

IOM AFGHANISTAN

RESEARCH SERIES ON RETURN AND REINTEGRATION IN AFGHANISTAN

RESEARCH BRIEF
DISPLACEMENT TRENDS
AND CHALLENGES IN
AFGHANISTAN SINCE
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Barikab township, Afghanistan (Credit: Samuel Hall 2022)

GLOSSARY

Community Health	The environmental, social, and economic resources to sustain emotional and physical wellbeing among people in ways that advance their aspirations and satisfy their needs in their unique environment (WHO)
Counselling	Counselling is a talking therapy which involves a trained therapist listening to you and helping you and helping you find ways to deal with emotional issues. ¹
De-facto authorities	A term used to describe a person or group that actually has control of a place, but which does not have the legal authority to do so.
Disability	A disability is any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions). There are many types of disabilities, such as those that affect a person's: vision, movement, thinking, remembering, learning, communicating, hearing, mental health, and social relationships. ²
Displacement	The movement of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters. ³
Gender	Gender refers to the socially constructed roles, behaviours, expressions and identities of girls, women, boys, men, and gender diverse people. It influences how people perceive themselves and each other; how they act and interact, and the distribution of power and resources in society. Gender is usually conceptualized as a binary (girl/woman and boy/man) yet there is considerable diversity in how individuals and groups understand, experience, and express it. ⁴
Mental Health	Psychological, emotional and social wellbeing. ⁵
Migrant	Any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of 1) the person's legal status, 2) whether the movement is voluntary or involuntary, 3) what the causes for the movement are or 4) what the length of the stay is. ⁶
Psychiatry	The branch of medicine focused on the diagnosis, treatment and prevention of mental, emotional and behavioural disorders. ⁷
Psychology	The scientific study of the mind and how it dictates and influences our behaviour, from communication and memory to thought and emotion
Psychosocial Support	Mental health and psychosocial support (MHPSS) includes any support that people receive to protect or promote their mental health and psychosocial wellbeing. ⁸

1 NHS, 'Counselling', (website accessed 28 June 2022)

2 Center for Disease Control and Prevention, Disability and Health Overview, (page updated 16 September 2020; accessed 22 March 2022).

3 IOM, 'Glossary on Migration', 2019.

4 Canadian Institutes of Health Research, Definitions of Sex and Gender, (website updated 17 June 2017; accessed 22 March 2022)

5 National Health Service (NHS) Child and Adolescent Mental Health Service, (website accessed 16 February 2022).

6 UN Definition

7 American Psychiatric Association, 'What is Psychiatry?', (website accessed 28 June 2022).

8 Government of the Netherlands, 'Mental Health and Psychosocial Support in Crisis Situations', (website accessed 28 June 2022).

LIST OF ACRONYMS

AFN	Afghani (currency)
ARTF	Afghanistan Reconstruction Trust Fund
BHC	Basic Health Clinic
CHC	Comprehensive Health Clinic
DfA	<i>De facto</i> Authorities
DH	District Hospital
DTM	Displacement Tracking Matrix
FGD	Focus Group Discussion
GCRF	Global Challenges Research Fund
GoIRA	(Former) Government of the Islamic Republic of Afghanistan
HP	Health post
IASC	Inter-Agency Standing Committee
IDP	Internally Displaced Person
IIED	International Institute for Environment and Development
IOM	International Organization for Migration
KII	Key Informant Interview
MDI	Multi-Dimensional Integration Index
PH	Provincial Hospital
SHC	Sub Health Clinic
SSSI	Storytelling-Based Semi-Structured Interview

INTRODUCTION

Afghanistan has now endured over forty years of conflict, displacement, and violence, resulting in a highly traumatised population and a deeply fractured society, characterised by entrenched poverty. Although armed conflict has decreased since the Taliban returned to power in August 2021, physical violence, persecution, discrimination, and harassment remain everyday realities for significant sections of the Afghan population. The international community's response to the Taliban *de facto* authorities (DfA) has aggravated the humanitarian crisis.⁹ The freezing of Afghanistan's external funds has contributed towards a situation in Afghanistan, wherein the United Nations Development Programme (UNDP) predicted that by mid-2022, 97% of the Afghan population will be forced below the international poverty line of \$1.90 per day.¹⁰ Vital infrastructure has also been negatively affected: one month after US forces withdrew from Afghanistan, only 17% of health clinics remained functional within a health system that has remained heavily dependent on donor funding.¹¹

Literature on mental health in Afghanistan focuses primarily on the psychological effects of decades of war, but much less attention has been paid to the relationship between displacement, mental health, and (re)integration. Displacement has a significant negative impact on mental health. Previous research conducted by Samuel Hall in Afghanistan found that both IDPs and forced returnees experience more acute mental health needs than the broader population:¹² IDPs were over a third more likely to be deprived than the general population, and forced returnees more than half more likely to experience this state of disproportionate deprivation.¹³ In general, Samuel Hall found that individuals with no migration background had healthier profiles, whilst return migrants and IDPs found themselves the most vulnerable to mental

health conditions, alongside other displacement-related challenges. Forced returnees had a significantly less healthy profile than the general population.¹⁴

Within the context of the current humanitarian crisis and contemporary mass displacement, this research is a vehicle through which to increase awareness and understanding of the mental health challenges confronting displaced Afghans – both IDPs and returnees – with a focus on changes since August 2021, and recommendations ahead.

RESEARCH QUESTIONS

This report seeks to answer the below research questions:

- What are the main mental health challenges returnees and IDPs living in protracted displacement face, and what are the most effective strategies for providing them with mental health support?
- What forms of trauma and stigma do returnees and IDPs face through their migration cycle?
- How do returnee and IDP individuals and communities respond to mental health conditions?
- What have been some of the post-August 2021 trends and changes identified by mental health practitioners, returnees and IDPs?
- What policy settings, and programmes can provide effective mental health support for returnees and IDPs?

9 Human Rights Watch, 'Afghanistan: Economic Roots of the Humanitarian Crisis', 1 March 2022; Hardin Lang, 'Fit for Purpose: Getting Humanitarian Aid Right in Afghanistan One Year after the Taliban Takeover', Refugees International, August 2022; Oppewal J. and Kamminga J., 'Tough Sanctions Against Taliban Undermine Right to Food', The Broker, 24 May 2022; Loy L., 'Afghanistan's Crises by the Numbers', The New Humanitarian, 15 February 2022; and UN OHCHR, 'Afghanistan: UN Experts Call on U.S Government to Unblock Foreign Assets of Central Bank to Ease Humanitarian Impact', 25 April 2022.

10 UNDP, '97 percent of Afghans could plunge into poverty by mid-2022, says UNDP', 9 September 2021.

11 Ferguson J., 'Afghanistan has become the world's largest humanitarian crisis', The New Yorker, 5 January 2022.

12 Samuel Hall, 'Urban Displaced Youth in Kabul Part One: Mental Health Matters', June 2016.

13 Ibid, p15.

14 Ibid.

KEY HIGHLIGHTS

This research brief presents the findings of research carried out by Samuel Hall and commissioned by the International Organization for Migration (IOM) into the mental health experiences of internally displaced persons (IDPs) and returnees in Afghanistan throughout May 2022. The research explored symptoms and challenges, as well as community perceptions of mental health, and treatment accessed or desired. Three key findings emerged:

1. **Population demographics are affected by different mental health stressors, with widespread mental health conditions.** In the cohort interviewed, substance abuse was reported to be on the rise among young men, alongside suicidal tendencies among men. In many households, domestic violence is rising as the result of an exponential increase in mental health conditions among the Afghan population. This is particularly affecting women and children. **Mental health needs are gendered.** Historical patterns of disadvantage among displaced women (IDPs and returnees) in Afghanistan exacerbate mental health stressors. Restriction of opportunities to generate income and reduced mobility are becoming the norm. Where women are able to work, they earn significantly less than men, making it particularly difficult for women-headed households. Meanwhile reduced mobility and disrupted support networks render women more susceptible to domestic violence and socio-economic isolation.
2. **Community health is on the decline.** This means that communities no longer have the environmental, economic and social resources to support their own. Our respondents noted a reduction in community and peer support since August 2021. As households focus on their own survival and mental health conditions, communities are experiencing a social fracturing which can, in the long term, damage social cohesion. Severe poverty is seen as limiting and reducing community resilience. **Mental health decline was consistently linked to the absence of employment opportunities and severe poverty.** There were mixed feelings among respondents as to whether mental health support would aid (re)integration into communities. Severe poverty combined with unemployment, inflation, debt, and overall absence of sufficient support in terms of meeting basic needs are the current causes of mental health conditions
3. **Mental health conditions are heavily stigmatised within Afghan society.** Individuals with mental health issues are often ridiculed, humiliated and ostracised from decision-making processes and social gatherings. Those with visible mental health disorders are perceived as dangerous. As a result, and overwhelmingly, respondents advocated for a holistic and area based approach to improving mental health, combining MHPSS with poverty alleviation through increased employment and income-generation opportunities. Durable solutions will remain unachievable without donor commitment to provision of long-term MHPSS support for IDPs, returnees, and host communities.

