the Khyber Pakhtunkhwa Mental Health Act in 2017, and Baluchistan province enacted the same in 2019. Khyber Pakhtunkhwa has established a Mental Health Authority under its Act, which is working

3 The Express Tribune. 2020. Pakistan's Afghan Refugees: A Timeline | The Express Tribune. [online] Available at: <https://tribune.com.pk/story/1193771/pakistans-afghan-refugees-timeline> [Accessed 27 August 2020].
4 UNHCR.,(December 2020) Afghan Refugees population factsheet UNHCR Pakistan
5 Nordland, Rod (November 20, 2013). "Afghan Migrants in Iran Face Painful Contradictions but Keep Coming". The New York Times. Retrieved November 22, 2013.), United Nations High Commissioner for Refugees (2013). "2013 UNHCR country operations profile - Pakistan". United Nations High Commissioner for Refugees. Retrieved November 5, 2013
6 KP-Commissionarate for Afghan Refugees- Peshawar., (December 2019) Camp wise Afghan refugees population
7 Tareen, A., & Tareen, K. I. (2016). Mental health law in Pakistan. BJPsych international, 13(3), 67–69. https://doi.org/10.1192/s2056474000001276
8 Daanika.,(September 2018). The state of mental health legislation in Pakistan.[online]. Daily Times. [Viewed 30 March 2020]. Available from: https://dailytimes.com.pk/291043/the-state-of-mental-health-legislation-in-pakistan/

under the Health Directorate.

It is estimated that 24 million people in Pakistan need psychiatric assistance. However, resources allocated for the screening and treatment of mental health conditions are not enough to meet the increasing needs. According to World Health Organization (WHO) data, Pakistan has only 0.19 psychiatrists per 100,000 inhabitants, one of the lowest numbers in the WHO Eastern Mediterranean Region.[9] In Pakistan there are 3,729 mental health outpatient facilities attached to a hospital, while there are only three specifically for children and adolescents, including services for children with developmental disorders. Moreover, for inpatient care there are only 11 mental health hospitals and there are 800 psychiatric units in general hospitals. There are 578 residential care facilities and 2 inpatient facilities specifically for children and adolescents in the country, with availability of beds for children and adolescents at 0.01/100,00. The 2014 MH Atlas reported that 38% of psychiatric hospital admissions were involuntary.

The prevalence of diagnosed mental health conditions in Pakistan have increased significantly in the last few decades, linked to both the current violence in Pakistani society and disruption in its social structure.[10] This has had a damaging effect on the psychological health of the host community in general and particularly on Afghan refugees, given their uncertain future and increasing restrictions on their mobility, affecting their ability to provide and receive economic and social services. Most people affected by emergencies will experience distress (e.g., feelings of anxiety and sadness, hopelessness, difficulty sleeping, fatigue, irritability or anger and/or aches and pains). This is normal, and will for most people improve over time. However, WHO estimates that the prevalence of common mental disorders such as depression and anxiety is expected to more than double in a humanitarian crisis.[11]

According to WHO's review, the estimated prevalence of mental disorders among conflict- affected populations at any specific point in time (point prevalence) is 13% for mild forms of depression, anxiety and post-traumatic stress disorder, and 4% for moderate forms of these disorders. The estimated point prevalence for severe disorders (e.g., schizophrenia, bipolar disorder, severe depression, severe anxiety and severe post-traumatic stress disorder) is 5%. It is estimated that one in 11 people (9%) living in a setting that has been exposed to conflict in the previous 10 years will have a moderate or severe mental disorder. In conflict-affected settings, depression and anxiety increase with age. Depression is more common in women than in men.

People with severe mental disorders can be especially vulnerable during and after emergencies, and need access to basic needs and clinical care. A review published in 2014 of the health information system from 90 refugee camps across 15 low- and middle-income countries (LMIC) found that 41% of healthcare visits for mental, neurological and substance-use disorders were for epilepsy/seizures, 23% for psychotic disorders and 13% for moderate and severe forms of depression, anxiety or post-traumatic stress disorder.[12]

This has important public health implications, especially for Pakistan, where the capacity for providing mental health services is already low. With no established model for mental health care in rural settings across the country—even for the local population—people living in these refugee villages become more vulnerable, considering the increased incidence of mental disorders in emergency settings and limited mobility and resources. This can lead communities to seek treatment from traditional healers and religious leaders, which may lead to negative consequences or the sharing of inaccurate information regarding the causes and treatment of mental health conditions.

According to WHO-Atlas Report 2014, there are 4,356 outpatient mental health facilities in the country. These facilities treat 373 users per 100,000 general population. There are five mental health hospitals in the country, with 654 psychiatric units in general hospitals and 344 in residential care facilities. The total number of inpatients in these care facilities are 104,059, while treated cases of severe mental disorders total 374,384.[13]

9 WHO., Pakistan Celebrates World Mental Health Day. [online]. WHO. [Viewed 30 March 2020]. Available from: http://www.emro.who.int/pak/pakistan-news/who-pakistan-celebrates-world-mental-health-day.html

10 Khalily MT., (2010). Developing an integrated approach to the mental health issues in Pakistan. Journal of Interprofessional Care. 24(2):168–72

11 Charlson F, van Ommeren M, Flaxman A, et al. New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. Lancet 2019; doi: 10.1016/ S0140-6736(19)30934-1

12 WHO., (June 2019). Mental Health in Emergencies. [online]. WHO. [Viewed 30 March 2020]. Available from: https://www.who.int/news-room/fact-sheets/detail/mental-health-in-emergencies

13 Who.int. 2020. [online] Available at: <https://www.who.int/mental_health/evidence/atlas/profiles-2014/pak.pdf?ua=1> [Viewed 30 March 2020].