WHY THIS BRIEF?

The IOM commissioned Samuel Hall to conduct a series of four briefs, focusing on the topics of mental health, urban migration, infrastructure and basic services, and climate change displacement. This is Brief 1 of the series. This knowledge and learning is intended to enhance IOM's understanding and migration response strategies and activities. The briefs are designed to be used by IOM and other interested stakeholders to inform future programming, including to develop evidence-based proposals and design interventions.

RESEARCH METHODOLOGY AND DATA USED

This research employed a qualitative data collection approach, through key informant Interviews (KIIs); storytelling-based semi-structured interviews (SSSIs); and focus group discussions (FGDs). Remote KIIs were held with five technical experts and mental health practitioners who were either based in Afghanistan or had significant understanding and knowledge of the Afghan context. Samuel Hall's research teams in Afghanistan conducted field research between 24 April 2022 and 30 May 2022. Field research commenced only after a period of training which included research objectives, familiarisation with tools, research ethics, and qualitative research techniques.

Overall, twenty-two SSSIs were conducted across Kabul, Herat and Nangarhar, alongside seven FGDs. During FGDs, respondents were asked to give verbal consent that they would not share details of the discussion with anybody outside the group after the FGD was completed. An equal number of FGDs were held for men and women, with the exception of the pilot FGD, which was held only for women. Likewise, the sample for SSSIs was roughly equal in terms of gender.

Table 1. Qualitative research sample

Province	FGD Participants (5-7 people)	SSSIs	KIIs
Kabul	16 (6 male, 10 female: 3 FGDs)	7 (3 male, 4 female)	
Herat	11 (7 male, 4 female: 2 FGDs)	7 (3 male, 4 female)	
Nangarhar	12 (6 male, 6 female: 2 FGDs)	8 (4 male, 4 female)	
TOTAL	39 (19 male, 20 female: 7 FGDs)	22 (10 male, 12 female)	5 (3 male, 2 female)
GRAND TOTAL	66 respondents (32 male, 34 female)		

Research teams ensured that a variety of age groups were included in the sample for both FGDs and SSSIs, with respondents varying in age from nineteen to seventy-one. The average age of respondents participating in FGDs and SSSIs combined was forty-five. However, the majority of the SSSI respondents were in their thirties. Members of stigmatised marginalised groups such as Jogi, Kuchi and Pashae, and persons with disabilities were also included in the SSSI sample in recognition of their unique social positionality, which presents distinct mental health stressors and experiences of (re) integration. Additionally, widows and single mothers were also included within the sample.

Table 2. Vulnerabilities among SSSI respondents beyond sex

Vulnerabilities among respondents	Number of SSSI respondents
Kuchi ethnicity	4 (2 male, 2 female)
Jogi ethnicity	1 (female)
Pashae ethnicity	3 (2 male, 1 female)
Person with disabilities status (physical disabilities)	3 (2 male, 1 female)
Widow and/or single mother	2

A snowball sampling technique was employed, with research teams visiting communities and utilising established contacts with gatekeepers and community members to gain access to an initial sample. From there, respondents were asked to direct the research team to other potential research participants who fit specific criteria, such as persons with disabilities. For respondents from stigmatised minority groups such as Jogi, Kuchi, and Pashae, researchers travelled to communities in which these groups were known to live to secure easier access.

The FGDs were conducted with IDPs, returnees and host community members. These groups were asked about community perceptions of mental health

conditions, preferred treatment for mental health conditions, and patterns in community mental health over the previous year. SSSIs enabled the respondent to decide which aspects of their lives they would, and would not, like to speak about. Furthermore, the storytelling approach provided a greater opportunity for free-flowing, respondent-led narrative. After each SSSI, respondents mapped and narrated their own personal lifeline, a short set of semi-structured questions was asked concerning mental health, treatment, stigma, and the relationship between mental health and (re) integration. Both the FGD and SSSI tools were drafted in response to a comprehensive desk review of Afghanistan-specific mental health literature, as well as literature focusing upon mental health research among traumatised respondents. A key piece of literature utilised was the *Afghan Symptom Checklist* by Dr Miller.¹⁵ This checklist addresses the cultural subjectivity with which mental health conditions can be experienced and demonstrated by compiling a list of symptoms specific to the Afghan context. Some of these symptoms were integrated directly into the tools produced for this research, while others were used as an analysis aid.

Ethical considerations remained at the forefront of the employed methodology in recognition of the context and the sensitive nature of the subject matter. As such, Dr Qais Alemi was hired as an external mental health expert to act as a consultant specifically for this research project. Dr Alemi is a researcher with expertise on mental health in the context of Afghanistan, particularly in developing explanatory cultural models of mental conditions among displaced Afghans. Dr Alemi was consulted during the research planning process to ensure an ethos of “do no harm” was adhered to, as well as during the data collection and data analysis phase, as a means through which to validate data. Furthermore, each respondent (as well as each member of the Afghan research team) was offered the opportunity to be referred for mental health support via a pathway established with IOM’s Reintegration Assistance and Development in Afghanistan (RADA) project teams in each province. In total, thirty-eight individuals (including one researcher) requested such a referral.¹⁶

All respondents participated in the research only after providing informed voluntary consent. The consent form was read aloud to respondents to accommodate for illiteracy, with their subsequent verbal consent being recorded by researchers. Throughout this process, it was made clear that respondents did not have to answer all questions, and that they could skip questions, or fully withdraw from the research without further questioning without repercussion.

Existing reports on mental health in Afghanistan

This research presents the only publicly available study into mental health in Afghanistan conducted since August 2021. Given the seismic shift in economy and socio-political dynamics resulting from the Taliban returning to power, it is perhaps unsurprising that the results of this research reflect a transition away from existing literature on established mental health patterns in the country. Respondents reported that since August 2021, the number of Afghans experiencing mental health conditions has increased rapidly due to the desperation and stress triggered by severe poverty, inflation, unemployment and debt, as the catalyst for this rapid decline. The mental health stressors previously cited as dominant – such as insecurity, injury resulting from conflict, losing a loved one to conflict, forced displacement¹⁷ – have now been exacerbated by the unprecedented political and humanitarian crisis.

Who, within the population, will be able to access mental health support? Previous research points to a general distrust of professional mental health support services and practitioners. Research conducted among urban displaced youth by Samuel Hall in 2016 found that female youth were over three times more likely to seek third-party support for their mental health than male youth.¹⁸ Respondents to this research, however, overwhelmingly positioned formal, or professional, mental health services as the most desired form of support, despite the pervasive stigmatisation of mental health conditions.

15 Miller K., ‘The Afghan Symptom Checklist: A Culturally Grounded Approach to Mental Health Assessment in a Conflict Zone’, *American Journal of Orthopsychiatry*, 76(4), 2006.

16 See annexes for referral breakdown by gender and province.

17 Kovess-Masfety V. et al, ‘A national survey on depressive and anxiety disorders in Afghanistan: A highly traumatised population’, *BMC Psychiatry*, 21: 314, 2021; Thoompail M. and Tacchi J., ‘The Impact of the Conflict in Afghanistan on Civilian Mental Health’, *Action on Armed Violence*, 1 October 2020; and Samuel Hall, *Urban Displaced Youth in Kabul*, 2016

18 Samuel Hall, *Urban Displaced Youth in Kabul*, 2016, p19.

This research shows a significant shift in perception and trust of formal Mental Health and Psychosocial Support (MHPSS) services, though it is unclear at what point over the past seven years this shift began. The consistent factor prohibiting respondents from accessing formal support was cost: cost of transportation, consultation fees and any associated prescription fees. Imams were often accessed only as a second-best to qualified doctors, where respondents had no recourse to the latter. There is a likelihood that this shift in mindset is at least partially driven by the tendency in Afghanistan to treat mental health conditions with psychiatric medication rather than counselling or other talking therapies. As Dr Wais Aria informed the research team during a KII, in contemporary Afghanistan there is a widely held belief that assistance is being provided only if medication is being prescribed.¹⁹

Though not decisive, this research also points to a potential shift in trends associated with suicide. Around 3,000 Afghans commit suicide every year in Afghanistan, with the vast majority of these being women.²⁰ More than half of these cases typically take place in Herat province.²¹ Media reports commonly cite domestic violence, absence of sufficient support for abused women, and poverty, as the primary causes of suicide and suicidal ideation in Afghanistan.²² Narratives from female respondents in Herat frequently mentioned suicide for various reasons or in varying circumstances, but in a departure from the norm, suicide among men was also regularly cited in Herat. While further exploration of this matter was outside of the realm of this research, it represents a key factor to bear in mind when formulating MHPSS programming in Herat province, as well as an opportunity for insightful future research.



Barikab, Alasghan township, Afghanistan (Credit, Samuel Hall 2022)

¹⁹ KII with Dr Wais Aria, Tabish, 3 April 2022.

²⁰ Safi S., 'Why Female Suicide in Afghanistan is So Prevalent', BBC News, 1 July 2018.

²¹ Ibid.

²² TOLO News, 'Attempted Suicide Cases, Mostly of Women, Rise in Badakshan', 16 May 2022; Hizbullah Khan, 'The families losing their loved ones to hunger suicide in Afghanistan', Prospect, 9 March 2022; and Sana Safi, 'Why Female Suicide in Afghanistan is So Prevalent', BBC News, 1 July 2018.

I. FORMS OF TRAUMA AMONG DISPLACED PERSONS

UNDERSTANDING OF MENTAL HEALTH, SYMPTOMS AND DIAGNOSES

“Mental health” is not a widely used term in Afghan society. For this reason, the tools used for FGDs and SSSIs contained a concept-checking question at the beginning. This question served a specific methodological purpose, but it also enabled researchers to develop an overview of what “mental health” means to people. Crucially, mental health in Afghanistan is understood through a relational lens, with mental health conditions often being described as a mental malfunction which disrupts the affected person’s relationships with their family, community, and others.

Respondents often viewed visible mental health disorders as dangerous, and described how they treated such people badly, often to scare them away from children and family members. Thus, broadly speaking, mental health conditions are perceived in Afghanistan as forms of brain dysfunction which prevent the individual from being able to behave in a socially acceptable manner. This understanding at the Afghan community level resonates with the definition of the American Psychiatric Association, which associates mental illness with “distress and/or problems functioning in social, work or family activities.”²³ The same organisation makes a distinction between ‘mental illness’ and ‘serious mental illness’, defining the latter as “a mental, behavioural or emotional disorder (excluding developmental and substance use disorders) resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.”²⁴ This contrasts with ‘mental health’ which should be understood as “a state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life,

can work productively and is able to make a contribution to his or her community.”²⁵

Literature produced over recent years analyses prevalent symptoms and conditions, but it overlooks what mental health means at an interpersonal, community level. A survey of fifty districts in Afghanistan conducted by the US Centre for Disease Control and Prevention found that 62% of respondents without physical disabilities and 72% with physical disabilities reported symptoms of depression;²⁶ 72% of respondents without physical disabilities and 85% of people with physical disabilities reported symptoms of anxiety; and 42% of both groups reported symptoms of post-traumatic stress disorder (PTSD).²⁷ In 2017, the World Health Organisation (WHO) estimated that over two million Afghans suffer from depression and anxiety disorders.²⁸ The following year, in 2018, the first nationwide survey, implemented across sixteen provinces was conducted on behalf of the Ministry of Public Health. The results found that 47.7% of those surveyed were suffering from psychosocial distress, with 24.3% of them badly affected.²⁹ Furthermore, of those surveyed, 36.5% of people were experiencing mild to moderate depression, while 13.4% were experiencing a major depressive disorder.³⁰ The International Psychosocial Support Organisation (IPSO) estimated that 70% of the Afghan population needed psychosocial support.³¹

There is some divergence among the most recent research-based literature concerning the most common mental health conditions in Afghanistan. In 2021, Kovess-Masfety *et al* published research which identified PTSD as being the most frequently experienced mental health condition compared with

23 American Psychiatric Association, ‘What is Mental Illness?’, August 2018

24 Ibid.

25 World Health Organisation, ‘Mental Health’, undated (accessed 7 September 2022)

26 For the definition of physical disability (within the definition of ‘disability’ more broadly) used by the U.S Centre for Disease Control and Prevention, please visit the Glossary for this report.

27 Human Rights Watch, ‘Afghanistan: Little Help for Conflict-Linked Trauma’, 2019.

28 Azad S., ‘Endless Conflict in Afghanistan is Driving a Mental Health Crisis’, Foreign Policy, 27 September 2019.

29 International Medical Corps, ‘Afghanistan MHPSS Needs Assessment Report’, 2021, p8.

30 Ibid.

31 Thoompail and Taachi, ‘Conflict on civilian mental health’, Action on Armed Violence, 2020.

other common disorders such as major depressive disorders or anxiety.³² This finding is notable considering the context, as PTSD diagnosis is rare in Afghanistan. Some sources explain this by pointing to normalisation of symptoms resulting from the widespread nature of the condition,³³ while others posit that Afghans may experience PTSD in ways which differ from models derived from research with other trauma-affected populations.³⁴ The International Medical Corps published a report based upon a survey conducted in Balkh, Laghman, Kunar and Nangarhar provinces.³⁵ The research survey found that stress, depression and anxiety are the most commonly reported mental health conditions in these provinces rather than PTSD.³⁶ It should however be acknowledged that “prior research/population-based surveys conducted in Afghanistan have found that depression, anxiety, and PTSD are highly comorbid, and symptoms of these unique conditions may mirror one-another.”³⁷

This research conducted by Samuel Hall for the IOM’s RADA programme was not concerned with diagnosis of prevalent conditions, as research teams were not composed of mental health professionals. However, researchers did discuss commonly experienced symptoms during both FGDs and SSSIs.

Anger, irritability, intolerance of noise, impatience, and inability to regulate emotions were the most frequently cited symptoms experienced by the respondents themselves. The same symptoms were also most frequently cited as those observed in family and community members. This finding correlates with reports of destruction of objects inside the home as respondent’s struggled to contain anger brought on by cumulative frustration and worry resulting from increasing debt, absence of employment opportunities and inability to provide for their families. Additionally, instances of domestic violence were reported to be extremely high. Aside from the above, **additional symptoms that were mentioned with regularity**

included: crying a lot; inability to sleep, or disrupted sleep patterns; loss of appetite; seeking isolation, even from family members; “thinking too much”; inability to concentrate; and inability to regulate emotions. Respondents commonly expressed concern at the effects of these symptoms on their interpersonal relationships, which were breaking down as a result.

MENTAL HEALTH CAUSES AND CHALLENGES

Aside from the trauma associated with experiencing war, displacement, insecurity, and violence, a confluence of factors contributes to increased individual susceptibility to mental health conditions. **Poverty and unemployment play a significant role in increasing such vulnerability, particularly for displaced people,** who disproportionately experience deprivation when compared to the broader population. Illustrating this, both men and women respondents expressed the pressures of being unable to meet their children’s needs, with one father explaining:

“Mental health problems arrive when you, as an unemployed person, return home at the end of the day. If your child, who doesn’t even have a pair of shoes, asks for something and you can’t fulfil it for him/her, then it would result in mental health problems. I face a lot of sleepless nights due to unemployment.”³⁸

The connection between nutrition and health has long been established,³⁹ while a growing body of literature also points to a connection between food insecurity and mental health conditions. Studies published in a range of countries from 2015 onwards largely concur that “food insecurity [is] significantly and positively associated with multiple indicators of psychological distress.”⁴⁰ Supporting this consensus, a study conducted among Afghan women of a reproductive age, published in 2022, found that “food insecurity was associated with

32 Kovess-Masfety et al, ‘Depressive and anxiety disorders in Afghanistan’, BMC Psychiatry, 21: 314, 2021, p10.

33 Diwakar A., ‘A Silent Mental Health Crisis Plagues Afghanistan at Home and Abroad,’ TRT World, 24 August 2021.

34 Miller K., ‘The Afghan Symptom Checklist,’ American Journal of Orthopsychiatry, 76(4), 2006.

35 International Medical Corps, ‘Afghanistan MHPSS Needs Assessment Report’, 2021.

36 Ibid.

37 Dr Qais Alemi, Mental Health Expert Consultant for the duration of this project, email received 20 July 2022.

38 FGD6: R4, (male), Herat, 24 May 2022.

39 Typing the search term ‘link between nutrition and mental health’ into Google Scholar raised 2,320,000 results (a cursory read through the first several indicated cohesion in findings), while there are thousands more articles, blogs, and reports on websites across the broader internet.

40 Myers C.A., ‘Food Insecurity and Psychological Distress: A Review of the Recent Literature’, Current Nutrition Reports, 2020.

depression, anxiety and stress.”⁴¹

Pre-August 2021 literature focused on conflict as the primary cause of mental health conditions, however the number of respondents who cited the de facto authorities (DfA) as a cause of mental health conditions was less than could have been expected. Those who did mention them often expressed significant trauma related to their encounters. Women stated that they had seen members of the DfA physically beating women in the street, and either could not stop thinking about it, or were otherwise severely affected by what they had seen. One woman relayed a story of Taliban torture of a father and his young adult son in her village. She explained that they had tortured these men within the village itself over several days, so the villagers could hear their screams. The torture was described by her as particularly gruesome, removing the eyes of the son and flaying parts of the father. Both men died according to the respondent’s accounts.