SECTION 3

Methodology

3.1 Data collection techniques

A desktop literature review of relevant documents included:

- WHO-AIMS Report on Mental Health System In Pakistan (2009)
- MH Atlas Report Pakistan, 2014
- Acbar Report on the margins: Afghans in Pakistan, December 2018
- Afghan Refugees population factsheet UNHCR Pakistan
- "Afghan Migrants in Iran Face Painful Contradictions but Keep Coming," by Rod Nordland, The New York Times [retrieved November 22, 2013]
- "2013 UNHCR country operations profile—Pakistan," United Nations High Commissioner for Refugees [retrieved November 5, 2013]
- Camp wise Afghan refugee population in KP-Commissionerate for Afghan Refugees—Peshawar, December 2019.
- Mental Health Laws in Pakistan, by Amina Tareen and Khalida Ijaz Tareen
- The State of Mental Health Legislation in Pakistan, by Daanika Kamal

In addition to the literature review, focus group discussions (FGDs) with community members, key informant interviews (KIIs) and a questionnaire were used to collect data at the health center level. Purposive sampling techniques were used for participants selection for FGDs and KIIs per RV. During the assessment, three main groups—adolescents, adults, and elders and influential community members (religious leaders, shura members and influential elders)—were targeted on the basis of their knowledge about the community and their availability and willingness to participate in the needs assessment. Due to cultural considerations, male and female groups were held separately.

The FGDs were conducted in three districts—Haripur, Mansehra and Lower Dir—in which a total of six FGDs (three male and three female: one adolescent, one adult, one elder) in each RV were held. Panian-I and Panian-II are situated at the same place, so these two RVs were considered as one. Altogether, six RVs and six FGDs in each RV were conducted, for a total of 36 FGDs. The data collection in the field was conducted in December 2019.

A total of 19 KIIs were conducted—six KIIs in Lower Dir, and seven in Haripur and Mansehra—with community and district administrations. The participants of the KIIs were one KII District Administrator (DA), three Refugee Village Administrators (RVAs), one religious leader and one influential leader in the RV. Furthermore, six KIIs were conducted with concerned healthcare providers in nearby health facilities.

A total of 433 individuals participated in FGDs and KIIs,

including 225 males and 208 females, split into the following: 141 adolescents aged 12 to 18 years (71 male and 70 female), 162 adults (89 male and 73 female), and 130 community and religious elders (65 male and 65 female).

3.2 Collection tools and data analysis techniques

The data collection tools used in this assessment are adapted versions of tools within the 2012 WHO and UNHCR "Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings." The questionnaire used for the survey in the health centers is the "Checklist for the Integration of Mental Health at the Primary Health Care (PHC) Level" of International Medical Corps, adapted from the WHO/UNHCR Assessment Toolkit.[1]

Survey tools were contextualized for the Pakistani humanitarian setting and Afghan refugee community. The database was designed for qualitative answer data entry and, after conducting FGDs, KIIs and PHC fieldwork, data entry was completed at the field level.

Senior program officers were responsible at the field level for coordination and administrative support to field teams, while at the country office level the MHPSS Coordinator provided day to day technical advice and support, and the MEAL Manager supported the teams in the methodology of data collection, analysis and report writing.

3.3 Data collection process

Before the start of fieldwork an orientation on tools and questionnaires was provided to data-collection staff, including psychosocial counselors and community mobilizers, in one-day workshops held in Haripur and Lower Dir field offices. The staff was oriented on matters related to security, ethical considerations, confidentiality, informed consent and overall targets in each district (number of FGDs and KIIs).

Program officers piloted the questionnaire at the field level at two locations, and reported no significant challenges in conducting FGDs and KIIs in the field.

Senior program officers and the Program Officer facilitated field teams, composed of men and women psychosocial counselors and community mobilizers, in development of the work plan for conducting FGDs and KIIs at each target RV. In each district, various groups were formed and they nominated note-takers and moderators before conducting FGDs and KIIs in the field.

Data collection was paper-based and later uploaded to the database by the same person who conducted the FGDs and KIIs. Debriefing sessions were held with the team on a daily basis in the field on phone or via Skype by the MHPSS Coordinator and MEAL Manager. Data entry was undertaken by the psychosocial counselors and community mobilizers, conducted at the field offices under the supervision of program officers.

After the data entry, the MEAL team reviewed and analyzed the data, and the results were generated, analyzed and integrated into the report.

1 WHO,UNHCR., (2012). Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings. [online]. Geneva: WHO. [Viewed 30 March 2020]. Available from: who.int/mental_health/resources/toolkit_mh_emergencies/en/

SECTION 4

Results of the Evaluation

4.1 Common problems and stressors

During the assessment, various common problems and stressors were talked about by the respondents in focus group discussions and individual interviews. In this section, the main themes are presented, in the order of frequency mentioned by the respondents.