Despite the extremely traumatising nature of this event, the respondent nevertheless stated that poverty and its effects were her primary concern and the overriding cause of her current mental distress.⁴² This statement does not so much present a hierarchy of trauma, but rather illustrates the cumulative nature of mental health stressors which are currently overridden by the daily battle for survival.

Displacement itself increases mental health pressures as they impact social ties and the presence of support networks. Primary among these challenges and stressors is the fracturing or erasure of longstanding kinship and support networks. This is particularly harmful to groups who historically have relied upon land for their livelihoods, such as women and stigmatised minorities. Displacement makes it more difficult to work, to access resources and employment opportunities, resulting in increasing severity of household poverty.

Lack of tenure security – not having a home of their own – for IDPs significantly contributes to mental stress for several reasons. Several respondents stated that security of tenure would provide immense relief as they would be able to view themselves as part of the

host community, and as such, work towards building relationships with community members. Kuchi and Jogi displaced persons find themselves without recourse to housing, land and property rights, which contributes to the perception that they are transient, and therefore not worthwhile recipients of temporal and emotional investment on the part of the host community. Some communities were reported to frame all IDPs, returnees and migrants through this lens, presenting a significant obstacle to (re)integration.⁴³ Precarity of shelter was frequently cited as a mental health stressor among displaced respondents. In some cases, officials have destroyed temporary housing, while in others, unsuitable land was provided for shelter (e.g., next to a rubbish dump), contributing to feelings of insecurity.

Bullying of IDP and returnee children by host communities was sometimes mentioned, as was harassment and derogatory comments towards the displaced. These aggressive behaviours seemed to be most common when the respondent was living in a neighbourhood characterised by displaced families and temporary-looking shelter, and particularly when such shelters were on squatted land. It must be noted that such discriminatory treatment is not always the norm, but rather, seems to depend on both individual host communities combined with the ethnicity and cultural practices of both host and displaced populations. If there is a significant degree of cultural and linguistic cohesion, it appears that (re)integration is much easier.

Among the ‘dimensions of vulnerability’ to mental health conditions identified by researchers in Afghanistan, membership of non-Pashto ethnic groups – particularly ethnic groups which are minorities, has been recognised. **This increased vulnerability of marginalised groups to mental health conditions, particularly non-Pashto groups**, was evident in the data generated through SSSIs with stigmatised groups such as the Jogi, Kuchi, and to a lesser extent, Pashae. For IDPs and returnees of these social groups, (re)integration was particularly challenging in certain host communities due to the perception that they are beggars, thieves, or otherwise ‘dirty’ (as in the case of the Jogi), or criminals, terrorists, and bandits (as in the case of the Kuchi). Furthermore, Afghan society often perceives the Jogi as originating

41 Zahidi F. et al, ‘Associations Between Food Insecurity and Common Mental Health Problems Among Reproductive-Aged Women in Kabul-Afghanistan’, *Frontiers in Nutrition*, January 2022, p1.

42 SSSI21, Taimani female IDP, Herat, 24 May 2022.

43 SSSI17, male IDP, Nangarhar, 15 May 2022.

outside of Afghanistan; as such, many Afghans resent the Jogi receiving aid or assistance of any kind.⁴⁴

Existing literature implies that depression and anxiety are more prevalent among women.⁴⁵ As a demonstration of this, in 2018 the Afghan Independent Human Rights Commission reported that approximately 3,000 Afghans attempt suicide every year, with around 80% of these attempts made by women.⁴⁶ In 2021, OCHA reported that 78% of women, particularly IDP women, experienced adverse mental health effects from the ongoing conflict.⁴⁷ The well-documented correlation between displacement and escalated violence against women resulting from increased stress and erosion of support networks likely plays a contributing role in the gendered nature of mental health conditions.⁴⁸ Indeed, in December 2021 UN Women reported that 87% of Afghan women have experienced intimate partner violence,⁴⁹ while the data generated through this research indicates that this number is likely to be far higher, particularly among displaced families.

Gendered patterns of disadvantage among IDP and returnee women are long-established in Afghanistan, though likely exacerbated by the current humanitarian crisis. Economic isolation resulting from rural women's absence of transferable skills for urban environments can have an extremely detrimental impact on the broader resilience of IDP women. For example, research published in 2014 found that employed male IDPs earned, on average, forty-three times more than female IDPs.⁵⁰ Contributing to the negative mental health effects of this economic isolation is social isolation, with IDP and returnee women commonly suffering from a combination of severed support networks, reduced mobility and labour opportunities (particularly if unskilled in terms of the urban labour market), increased violence within the home, and a reification of social relations detrimental to women, as men and households struggle to adjust to new environments.⁵¹

Despite a clear trend in gendered symptoms and conditions, respondents' conceptions of whether women or men currently face the most challenges to their mental health were mixed.⁵² Among respondents, the overall consensus was that society is more sympathetic towards men with mental health conditions than women. This was largely understood to be the result of men being responsible for providing for their family, which in the current humanitarian crisis is near impossible. In contrast, women with mental health conditions were often perceived as being lazy, and were often mocked, or gossiped about. This was reflected in the gendered dimensions of access to mental health support reported by both men and

KEY FINDINGS ON GENDERED DIFFERENCES IN MENTAL HEALTH

Displacement combines with economic and social isolation to disproportionately affect women, and displaced women who suffer from reduced resilience as a result of severance from support networks.

Female IDPs and returnees experience economic isolation during displacement and return, particularly if they are low skilled in terms of the urban labour market, which often also leads to being exposed to greater incidences of domestic violence.

Literature indicates that Afghan women are more susceptible than men to depression and anxiety. Narratives of respondents supported this. Men are often perceived to be more justified in experiencing mental health conditions than women.

44 SSSI7, Jogi female IDP, Kabul, 15 May 2022; SSI5, Kuchi male cross-border returnee, Kabul, 15 May 2022; enumerator note "Host community believes Kuchi's are not trustable people. they are always moving from one place to another and they have the background of being terrorists and thieves."; SSI18, Kuchi male returnee, Nangarhar, 14 May 2022; SSSI9, Pashae female IDP, Nangarhar, 15th May 2022.

45 Ashna M., 'Stigma and Taboos: The Absence of Mental Health Awareness in Afghanistan,' The Khaama Press News Agency, 10 March 2019.

46 Azad S., 'Conflict is Driving a Mental Health Crisis,' Foreign Policy, 2019.

47 OCHA, 'Humanitarian Needs Overview 2021: Afghanistan,' p88.

48 Ross-Sheriff F., 'Contagion of Violence Against Refugee Women in Migration and Displacement,' 2013, Majidi N. 'Displacement and Violence Against Women in Afghanistan,' Forced Migration Review, 2014, p34.

49 UN Women, 'Gender Alert No.1, Women's Rights in Afghanistan: Where are we Now?,' December 2021.

50 Majidi N, 'Resilience in Displacement? Building the Potential of Afghan Displaced Women,' Journal of Internal Displacement, 4(1), 2014, p81.

51 Ibid.

52 It should be noted here also that the above literature cites research which was carried out prior to August 2021, and therefore does not accurately depict the current mental health crisis in Afghanistan, which is now extremely widespread.

women. Overwhelmingly, both men and women reported that professional mental health support was the most desired form of assistance, but its cost proved to be prohibitive. Some respondents reported that their families were too poor for either men or women to access professional support, in which case both would often refer themselves to their local Imam. However, in other families, men were much more likely to access professionals than women, with women more likely to visit their local Imam.

Correspondingly, some respondents stated that women with mental health conditions are more likely to be beaten inside the home by their husbands and other relatives, whereas men with mental health conditions will only be beaten by male community members if they have destroyed community property. The community often believe that if a man has mental health conditions it is “God’s will”, without extending this degree of understanding or sympathy to women. Nonetheless, some respondents (both men and women) believed that men and women with mental health conditions are treated poorly by the community, and this is perhaps best summarised by a Pashae IDP, who stated that people with mental health are not valued by society.⁵³

Trends since August 2021

The effects of the Taliban assuming the position of DfA in August 2021 have had far-reaching and complex consequences which affect different population demographics in different ways. Across demographic categories, however, patterns have emerged which reflect a rapid decline in mental health. Respondents unanimously agreed that community mental health has significantly declined since August 2021, despite the perception of almost complete eradication of publicly visible conflict and violent crime. One male FGD respondent stated that, whereas prior to August 2021 most households contained one person who was suffering a mental health condition due to the war, now everybody was suffering from mental health

conditions as a result of poverty, unemployment, inflation and debt.⁵⁴ Building upon this, a respondent in Nangarhar pointed to how the previous national army was an important source of income for poor families, but with the collapse of the former government, these opportunities evaporated.⁵⁵

Exacerbating the crisis is the absence of development aid in many communities. Prior to August 2021, though prey to corruption and nepotism, aid organisations were accessible. In contrast, immediately after the events of August 2021, OCHA reported that 54% of humanitarian partners had paused or suspended their programmes. There is currently no clear data on the proportion of partners that have resumed activities, or in what capacity.⁵⁶

Women have faced particularly harmful challenges since August 2021. Female-headed households’ mental health has been dually impacted by the combination of severe poverty alongside restrictions on women’s rights, notably their ability to generate an income.⁵⁷ All female respondents spoke of the negative impact the economic climate is having on their mental health. For women who worked laundering clothes, cleaning, breaking peanut shells and other such roles, restrictions on women imposed by the DfA have severed them from their means of income generation, as they are no longer able to move around their communities freely; often, former wealthy employers have migrated. The women spoke of the pain they feel when confronted with the hunger experienced by their children, knowing that they can do nothing about it.

Additionally, a rise in domestic violence resulting from mental health conditions expressed through anger has had a negative impact on women. While such violence perpetrated by men against women was often spoken of by men purely in terms of it being an expression of their declining mental health and commensurate inability to control their anger and frustration, in some cases it was articulated as a positive element of the changes since

53 SSSI9, female Pashae IDP, Nangarhar, 15 May 2022.

54 FGD5: R4, male, Nangarhar, 14 May 2022.

55 SSSI8, female Pashtun cross-border returnee, Nangarhar, 15 May 2022.

56 OCHA, ‘Humanitarian Needs Overview Afghanistan: 2022,’ p25

57 Since August 2021, the Taliban have issued edicts such as banning women from governmental employment; prohibiting women and men working together in the same physical space, prohibition from attending secondary schools; and requiring a mahram if travelling more than forty-five miles. Additionally, women must attend services such as health clinics in the company of a mahram. Despite these institutionalised changes, geographic differences continue to exist in restrictions placed upon women, with particularly conservative communities often remaining relatively unchanged by the Taliban’s return to power. In some rural communities where women and men used to perform agricultural roles together, this is no longer allowed, whilst in other communities, women are able to move around relatively unhindered, though their opportunities have been dramatically restricted.

August 2021. Several male respondents in Herat for example, lamented the economic catastrophe that was triggered by the Taliban regaining control, but on the other hand, they cited a positive outcome being that they could now control their family through violence without any repercussions.⁵⁸

This rapid decline in mental health and corresponding rise in domestic violence is doubly harmful for children. While men reported beating their wives – violence which is very likely witnessed by children – both men and women reported beating their children, sometimes brutally. Women in particular reported administering beatings to their children on a near daily basis. One woman reported that she had caused her son serious physical injury by beating him,⁵⁹ while another respondent witnessed the aftermath of a neighbour beating her child to death.⁶⁰ The prevalence of women beating children was explained by women as the result of their intolerance of noise, irritability and anger, which left them unable to cope with their children, particularly when confined to the home.

Girls and boys are also affected in specifically gendered ways. For girls, who are unable to access education, and whose realm of opportunities outside of the home has now been erased, a loss of hope is common. Many respondents, especially women, pointed to girls as having a uniquely negative mental health experience since August 2021. Respondents pointed to how the lives and futures of girls have been badly impacted by Taliban edicts, while additionally explaining that girls are very unlikely to talk about their mental health struggles or feelings outside of the home (and even then, only to select, trusted individuals) for fear of ruining their marriage prospects. **Girls fear that if people in the community find out that they have mental health conditions, they will either be unable to command a good dowry or will be deemed to be completely unfit for marriage, rendering them particularly vulnerable in the event of their parents' death.** This concern regarding marriageability represents an additional stressor, exacerbating the rapid decline in mental health

among girls since August 2021. Boys are growing up in an environment where there is little hope for the future of Afghanistan, and little indication that they will be able to find work when they are older.

Families are increasingly relying upon negative coping mechanisms to ensure the survival of household members. Child marriage has risen dramatically since August 2021,⁶¹ with families selling young daughters to cover basic needs in a context characterised by inflation, unemployment, and absence of aid, and for their daughters to have a chance to survive food insecurity. Such coping mechanisms negatively impact the mental health of the children and cause psychological distress for the parents, who often feel they have no other choice. Although host community members are also affected by the current humanitarian crisis, IDPs and returnees are more vulnerable in that they are removed from traditional support networks, and face greater barriers to accessing resources and employment.⁶²

The post-August 2021 economic decline and resulting humanitarian crisis have hit men in a very specific way, as they are now unable to fulfil their socially prescribed role as the sole provider for their families. In Herat particularly, this appears to have resulted in a significant increase in suicidal ideation and suicide among men. Male respondents detailed how they have developed symptoms of mental health conditions (particularly anger, irritability, disrupted sleep patterns, and physically lashing out at family members) due to the current economic climate. Illustrating this trend is the narrative of an IDP man exhausted by being unable to either provide for his family or fulfil other social obligations such as attending funerals. He explained:

“There have been times that I have brought rat poison in the house [for committing suicide]. I don't want people to remember me with nasty names due to this living condition...I have seen many people in bad condition. For example, they wanted to kill their entire family members by giving them rat poison.”⁶³

58 FGD6, male IDPs, returnees and host community, Herat, 24 May 2022.

59 SSSI7, female Jogi IDP, Kabul, 15 May 2022.

60 SSSI2, female Tajik IDP, Kabul, 11 May 2022.

61 UNICEF USA, 'Girls Increasingly at Risk of Child Marriage in Afghanistan', 12 November 2021; Amnesty International, 'Afghanistan: Death in slow motion: Women and girls under Taliban rule', July 27, 2022

62 Nassim Majidi, 'Resilience in Displacement' Journal of Internal Displacement, 4(1), 2014.

63 SSSI22, male Pashtun IDP, Herat, 29 May 2022.

Corroborating this emerging trend in Herat, a province which is notorious for extremely high rates of suicide among women, a female IDP respondent stated her belief that men are now more likely to commit suicide, because they cannot endure unemployment.⁶⁴

In our interviews, drug abuse rates were reported to have risen exponentially since August 2021, largely due to a sense of despair among men at being unable to provide for their families, within their socially constructed roles in Afghan society. Respondents explained that in response to the current economic situation in Afghanistan, some men turn to drugs (which are heavily stigmatised in Afghan society), whereas others, particularly younger men, were attempting to migrate to Iran and Pakistan for work. Several respondents reported that young male relatives who had attempted irregular migration to Iran had been caught by border police, badly beaten, then forcibly returned to Afghanistan. In such instances, substance abuse becomes a negative coping mechanism born of despair and shame. This was a significant concern for respondents and a frequently discussed theme throughout FGDs and SSSIs. A respondent in Kabul talking about mental health conditions in the community, succinctly stated that:

“Everyone has mental, stress and distress problems. It is directly related to [poor] living conditions, political issues, unemployment and [lack of access to] education. Most of our youth are addicted to drugs.”⁶⁵

While in Kabul and Herat most respondents spoke of a trajectory of substance abuse which began with marijuana and escalated over time towards opium, in Nangarhar, several respondents reported that ‘Tablet-K’, a methamphetamine, was the drug of choice among young men.

Beyond the physical trauma, the mental health impacts of being contained within the borders of Afghanistan, with no legal recourse for migration, can have an enduring impact on mental health, notably among those experiencing rounds of rejection and forced returns, and among women left behind. After the fall of Kabul in August 2021, the irregular passage of Afghans to Iran dramatically increased: records show that 63% of exits in 2021 towards Iran took place after August 2021. However, these passages imply elevated risk and traumatic events, as reported by Amnesty International – including Afghans unlawfully returned after coming under fire at borders.⁶⁶



Barikab township, Afghanistan (Credit: Samuel Hall 2022)

64 SSSI21, female Taimani IDP, Herat, 24 May 2022.

65 FGD3: R6, male host community member, 11 May 2022.

66 Amnesty International, 'Iran/Turkey: Fleeing Afghans unlawfully returned after coming under fire at borders', August 31, 2022.

II. RESPONSES TO MENTAL HEALTH: TREATMENT AND SUPPORT

This section explores prevailing social attitudes towards mental health conditions before analysing the ways in which respondents accessed, or articulated, their preferred form of mental health support. Mental health and psychosocial support (MHPSS) should be understood as comprising three categories: institutional support incorporating broader MHPSS planning typically at the governmental and organisational level; community support, consisting of various approaches to community development provision; and individual support, which this research report refers to as peer support.