Table 1: Common problems and stressors in Haripur and Mansehra

Common Problems and Stressors	
Education	Problems with education—e.g., non-availability of books, the difference in curriculum, a small number of teachers, lack of qualified teachers, non-availability of classrooms and furniture, non-availability of clean drinking water in the schools, lack of girls' schools in the area, as well as no middle and high schools for girls after 5th class, corporal punishment in educational institutions).
Health	Lack of basic supplies and facilities in basic health units (BHUs)—e.g., medicines, proper vaccination, labor room, child care, first-aid services and availability of doctors. High prevalence of dengue fever, hepatitis, heart diseases, diabetes, malaria, typhoid (*sra tabba*) in the RVs, no outpatient department (OPD) in BHUs on daily basis, fee is not affordable for most of the people, no treatment for mental health conditions in BHUs, chronic illnesses are not treated, and access issues to main hospitals, which are located at long distance in the main cities, making it difficult especially for women who are pregnant and have other complications.
Poverty	Unemployment, lack of job opportunities for Afghan refugees, inflation and high prices of items, including school fees, books, bills of electricity and water.
Infrastructure	Insufficient and poor infrastructure of schools and health facilities, poor condition of roads, homes and streets. Poor water and sanitation system in RVs.
Vocational and skills training	Children are unskilled; after 5th class, girls have no school to continue their studies. There are no vocational and skills centers in the area for boys and girls.
Property issues	Due to their refugee status, the refugee community cannot buy land for accommodation. People live in rented houses that are very congested.
Government policies for Afghan refugees	Afghan refugees face problems during entry and exit points at the border, hurdles in receiving POR cards, driving licenses, issues in receiving aid in legal affairs.
Mental Health and Psychosocial Problems	
Depression	Feeling of isolation, anger, helplessness, sadness (*Khafgaan bemari, khafgaan*), sleeplessness, aggression, withdrawal, stress (*asabi dabao*).
Anxiety	Anxiety (*vaham*); the community is confused and concerned about refugee's status in the country.

Table 1: Common problems and stressors in Haripur and Mansehra	
Substance abuse	The issue is perceived as increasing day by day. Drug consumption is affecting mostly the youth. The common substances mostly used are hashish (chars), heroine (powder), opium, alcohol and ice (crystal methamphetamine).
GBV	Harassment and child sexual abuse exist in Afghan refugee villages. Refugees also face protection issues as they cross the border during entry into Pakistan. Participants also shared that a pregnant woman and a child died when caught in a stampede during the visa stamp process at the Afghanistan side of the border. In addition, during FGDs, the adults shared that there are issues of inappropriate touch and staring at women and girls by support staff at voluntary return centers.

Table 2: Common problems and stressors in Lower Dir District	
Common Problems and Stressors	
Education	Non-availability of middle and high schools, lack of schools in the refugee villages, poor access to schools. Afghan refugees face difficulties in sending their children to schools due to poverty and fee issues.
Health	Lack of health facilities; no basic facilities, medicines, vaccination, laboratories, LHVs (Lady Health Visitors); private health facilities are costly.
Poverty	Expenditure is high and the income of people is low. Education, technical skills and job opportunities are lacking for Afghan refugees; people do not have enough money to start their own businesses.
Poor hygiene, infrastructure, slum houses	There is no proper place for waste disposal, which creates problems for the community. Muddy small houses, poor infrastructure and drainage systems in the RVs. After heavy rains they are worried that their houses may collapse. As a result, they fear the loss of life and damage to their house infrastructure.
Emotional abuse and GBV	Lack of respect for each other, "backbiting," unethical communication, use of abusive language, mobility and permission issues for girls' education. Marriage decisions are taken by others, leading to forced marriages. A low level of tolerance among the community.
Mental Health and Psychosocial Problems	
Substance abuse	According to the respondents, many people abuse substances as a coping mechanism to release stress due to unemployment, poverty and the burden of responsibilities to support large families. Substance abuse is mainly affecting youths. The most commonly reported abused substances are heroin, ice (crystal methamphetamine), hashish (chars) and *Majoon*.

Table 2: Common problems and stressors in Lower Dir District	
Aggression	Low level of tolerance due to unemployment; people get aggressive very easily. Youth are more aggressive than any other age group because no one listens to and understands them; whenever any decision is made, the youth are not consulted.
Mental health and neurological conditions	Mainly equated with "madness" by community members; epileptic seizures exist in the community along with aggression and anxiety.

4.2 Local conceptions of mental health, neurological and substance use conditions and expression of psychological distress

Depression *(Khafgaan)*

According to community members most of the elders faced the issue of sadness, aggression and intolerance. It affects their daily life and productivity. They are unable to focus on their work and family matters. Sometimes they think that life should be ended. Due to these issues, they take the least interest in household responsibilities, avoid social gatherings and recreational activities, remain isolated and sad, which disturbs their work life as well. Common symptoms shared by the community are suicidal ideation, overthinking, disturbed appetite, constant stress, weeping, hopelessness, self-harm and irritation. Due to depression (*khafgaan*), women and men cannot take care of their children and families.

Other mental health issues

Many within the Afghan community face anxiety and confusion due to their refugee status in Pakistan and are facing such issues as aggression in the community (verbal and physical). It was reported that most of the elders face memory problems. Epilepsy, mainly equated with "madness" by community members, also exists in the community.

The presence of mental health issues in the community disturbs their daily activities, like home chores, child care, health and mobility, schooling of children, personal hygiene and family care.

Substance use

Due to the lack of jobs and educational facilities people are involved in substance use. The main drugs used in the community are heroin, ice (crystal methamphetamine), hashish (*chars*), and Majoon. According to the community members some people are also using alcohol.

Drug misuse is affecting youth, whereby they are becoming more aggressive. According to the community, the main cause of becoming a drug user is peer pressure. Because people in the Afghan refugee community are also uncertain about their status in the country, they remain under constant stress. It was suggested by some that this could also be one of the reasons why some begin to misuse drugs. Due to drug misuse people cannot take care of their families and social relationships, and are unable to continue their paid work and education. When they have no money for drugs, they take money forcefully and steal things to be able to purchase drugs. Respondents in this assessment felt that it ruins their life because they are unable to be productive for their family or for the community.

Emotional abuse and GBV

The issue of bullying is very common in the RVs; people call one another bad names and bully them for their color and caste. There are instances of forced marriages and GBV issues in the community as well. Threats of divorce are common examples of emotional abuse toward women. The elders use derogatory language for youngsters. During FGDs with adolescents, they shared that child sexual abuse also exists in the community.

Respondents shared that people who face emotional abuse tend to stay isolated from social gatherings, and show a lack of interest in their activities.

4.3 Current community support and coping strategies

In this section, the way in which the communities manage the main mental health and psychosocial problems identified are presented, highlighting the resources they mobilize.

Coping strategies for mental health issues

To deal with depression, the community shared that they usually go for spiritual healing (*Namaz, Prayers, Zikar, Dam Darood, Taweez*), herbal treatments and counseling, meeting with either religious leaders or community elders. However, if people have available financial resources, they also consult a doctor, which was noted to be useful by the respondents. It was also noted that in general members of the community do have sympathy for people with mental health conditions, and that families and friends provide

emotional support to their loved ones. Recreational activities such as cricket were noted as positive ways to deal with stress.

Less positive ways of coping were noted by the community as self-medication using substances such as hashish and opium (Chars, Garda, Afeem). Involvement in gambling (Jawari) is also used by some people as a way to deal with depression. Sometimes the community also opts for some other ways of healing, like electric shocks and beating. Most of the time people with mental health conditions remain isolated and avoid gatherings.

Coping strategies for emotional abuse and GBV

To deal with the issue of emotional abuse, members of the community usually share their feelings with friends and other trustworthy people. To manage GBV-related issues, survivors recite the Holy Quran and offer prayers, following religious practices, and share their problems with friends and relatives. Survivors also engage with NGOs like International Medical Corps and SHARP (Society for Human Rights and Prisoners' Aid) to access support services such as case management, psychosocial support and legal aid.

Additionally, females engage in handicrafts and local female-only games. Within the Afghanistan culture it is considered a dishonor for the family if GBV survivors decide to discuss or seek support outside of the immediate family members. Respondents in this assessment shared that GBV survivors cope by crying in isolation.

Coping strategies for substance abuse

People in the community seek homeopathic treatment, traditional herbal healing (*Hakemi elaj*), spiritual healing (*Dam, Drood*), advice and support from the close circle in the community to deal with the issue of substance abuse. Usually, people who misuse drugs spend time with friends and play some games (e.g., laddo).

Community elders try to support these individuals by visiting where they live to provide advice and counseling. They also provide support and guidance to the affected families. The community elders also discuss these issues at various platforms; religious leaders raise awareness in the community as well.

If individuals continue to abuse substances, they are physically punished by the family elders. The community shared that the fear of punishment will keep the substance abuser away from using substances. The community also engage the police to arrest individuals who they believe are abusing substances.

Available strengths and support in community

Community members value their strong Jirga system, where a group of influential community leaders, made up of shura members and religious leaders, resolve conflicts among community members. Respondents also shared that the *Hujra* system (a place for social gatherings for males in the community) is also seen as providing support. In addition, the community cooperates with each other (*Ashar* is a type of community service, a task performed by a group of volunteers as a relief for a community member), which is a good tradition to provide voluntary labor services to fellow community members. Respondents felt that the community in general is hospitable (*Melmastyaa*) and respects each other as per the *Pukhtoonwali* (a Pashtun code of conduct) system.

The participants of the survey also shared that there is community support provided to families during marriage and death. The community provides support to bereaved families and participates in combined community-level recitation of the Holy Quran (*Quran Khwani*). There is a sense of respect for religious teachings, the spirit of brotherhood and unity. There is also a good practice of participating in social gatherings (e.g., childbirths and marriages).

SECTION 5

Resources and Practices in Health and Mental Health Services

5.1 Health facilities overview

For this assessment, only those health facilities were targeted that are situated in the proximity of our targeted RVS and that are usually accessed by our targeted beneficiaries. The health facilities and staff presented below provide health and mental health services.

Table 3 Basic Clinical Information

Type of facility:	Type of services	Location:	Average number of monthly patients:	Population:	Days and hours of operation
NGO	Primary	Haripur	450	15,670	6 days a week, 6 hours a day
Public	Tertiary	Mansehra	1,000	1200,000	6 days a week, 7 hours a day
Public	Tertiary	Haripur City	900	D/K	6 days a week, 6 hours a day
NGO	Primary	Mansehra	240	14,622	6 days/24 hours for labor room, and 6 hours OPD
Public	Tertiary	Munda THQ	10,000	D/K	24/7
NGO	Primary	Chakdara	150	D/K	6 days a week, 5 hours a day

The table above shows that community members around PHCs are regularly visiting these PHCs for health services. Moreover, the public health facilities are receiving more patients than health facilities run by NGOs due to their strength in terms of capacity and resources.

Table 4 Staff Work Load

The following table shows health facilities staff workload, as recorded per the questions asked during the assessment.