ACCESS TO FORMAL MENTAL HEALTH SUPPORT

In the current context, ascertaining how many people access formal mental health support is extremely difficult. In 2015, fewer than 10% of Afghans were thought to be accessing formal mental health support,⁶⁷ with this number likely to have decreased dramatically since the Taliban takeover. A survey commissioned by the EU in 2018 found that 88% of respondents never sought mental health support, despite half of them having experienced a mental health condition.⁶⁸ Of the 12% who had sought support, 47% had consulted a doctor, 36% had consulted community health workers, and 17% had consulted their Imam.⁶⁹ However, Imams can perpetuate stigmatisation of mental health conditions, which in some cases they present as possession of the individual by evil spirits. As an illustration of this, one respondent stated:

“My daughter-in-law also has mental health problems and she sometimes goes to the Imam [who tells her] ‘let’s see whether someone has witch-crafted or done black magic on you or not?’ and then the Imam entreats her and gives her an amulet and tells her to... hang it from her neck.”⁷⁰

This research provided mixed results in terms of access to formal support, with socio-economic background, culture, age, and physical location all salient factors. Importantly for those living in rural areas, most qualified mental health staff are based in city hospitals rather than community clinics. City hospitals were too expensive to

access for many respondents due to transport costs, and consultation and prescription fees. Where doctors were consulted for mental health conditions, they were sometimes visited secretly due to stigmatisation, but in other cases no such mention of secrecy was made. Several women respondents were taking prescribed medication; mostly antidepressants with a lesser number prescribed anti-anxiety medication.

Data generated through this research reflected the long-standing neglect of sustainable MHPSS provision for both displaced populations and host communities. Although a few respondents mentioned that mobile health clinics used to provide sporadic mental health support, most respondents had never had access to formal mental health provision. Younger people were more open about mental health conditions, with young men more likely to take their wives to seek professional mental health support if they could afford it. There was a consensus among respondents that if finances allowed, doctors would be the first choice of mental health support accessed, but due to their cost, many sought advice from their Imam instead. Respondents provided mixed reports on the perceived efficacy of doctors and Imams in relation to alleviating mental health conditions, but it was suggested several times that each avenue of support was complementary to the other. Mobile health teams visited some communities prior to August 2021. Respondents found this service helpful and wished for their return because of the prohibitive costs of attending clinics and hospitals outside of their communities.

67 Ministry of Public Health: Mental Health and Substance Abuse Department, 'National Strategy for Mental Health 2019 – 2023,' p6.

68 Human Rights Watch, 'Afghanistan: Little Help for Conflict-Linked Trauma,' 2019.

69 Ibid.

70 FGD5:R3, male, Nangarhar

MENTAL HEALTH TREATMENT AND SUPPORT

The majority of respondents voiced a desire for mental health support provided that it is culturally sensitive, accessible, and free of charge. Men often advocated for MHPSS provision via a community health clinic permanently situated within their community, or operating on a mobile basis, delivering support on certain days of the week. Women, however, were more aware that restrictions on their movement may render access to such generalised provision impossible. Instead, they frequently advocated for gender-specific mobile health teams who could operate on an outreach basis either visiting women door to door, or delivering support from the community mosque.

Key informants interviewed for this research unanimously agreed that MHPSS provision would be most effectively delivered if integrated into other assistance and service provision such as distributions and WASH, as this enables people to access MHPSS discreetly, and thus navigates the stigma attached. Overwhelmingly, respondents advocated for a holistic approach to improving mental health, combining MHPSS with poverty alleviation through increased job opportunities and livelihood generation. Importantly, greater emphasis was placed on the latter, with several respondents explaining that without poverty alleviation and income generation, any mental health support would be limited, given that severe hardship was the cause of mental health conditions for so many. Supporting this sentiment, the technical expert who consulted during this research also emphasised the need for a strong economic component to be integrated throughout any MHPSS provision.

Given the degree of trauma, and the widespread nature of mental health disorders experienced by Afghan communities, any MHPSS provision should be long-term. It will be crucial that donors commit to multiple generations, particularly as children have been subjected to so much violence as a result of their parent's mental health issues.

Community perspectives on mental health

Respondents felt that their society stigmatised people with mental health conditions: people were often ridiculed, humiliated, and framed as dangerous. One respondent mentioned knowing of a person with a mental health disorder whose family kept him chained up so he was unable to get out and “disturb others.”⁷¹

For IDPs and returnees treated with hostility by the host community, they faced double discrimination; they may have been harassed and verbally abused for their displaced status, and then experienced additional harassment for any obvious mental health conditions.⁷² While it seemed that only those with visible mental health disorders were ostracised, it appeared that anybody with a recognised mental health condition

was excluded from all decision-making processes, regardless of how insignificant. For example, one male IDP respondent stated that his friends would not listen to his opinion on where they should go for an *Eid* picnic because he had mental health conditions. He recounted that they responded to his suggestion by saying “**why are you talking? You are crazy.**”⁷³ This exclusion from decision-making processes was true at the household and community levels, and contributed to persons with mental health conditions internalising the idea that they were ‘mad’ or ‘crazy’. Furthermore, respondents stated that negative behaviour towards them based on their poor mental health increased their sense of isolation, resulting in intensified feelings of depression, irritability and anger.

Social stigmatisation of mental health conditions presents a significant barrier to people seeking

71 FGD7: R1, female IDP, Herat, 24 May 2022.

72 Respondents did not articulate what for them, distinguishes between obvious, or visible mental health conditions in contrast to the mental health conditions that most of them reported experiencing. The technical expert who consulted on this research notes that such visibility could be as small as physical tick or inability to regulate emotions in public.

73 SSS117, male Pashtun IDP, Nangarhar, 15 May 2022.

support at the family, community, and formal level. Most respondents stated that they were very careful about who they talked to about their mental health conditions, with many confiding only in close family members, Imams, and if they could afford it, doctors. Some respondents experienced a great deal of mental anguish but were scared of community members finding out. As a female respondent in Nangarhar explained:

“I haven’t received any assistance for suicidal thoughts because we are Pashtuns and when we mention something like suicidal thoughts or attempts with someone, or that I have such thoughts, they will think that I am mad and instead of helping me, they will tie me with chains because they will think that I will harm myself or others in the family because those people who think about suicide are mad.”⁷⁴

In cases where mental health support has been available, persons with disabilities are often excluded:

“A couple of times mental health-related sessions were conducted in our area, but I didn’t participate in them [because] I have a disability and I am not able to walk alone.”⁷⁵

At the individual level, peer support varies

Many respondents equated ‘peer support’ for mental health conditions with providing financial assistance to alleviate the perceived economic causes of such

hardship, indicating that no other form of mental health support was practised or accessible at the community level. Again, many respondents stated that financial assistance would have been widely provided by community members prior to August 2021, but due to the pervasive and widespread nature of the humanitarian crisis, few people were able to contribute financially or materially to assist their community members. In cases where the host community was also suffering from extreme deprivation and resource scarcity, such peer support through financial assistance is even less likely to be available, as every household is focused entirely upon its own survival.

Despite these circumstances, there were a small number of cases where material assistance was provided, and in turn recipients experienced a significant, albeit short-term, psychological relief. For example, a Pashae IDP in Nangarhar described how her family’s landlord, upon realising their dire financial situation, halved their rent, before reducing it by a further 500 AFN (\$5.60).⁷⁶ Additionally, a Jogi IDP described how a former employer, upon seeing the poor conditions in which her family lived, now assists her family financially whenever they can.⁷⁷ Such examples were rare, representing instances of host community members assisting IDPs. For IDPs, they uniformly stated that they absolutely did not have the resources to assist other IDPs materially, no matter how much they wished they could.



Health clinic in Barikab township, Afghanistan (Credit: Samuel Hall 2022).

74 FGD4: R1, female, Nangarhar, 14 May 2022.

75 SSSI16, Pashtun IDP, Nangarhar.

76 SSSI19, female Pashae IDP, Nangarhar, 15 May 2022.

77 SSSI17, Female Jogi IDP, Kabul, 15 May 2022.

III. BARRIERS TO MENTAL HEALTH AND (RE) INTEGRATION

DEFINITION OF SUSTAINABLE REINTEGRATION

“Reintegration can be considered sustainable when returnees have reached levels of economic self-sufficiency, social stability within their communities, and psychosocial well-being that allow them to cope with (re)migration drivers. Having achieved sustainable reintegration, returnees are able to make further migration decisions a matter of choice, rather than necessity”. – IOM 2017

(RE)INTEGRATION CHALLENGES AND MENTAL HEALTH

The effects of displacement and return on mental health are under-researched, particularly within the context of Afghanistan.⁷⁸ Feelings about (re)integration among IDPs and returnees varied significantly, being entirely dependent upon context in terms of the degree of ethnic, cultural, and linguistic (in)cohesion between host and displaced populations. Incompatibility of ethnic groups or tribes often resulted in failure to understand each other’s customs, therefore presenting significant obstacles to reintegration. In circumstances where resources are scarce, the need for cohesion becomes increasingly pronounced, though less likely to occur, with fractured support networks rendering IDPs and returnees unable to access the basic resources required for material integration. Several respondents of a different ethnicity or language group to the host community or other IDPs and returnees reported feeling lonely and alienated as result of their severance from their traditional support networks.