Numbers and frequency	Haripur		Mansehra		Lower Dir	
	Primary	Tertiary	Primary	Tertiary	Primary	Tertiary
Number of general physicians working at any given time in the clinic	0	28	N/A	40	1	12
Number of general nurses working at any given time in the clinic	2	50	2	80	0	6
Approximate number of other clinical staff	4	100	4	60	0	15
Approximate number of patients with health problems in previous week	130	100,000	60	20,000	D/K	1,900
Approximate number of patients (with any type of health problem) seen by general physicians every hour	N/A	60	N/A	600	D/K	D/K
Approximate number of patients (with any type of health problem) seen by general nurses every hour	5	N/A	3	30	D/K	D/K
Approximate number of community health workers in the catchment area	30	D/K	22	D/K	D/K	D/K

The table shows that there are no general physicians working at PHC facilities in Haripur and Mansehra, while only one physician is in Lower Dir. All these PHC facilities are run mainly by local NGOs and, due to their limited resources, they are unable to hire a physician. Similarly, there are very few nurses (two) working at each PHC facility in Haripur and Mansehra, while in Lower Dir there is no nurse working in BHU.

Table 5 Social indicators

The table below shows the numbers of health facilities staff workload, as recorded per the questions asked during the assessment.

S#	Social Indicators	Haripur		Mansehra		Lower Dir	
		Primary	Tertiary	Primary	Tertiary	Primary	Tertiary
1	Healthcare facility is in safe walking distance of the affected community	No	Yes	Yes	No	Yes	Yes
2	Furthest distance traveled by patients to access the health facility (in km)	3–4	40	3	30	1	5–6
3	The clinic has at least one female healthcare provider	Yes	Yes	Yes	Yes	Yes	Yes
4	Each of the local languages is spoken by at least one clinic staff member	Yes	Yes	Yes	Yes	Yes	Yes
5	Procedures are in place to ensure that patients give consent before major medical procedures	Yes	Yes	Yes	Yes	No	Yes
6	Healthcare provision is organized in a way that respects privacy (for example, a curtain around the consultancy area)	Yes	Yes	Yes	Yes	Yes	Yes
7	Information about the health status of people and potentially related life events (e.g., rape, torture) is treated confidentially	Yes	Yes	Yes	Yes	D/K	Yes
8	PHC care is affordable for all patients	Yes	Yes	Yes	Yes	Yes	Yes

The above table shows that PHC facilities are easily accessible as per the distance recorded while the tertiary care hospitals in Haripur and Mansehra are at a distance of 30 and 40 km, respectively. In Lower Dir, the tertiary care hospital is at a distance of 6 km. These healthcare facilities do have female healthcare providers and procedures in place to ensure that patients give consent before major medical procedures.

Table 6 Health Information System

Type of Facility	Type of Services:	Location:	Mental disorders are documented in the weekly morbidity report	Depression	Epilepsy	Psychosis	Other MH
NGO	Primary	Haripur	No	0	0	0	0
Public	Tertiary	Mansehra	Yes	120	30	60	120
Public	Tertiary	Haripur City	Yes	300	25	50	100
NGO	Primary	Mansehra	No	1	No	No	1
Public	Tertiary	Munda THQ	Yes	3	2	0	2
NGO	Primary	Chakdara	No	0	No	No	0

Table 6 shows that PHC facilities run by NGOs were not documenting mental disorders in the weekly morbidity report, as they do not have the capacity. Moreover, 300 cases of depression were reported in a tertiary healthcare facility in Haripur.

Table 7 Health Workers Competency in MNS Conditions Indicators

Below table shows the healthcare providers' competency in identifying and clinically managing the following mental health conditions at each clinic:

Type of Facility	NGO	Public	Public	NGO	Public	NGO
Location	Haripur	Mansehra	Haripur	Mansehra	Munda	Chakdara
Type of Services	BHU	Tertiary	Tertiary	BHU	Tertiary	BHU
Depression	YES	YES	YES	NO	YES	YES
Psychosis	NO	YES	YES	NO	YES	YES
Epilepsy	NO	YES	YES	NO	YES	YES
Developmental & behavioral disorders in children and adolescents	NO	YES	YES	NO	NO	YES
Problems with alcohol use	NO	YES	YES	NO	NO	NO
Problems with drug use	NO	YES	YES	NO	YES	YES
Post-traumatic stress disorder	NO	YES	YES	NO	N/A	NO
Acute trauma-induced anxiety that is so severe that it limits basic functioning	NO	YES	YES	NO	N/A	NO
Self-harm/ suicide	NO	YES	YES	NO	N/A	NO
Medically unexplained somatic complaints	NO	YES	YES	NO	NO	NO

YES
NO
N/A

Table 7 Health Workers Competency in MNS Conditions Indicators

Below table shows the healthcare providers' competency in identifying and clinically managing the following mental health conditions at each clinic:

In Haripur and Mansehra, head of the tertiary healthcare facilities shared that they are able to identify and clinically manage all the mentioned mental health conditions, while NGOs do not have enough capacity to manage such conditions.

In the above table, "Yes" shows that healthcare providers have the capacity to identify and clinically manage the mental health conditions, while "No" means that the healthcare providers have no competency in identifying and clinically managing the mentioned mental health conditions. N/A (not aware) shows that the staff was not aware of the services.

All of the respondents did have knowledge about the referral system for mental health conditions. In all three tertiary level healthcare facilities, healthcare staff have no knowledge about available supports (protection agencies/networks, community/social services, community support systems, legal services) offering protection and/or social support for protection problems such as domestic violence and rape. Respondents of all six health facilities shared that within the last two years staff have not received any training in four topics: communication skills, basic problem solving and counseling approach, offering basic support to people who are bereaved and offering psychological first aid.

In Haripur's primary healthcare facility, staff reported that there is a need for training to manage common mental health conditions. In the tertiary healthcare facility, they requested training such as WHO's Mental Health Gap Action Program (mhGAP) and provision of supportive supervision for staff. In Mansehra tertiary healthcare facility, they requested capacity building on MHPSS detection, diagnosis, treatment and referral of clients, while in the primary healthcare facility they requested training on clinical supervision for management of depression and anxiety in antenatal cases. In Lower Dir, in both health facilities, staff shared that there is a need for capacity building of staff on mhGAP.

Table 8 Referral Indicators

The below table is the matrix of two-way referral mechanisms: receiving and referral of mental health clients to various settings in the last two weeks. The responses are presented in three categories: Never, Sometimes and Frequently.

Type of Facility		NGO	Public	Public	NGO	Public	NGO
Location		Haripur	Mansehra	Haripur	Mansehra	Munda THQ	BHU Chakdara
In the last two weeks PHC clinic received mental health related referrals from	Mental health specialist care (secondary, tertiary or private care)						
	Community health workers, other community workers, schools, social services and other community social supports, traditional / religious healers						
In the last two weeks PHC clinic referred mental health related referrals to	Mental health specialist care (secondary, tertiary or private care)						
	Community health workers, other community workers, schools, social services and other community social supports, traditional / religious healers						

NEVER

SOMETIMES

FREQUENTLY

BHUs from Chakdara and Mansehra frequently refer mental health-related cases to specialist care, while the tertiary healthcare facility at Mansehra frequently receives related referrals from the specialist care. Respondents reported that they have not received any mental health-related cases from the community or specialist care.

Table 9 Availability of drugs for the clinical management of mental and neurological disorders at surveyed health facilities

The below table is the matrix of availability of psychotropic medicines in the PHC clinic or nearby pharmacy in the previous two weeks. Responses are presented in three categories: Always, Never and Sometimes. Core medications recommended by WHO for the management of mental and neurological disorders are listed in the table below, with a description of their degree of availability within each of the districts.

Psychotropic Medicines	Haripur		Mansehra		Lower Dir	
	Primary	Tertiary	Primary	Tertiary	Primary	Tertiary
Generic antidepressant medication (amitriptyline, fluoxetine)						
Generic anti-anxiety medication (diazepam)						
Generic anti-psychotic medication (haloperidol, chlorpromazine, fluphenazine)						
Generic anti-epileptic medication (phenobarbital carbamazepine, diazepam injections, lorazepam injections, phenytoin, valproic acid)						
Generic antiparkinsonian medicine for the management of side effects from antipsychotic medication (biperiden)						

ALWAYS

NEVER

SOMETIMES

At tertiary care-level health facilities in both Haripur and Mansehra districts, the core medication recommended by WHO is available in the nearby pharmacies. However, in Lower Dir at the tertiary care level, medications like anti-psychotic and anti-epileptic drugs are available only sometimes. Anti-Parkinsonian medicine is not available.

At the PHC level both in Mansehra and Lower Dir, none of the WHO-recommended core medications for the treatment of mental or neurological disorders are available in healthcare facilities or in nearby pharmacies.

5.2 Barriers and solutions related to accessing mental health services identified by Key Informants

According to key informants from local NGOs, the organizations are providing limited primary healthcare services at RVs. Similarly, key informants from both NGOs and public healthcare facilities believed that the main barriers related to mental health services are illiteracy, lack of awareness, non-availability of specialized staff for treatment of mental health conditions and availability of medicines. In addition, the stigma associated with mental health plays a major role in restricting the community from accessing and obtaining mental health services. According to respondents there are no formal health facilities available at RVs for managing mental health issues. Key informants from the public healthcare facilities reported that the non-availability of specific psychiatric units is the main obstacle related to providing mental health services.

In terms of solutions proposed to these barriers, key informants from both NGOs and public healthcare facilities reported that awareness-raising can play an important role to sensitize the community, and that mental health issues are just like any other disease for which treatment is available. In addition, they suggested establishing proper healthcare facilities with specialized staff and essential medicines.

The key informants from public healthcare facilities shared that if the government is unable to provide free treatment for mental health conditions, it should be made available at subsidized rates. They also shared that some mental health conditions can be effectively treated with counseling and psychotherapy, for which psychologists should be hired within the health facilities. They suggested that there also should be separate mental health units established within the health facilities.

SECTION 6

Summary

6.1 Summary

In summary, this rapid assessment of MHPSS needs highlighted the following.

Regarding mental health systems, all the provincial and federal governments have enacted mental health acts, which shows their willingness and commitment to providing mental health services to the community. Tertiary care health facilities are located at a manageable distance within the target districts for mental health referrals.

There is a strong willingness of influential community members and elders to support mental health activities in the target locations. There is robust local community support—e.g., Jirga, social gatherings, and Ashar available in the community. Although stigma related to people having mental health conditions and seeking support does exist, there is also a level of community acceptance to respond to sensitive and potentially stigmatizing issues, as evidenced by the engagement with International Medical Corps GBV prevention and response services in the target areas since 2016, which can be expanded.