A great deal of emphasis was placed on the relational nature of (re)integration with respondents viewing it as having a dual dynamic. Respondents frequently recognised that (re)integration is not simply down to what the individual displaced person feels, but how the host community feels about them also. In circumstances where displaced and host populations enjoyed a greater degree of cohesion, respondents continued to express a lack of certainty or positivity about the prospect of (re)integration.

Income and livelihoods

Economic concerns tended to override all others and centred around sheer survival. Overall, respondents identified the biggest obstacle to (re)integration as absence of employment opportunities or other forms of income generation. For IDPs and returnees particularly, their displacement has severed them from support networks and access to resources, rendering them increasingly precarious. For such families, escalating debt has been the primary means of survival, which in turn contributes to a decline in mental health, as many reported that lenders regularly approach them for payment. For many displaced respondents, the combination of precarious shelter and absence of livelihood prevents them from being able to imagine (re) integration. Compounding this in some communities is tension between the host community and the displaced.

Community perspectives

Social concerns about (re)integration often centred around the host community’s negative perceptions of displaced populations in conjunction with a broader fracturing of society. Such prejudice and negativity was exacerbated if the displaced were members of stigmatised minority groups. A respondent in Nangarhar eloquently described what he perceives to be the key challenge to reintegration, pointing out how displaced communities are perceived as transient, even if they do not wish to be. This perception discourages host community members from emotionally investing in displaced households among them, serving to perpetually alienate IDPs and returnees. The narrative

⁷⁸ Samuel Hall is currently conducting research into global mental health on behalf of the IOM. This forthcoming research report will address this gap in the literature.

below effectively demonstrates the need to deliver MHPSS alongside shelter, livelihoods, and broader community development:

“I will say one thing that this is hardly possible. I don't believe that we will get together in society again because we have lost everything. We should think on how to assemble back in society, but the knowledge that is required for getting together, we don't have. The place we are living in, they think of us as migrants. They regard us as strangers. Those who are the original residents of this area don't give us a share in aid and assistance. They don't respect migrants because they think that these migrants will be here today, but tomorrow they won't be.”⁷⁹

Basic services and shelter

Respondents shared their belief that provision of basic services within a broader package of community development would assist with both improving mental health and fostering social cohesion simultaneously. Language classes were given as a potential vehicle to facilitate improved relations and foster (re)integration, which in turn would contribute to improved mental health.⁸⁰ Access to schools was also a salient factor when considering feelings towards and outcomes of (re)integration. Respondents who had no access to schools in their host communities were more likely to feel like strangers to the community. Conversely, where

NO DURABLE SOLUTION WITHOUT MENTAL HEALTH SUPPORT: COMMUNITY HEALTH ON THE DECLINE IN AFGHANISTAN

WHO describes community health as the environmental, social, and economic resources to sustain emotional and physical well-being among people in ways that advance their aspirations and satisfy their needs in their unique environment. This research finds that such resources are inaccessible, and that community health is on the decline.

Employment opportunities, livelihood generation, and provision of suitable shelter should be prioritised as fundamental components of any MHPSS support.

In a displacement landscape in which symptoms commonly consist of irritability, anger, violence, and inability to control emotions, many respondents reported that they constantly quarrelled with neighbours, had little patience with people, sought isolation, and physically lashed out at family members. Such a context illustrates fractured communities and damaged family bonds. MHPSS support will be crucial, provided that it is implemented in a holistic manner, incorporating strong economic and social cohesion components.

Key to the success of MHPSS in facilitating (re)integration will be that support and services are available to the host community as well as IDPs and returnees. The host community is likely to require MHPSS support due the current humanitarian crisis, while this approach will reduce tension between the communities and provide venues in which different demographics can come together and begin to build relationships.

Accessibility is vital. Women, persons with disabilities, and stigmatised minorities must be able to access any programming or support as (re)integration is impossible unless positively experienced by all.

Durable solutions cannot be achieved in the short term. Nor can mental health. **(Re)integration success, like success in achieving durable solutions, relies upon long-term funding and programming commitment.** An integral component of any durable solutions and/or MHPSS programming will be an evidence-based, culturally sensitive approach to dismantling the stigma associated with mental health conditions. While this stigma exists, (re) integration could remain an insurmountable challenge, while poor mental health in both host and displaced communities will obstruct healthy, interpersonal relationships.

79 SSSI17, male Pashtun IDP, Nangarhar, 15 May 2022.

80 SSSI7, Jogi IDP woman, Kabul, 15 May 2022.

respondents were not living on squatted land and did not have access to schools, they tended to report much more positive, hopeful feelings about (re)integration. Schools facilitated relationship building and social cohesion through simple avenues such as children getting to know each other, then walking with each other to school, enabling parents to form bonds also.⁸¹

“If children had access to a nearby school, then they would be able to grow up in the same environment. This can, in turn, boost their motivation. Similarly, if the men were given job opportunities in the community, then they can easily get acquainted with each other. The same applies to women. They [women from different communities] can talk and tell each other stories. This is the first step for people to get acquainted with each other.”⁸²

Provision of shelter in the host community plays a significant role in feelings towards, and outcomes of, (re)integration. Respondents consistently articulated a **sense of precarity and enforced transience resulting from inadequate or temporary shelter**. This was particularly the case where the displaced community comprised stigmatised minorities, or shelters built on squatted land. In such cases the local authorities and host community had often made repeated attempts to evict them, making the IDPs and returnees feel unwelcome and unable to ever integrate:

“I feel difficulty integrating into this community because the places where we live belong to the municipality. A week ago, some people came from the authorities and insisted that we evacuate this place. The host community doesn't like us and blames us for creating insecurity, pollution, and disturbance.”⁸³

Such barriers to (re)integration left respondents feeling that they were perpetually stuck in a survival mode. Some respondents reported that their children were bullied due to their displacement status, in some cases to the point where parents no longer asked them to collect water from the village pump, or decided to remove them from school. Such bullying behaviour appeared to be most common where IDPs lived on squatted land.

Discrimination

Obstacles to integration become more challenging where stigmatised minorities are part of the displaced population. Peace of Mind Afghanistan explained during a KII that:

“Discrimination can affect access to- and acceptance in- displacement camps, access to health services, lack of accountability for those who commit violence against them. Vulnerabilities increase in displacement for ethnic minorities, those with disabilities, and women and children, at greater risk of trafficking and sexual and gender-based violence.”

Stigmatised minorities such as Kuchi, Jogi and Pashae are particularly susceptible to mistreatment and exclusion during displacement, which significantly impacts their ability to access resources and services, and (re)integrate. Additionally, Jogi are commonly perceived as originating from outside Afghanistan, so other Afghans often resent them for being provided with aid or assistance. This discrimination is not uniformly practiced, but it is widespread and socially entrenched; such additional mental health stressors significantly restrict the ability of stigmatised groups to (re)integrate.

Diagnosis and treatment

Finally, the consequences of an absence of diagnosis, or lack of adequate treatment and support for individuals with mental health conditions are damaging. Peace of Mind Afghanistan explained that **“prolonged exposure to trauma causes inability to regulate emotions. Research shows untreated mental health leads to increased risk of psychosis, radicalization, being subject to abuse, unnecessary disability,⁸⁴ unemployment, substance abuse, homelessness, [and] inappropriate incarceration.”** This cautionary note illustrates the seriousness of absence of diagnosis and treatment, both for the individual, and in terms of (re)integration. Until MHPSS is delivered in an easily accessible, long-term, holistic manner, (re)integration is unlikely to be successful.

81 SSSI2, Tajik IDP woman, Kabul, 11 May 2022.

82 SSSI6, Tajik IDP woman, Kabul, 15 May 2022.

83 SSSI5, male Kuchi IDP returnee, Kabul, 15 May 2022.

84 Within the context of this quote, “unnecessary disability” refers to forms of preventable disability resulting from placing oneself in physically risky situations due to impaired judgement or inability to regulate emotions, as well as consequences of deteriorating physical health resulting from inability to adequately care for oneself.

CONCLUSION

This research shows a rapid decline in mental health in Afghan society – at individual and community levels. Both host communities and displaced populations have been hit extremely hard by the deterioration of the Afghan economy and corresponding humanitarian crisis. Although IDPs and cross-border returnees are particularly impacted by the current situation, the shared needs of the population present an opportunity to provide assistance in a holistic, area-based approach, to improve social cohesion at a time of fracture.

Negative coping mechanisms employed by families as they attempt to survive are having a significant traumatic impact on all family members, with girls disproportionately affected. Every demographic of Afghan society has been impacted by the humanitarian crisis, in gendered, and age-specific ways. Men are no longer able to fulfil their socially constructed role as provider for their families, causing severe mental distress. Women are unable to sufficiently care for their families, and must watch their children go hungry. They are subjected to increased levels of domestic violence. Children are watching these higher levels of domestic violence within their homes, whilst also being beaten themselves. Girls are unable to access secondary education in most parts of the country and their future looks bleak. For boys too, a potential lack of opportunity in the future looms large.

In a context where mental health conditions are heavily stigmatised, it is impossible for Afghans to speak about what they are feeling or experiencing openly. Professional support is scarce and often rendered inaccessible due to prohibitive costs. As mental health conditions worsen and society becomes increasingly fractured, (re)integration will become increasingly difficult to achieve.

Afghans, and particularly displaced Afghans, are in dire need of mental health support, but given that the primary driver of poor mental health is the current humanitarian crisis, a holistic approach will be required if long-term mental health improvement is to be sustainably achieved. Such an approach may incorporate sustainable steps towards poverty alleviation alongside improved social cohesion.

RECOMMENDATIONS

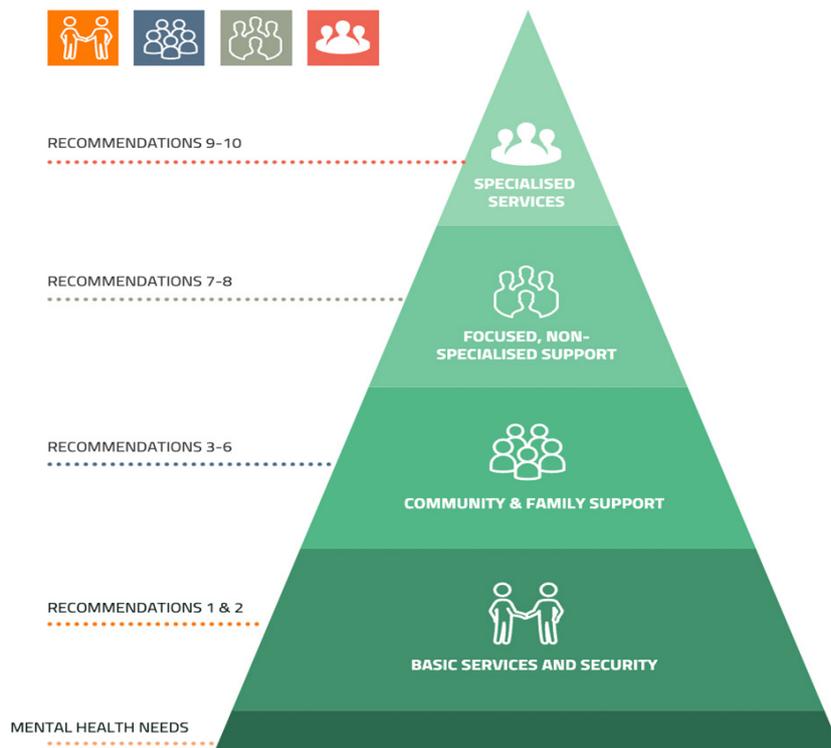


Figure 1. IASC intervention pyramid for MHPSS support in Afghanistan

The recommendations are presented following the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings. The figure below presents the intervention pyramid as recommended by the IASC guidelines, with this brief's ten recommendations.

BASIC SERVICES AND SECURITY

1. **View (re)integration support holistically.** MHPSS should comprise one component of (re)integration assistance, but additional components should focus on building social cohesion through provision of language classes, women's centres, schools, community centres, etc. Provision of adequate shelter, accessible MHPSS support, accessible livelihood generation and community sensitisation campaigns about mental health will likely comprise key aspects of any programming.
2. **Integrate MHPSS programmes into community development, livelihood generation, and WASH and other health projects, or design MHPSS programming with strong economic and social cohesion components.** Integration of MHPSS into other thematic areas of programming increases accessibility for beneficiaries, as it enables more discrete access to MHPSS in light of the stigma associated with mental health conditions and MHPSS support. Women-only spaces used for provision of WASH or legal counselling provide a particularly useful venue for MHPSS support which is accessible for women.

A successful example of this approach is seen in the work of the International Medical Corps in the Central African Republic (CAR). Recognising the serious mental health needs of populations in conflict-affected areas of CAR, but also acknowledging the insufficient number of mental health professionals in the country, the International Medical Corps integrated MHPSS into general healthcare provision. General healthcare providers (including health assistants, nurses, doctors, traditional birth attendants and community health workers) working with conflict-affected populations were given training on identification, treatment, and management of common mental health conditions. Before the training was delivered, the majority of mental health patients had epilepsy and were self-referred. After the training, the diagnoses of mental health conditions rose, with those conditions treated alongside a community sensitisation campaign.⁸⁵

COMMUNITY & FAMILY SUPPORT

3. **Communities should be consulted on the best means of delivering MHPSS support to them: women and people with disabilities should proactively be consulted on how best to ensure accessibility for them.** Crucially, MHPSS programming will need to be free of charge and delivered within the community (for example, through mobile health teams) to avoid prohibitive costs which significantly reduce accessibility, particularly for women.
4. **Stigmatised minority groups face unique mental health and (re)integration challenges. The onus should not be placed on stigmatised groups to (re)integrate, but rather, on improving social cohesion.**
5. **Build on existing community and social dynamics. Where Mullahs, Imams and community elders are relied upon for mental health support, training on mental health conditions and psychological first aid should be provided to these individuals.** Additionally, these religious and community leaders should be informed and trained on referral pathways for free MHPSS services and mobile MHPSS sessions. A programme that has been rolled out in Sudan by the World Health Organisation demonstrates how this can be effective, as providing community leaders and gatekeepers with training can ensure community buy-in, whilst adopting a 'Training of Trainers' approach can ensure that the benefits of psychological first aid are more widely accessible.⁸⁶

85 IASC, [Guidelines on Mental Health and Psychosocial Support in Emergency Settings](#), 2007

86 Davin Mpaka Mbeya et al, 'Integrating Mental health into Primary Healthcare in the Central African Republic', Humanitarian Practice Network, 5 July 2018

6. De-stigmatisation of mental health conditions through local-level community campaigns will be key to both facilitating access to MHPSS support, and encouraging (re)integration. Particular attention should be paid to addressing gender differences surrounding mental health stigma. Community and religious leaders should be consulted as part of this process and encouraged to participate. Messaging should be adapted to be culturally and politically sensitive. For example, framing mental health as an issue of family and community health; and raising awareness about likely causes and triggers among men, women, boys and girls to reduce perceptions that women ‘do not have a justifiable reason’ to be suffering from mental health conditions.

FOCUSED, NON-SPECIALISED SUPPORT

7. Address the specific needs of women, men, girls, and boys. Holistic MHPSS programming should respond to the distinct mental health challenges experienced by different population demographics. Women and children will require a great deal of assistance to recover from increased levels of intimate violence, aside from broader economic and social cohesion programming components. **Group MHPSS sessions should be provided for both men and women to address the causes and consequences of domestic violence.** Such groups should promote the family unit as a cohesive entity in which husband and wife play equally important roles and have different, but equally important responsibilities and burdens.

8. **Conflict and gender sensitivity should be ensured throughout design, implementation, and evaluation.** Such sensitivity will be dependent on comprehensive mapping of community power and social dynamics, including presence and positionality of stigmatised groups; focus should be on inter-group support systems and inter-group tensions, while spaces are made available to various social demographics. This mapping exercise should be underwritten by a thorough power analysis which adopts a gendered lens, foregrounding social norms, accessibility, roles, and expectations.

SPECIALISED SERVICES

9. Increased drug rehabilitation provision is urgently needed in order to address the contemporary widespread addiction problem and ensure that men are able to function and return to work when opportunities arise.

10. Train individuals in anger management to enable them to deal in a non-violent manner with stress and mental health conditions, and raise awareness about the negative long-term effects of domestic violence against intimate partners and children.

ANNEX 1: MENTAL HEALTH REFERRALS MADE DURING RADA RESEARCH

Province	Number of Men	Number of Women
Kabul	9	13
Nangarhar	2	3
Herat	5	6

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