There are, however, the following gaps and challenges.

- Lack of allocated funding on the part of the government to implement mental health legislation.
- Lack of awareness regarding mental health issues and available services, along with stigmatization in the target community.
- Mobility restrictions due to lack of proper documentation (POR card), for Afghan refugees to tertiary-care health facilities.
- Non-availability of psychotropic drugs at healthcare facilities.
- Few NGOs currently working in the target areas for Afghan refugees, with limited mental health resources and services.
- Lack of health personnel in mental health and short-term training programs in mental health. Psychiatrists are available only in some DHQ hospitals, while there is no psychologist available in any health facility in our targeted districts.

According to the responses from the FGDs, the communities also face the following broader concerns that impact their mental health.

- Lack of education, health, employment opportunities and building up professional skills.
- Poverty.
- Poor infrastructure and housing, including sanitation and drinking water.
- Security situation, including the uncertainty about their stay as refugees in Pakistan.
- No access to formal documentation (e.g., passport, POR card).

Child sexual abuse and harassment also were reported during discussions with adolescents in RVs. There are mobility issues to people who do not have proper documents (e.g., POR cards and Afghan Citizen Cards).

Depression, anxiety and drug misuse were the most common mental health and psychosocial problems reported by the community that negatively affected their routine daily lives. Women in the community also face the issues of GBV and inequality.

Mental health conditions have devastating consequences not only for individuals and families, but also for local economies, because of the loss of individual productivity.

Stigmatization of mental health is an important concern because of the derogatory labels associated with mental health conditions and how they may restrict people from leading full and meaningful lives in their communities. Most people who have mental health conditions that do not noticeably affect their day-to-day functioning avoid seeking professional help for the fear of being branded "crazy" by the community. Mental health conditions are mainly understood through local cultures and religious explanations. Such explanations, for example, include the influence of black magic and evil eye, possession by demons and effects of visitations to graveyards, etc. Other explanations include the toxic effect of medications or simply God's way of testing people.

Rather than seeking professional help, most people solicit faith healers or religious figures for the treatment of mental health conditions. Somewhat impractical, spiritual healing does not get to the root cause of the psychological problem and cannot provide the benefits proffered by mental health treatment.

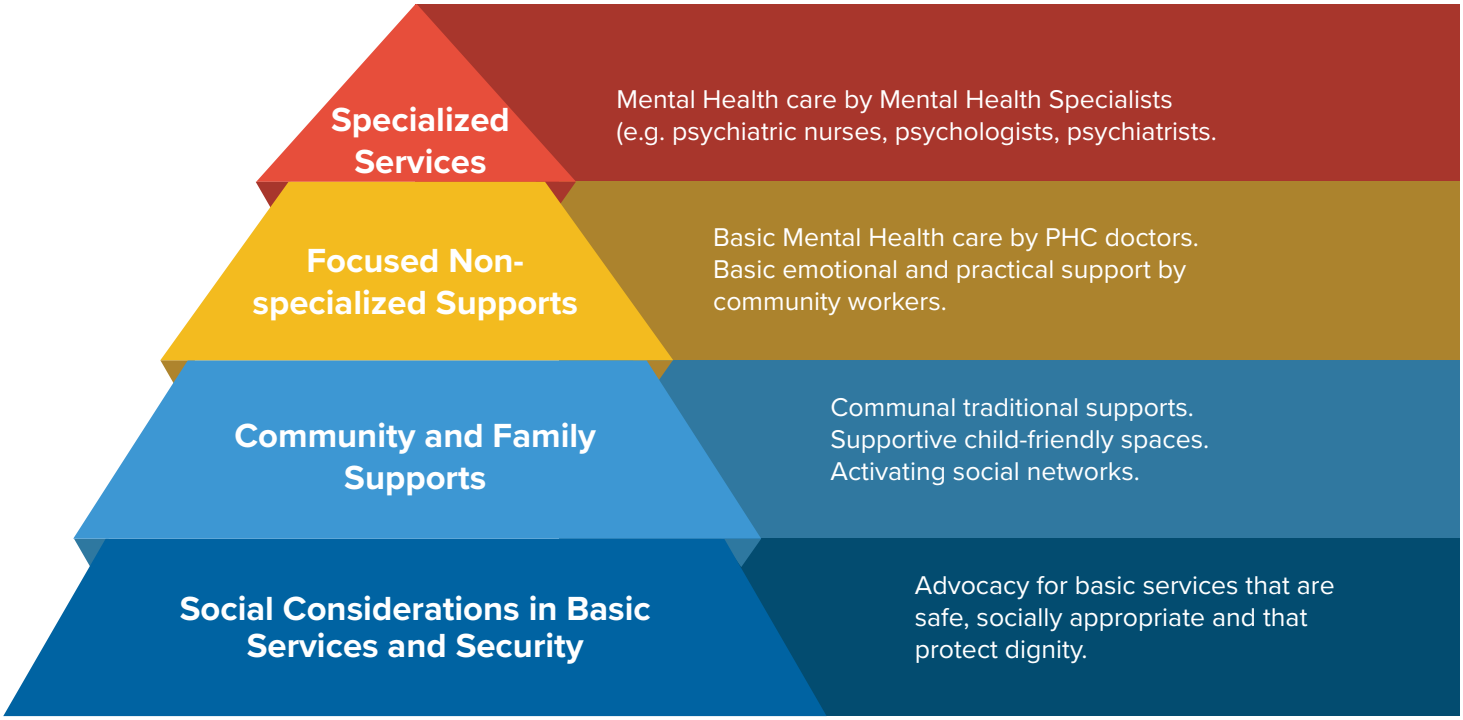
Another reason that people seek mental health support from faith healers is the lack of financial resources to pay for supportive services and the non-availability of professional help and treatment at the local levels.

6.2 Recommendations

According to the IASC guidelines on MHPSS in emergency settings, health systems should provide an optimal mix of mental health and multilevel psychosocial and well-being services, using the pyramid approach shown in Figure 1.

The following recommendations are made with the aim to respond to the different MHPSS needs and gaps identified in Haripur, Mansehra and Lower Dir districts, and to improve the quality and comprehensiveness of MHPSS services available to Afghan refugee and host communities in those locations.

Figure 1:
Intervention Pyramid for Mental Health and Psychosocial Support (IASC Reference Group MHPSS, 2007)



A. Recommendations for national mental health system strengthening

- International Medical Corps will advocate at different platforms for the allocation of adequate resources at the provincial level to support the implementation of their mental health legislation.
- Use simplified protocols to enable non-specialist staff to respond effectively to immediate mental health needs.
- Advocate for investment in the education and clinical training and supervision of psychologists and psychiatrists, to enable them to better deliver comprehensive and specialized mental health services
- Create and/or strengthen mental health units in Tehsil (an administrative unit within the district) and district-level health facilities.

B. Advocate for dedicated programming and professionals to support children's wellbeing.

- Invest in the education, training and supervision of professionals in child psychology and psychiatry, given the lack of specialists and the critical need for qualified professionals to offer advanced mental health services.

C. Recommendations for capacity building

- The staff of healthcare facilities from our targeted locations should be provided training on mhGAP. Training should follow the WHO guidelines contained in the mhGAP-HIG (Mental Health Gap Action Programme-Humanitarian Intervention Guide) to address mental, neurological and substance-abuse conditions in non-specialized care settings.
- Since the public healthcare facilities, along with BHUs run by NGOs in the target locations, do not have any psychologists, to fill this gap it is recommended that International Medical Corps staff should also be trained on WHO's Problem Management Plus (PM+), an evidence-based scalable psychological intervention for non-specialists to safely deliver psychological support (under supervision). The same training can also be provided to psychosocial counselors and social workers of other organizations working in the target locations.

Psychological treatment of the different types of observed stress, anxiety, depression

- Train MHPSS staff, including doctors and nurses, and community health workers (CHWs) and other NGOs to use evidence-based treatments. This could be done effectively through a short training program with an initial phase and a follow-up. In addition, it will be important to train MHPSS staff on WHO psychological evidence-based interventions that are potentially scalable, which could include:
    - Brief, basic, non-specialist-delivered versions of existing evidence-based psychological treatments (e.g., basic versions of cognitive behavioral therapy, problem management plus, individual and group interpersonal therapy); and
    - Self-help materials drawing from evidence-based psychological treatment principles, in the form of self-help books, self-help audiovisual materials, and online or app-based self-help interventions (e.g., WHO self-help plus).
- Healthcare providers should be trained to be able to diagnose mental health conditions and recommend clients with mental health conditions to professional and medical treatment.
- Integration of MHPSS into protection programs. As GBV was reported as a significant concern by focus group participants and key informants, in this regard MHPSS staff should be trained on best practices for supporting GBV survivors and for making referrals for protection services in collaboration with protection actors. Moreover, GBV actors should be trained on psychological first aid, and on the identification and referral of MNS conditions.

D. Recommendations for service delivery

- Develop preventative mental health actions for children and youth—train International Medical Corps staff on group interventions, such as International Medical Corps' youth empowerment program.
- Train and deploy mental health professionals (psychiatrists, psychiatric nurses, clinical psychologists) in Tehsil and district-level health facilities.
- Referral pathways should be developed for effective case management. There should be a two-way referral of International Medical Corps' MHPSS team with healthcare facilities (e.g., referring severe cases to the healthcare facilities and receiving those cases from healthcare facilities that require support and follow up at the community level within the RVs).

E. Recommendations for awareness-raising

- Prioritize community awareness-raising on wellbeing, emotional distress and mental health conditions to promote community knowledge and address stigma.
- Develop and disseminate MHPSS-related information, education and communication materials, such as materials on stress responses following distressing events, as well as on positive coping mechanisms.
- Engage local leaders, religious figures and traditional healers to explore collaboration for awareness-raising and anti-stigma campaigns.
- Support the creation of a group of mental health service users who, as individuals with lived

experiences, could promote awareness-raising and advocacy for mental health services.

- International Medical Corps' MHPSS and GBV teams should work closely to effectively reach survivors and those at risk of GBV and child sexual abuse about internal referrals and services.
- Awareness-raising activities should be conducted regularly in the targeted RVs regarding the importance of mental health and how to effectively deal with the issue of stigmatization.
- The community should be sensitized on the importance of seeking professional support and medical treatment for mental health conditions.
- Support groups—e.g., community activists, elders and gender support groups that usually provide a safe space for people who share personal experiences and feelings, and share practical coping strategies with them—should be sensitized to share information and recommend counseling and professional treatment for mental health conditions in the community.
- The identification and use of clients and families in success stories is an approach that could give good results at a lower cost to counter false beliefs about the mental health care offered by I/NGOs.

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