While acknowledged broadly in humanitarian coordination strategies that mental health, in particular, trauma-care for conflict affected people, is a dire need for men, women and children, it is available in Afghanistan only on a limited scale. The Humanitarian Response Plan, January 2018-December 2021 reports that an estimated 10 million people have limited or no access to essential health services, and this includes mental health and basic psychosocial supports. However the practice of mental health support remains a secondary addition to other more common actions – that respond primarily to visible, audible and tangible needs such as Water, Food, Shelter and Sanitation. Given the scale of the mental health needs in Afghanistan related to conflict and trauma, Mental Health and Psychosocial Support (MHPSS) needs to be better integrated across emergency, humanitarian and development (specifically health system strengthening) interventions.

The ongoing conflict, characterized by cycles of displacement, violence and fear creates a landscape of risks in which Women, Men, Boys and Girls live, interact with each other and develop, with both immediate and long term consequences. Children in particularly are potentially most susceptible to long term adverse outcome, as they are still on an early developmental trajectory. However, there is little understanding as to exactly how the Afghanistan risk scape affects the psychological developmental needs of these children and the adults they become. Considering children’s development in general in developing countries, multiple factors including civil war have severely impacted children’s developmental potential (Grantham-McGregor et al 2007). Adverse childhood experiences have been identified as childhood traumatic stressors and a consistent relationship between these stressors and mental health problems in adulthood such as anxiety and mood disorders have been found (Anda et al 2007).

1 Based on current mapping of MHPSS actors and responses by MHPSS Working Group Co chaired by Action Against Hunger, Tabish and Department of Mental Health, Afghanistan
Psychological trauma post conflict and violence can trigger such pervasive psychiatric conditions, altering neurological development leading to issues in children such as detachment and behavioral difficulties. For example, in a fearful situation where a child is forced to kill another child or face being killed themselves, the level of fear could be a significant influence on neurological activity. Chronic fear or anxiety would increase the activity of the brainstem and/or decrease the capacity of the limbic or cortical areas to curb the brain's responses to this fear. In cases of extreme fear and anxiety, such as the example given, the pattern of sensory perception and emotional regulation could be altered. The consequences of these different types of programming may be that the critical stages and experiences currently felt to be core to development for children – psychosocial, attachment, familial – may be questionable realities in a child's development more characterized by displacement and violence.

While it is also possible that this type of fear and stress based trauma could be triggered by one or more other risk factors such as sexual violence (including enforced prostitution, enforced marriages) and or displacement, the reintegration context has potential relevance in understanding and explaining contributing factors to children's development in conflict and emergency based risk scape of Afghanistan. However, there is very limited attention to the impact of the cycles of displacement experienced by many Afghans – having lived through periods as refugees in countries such as Pakistan, repatriation back to Afghanistan, and then displacement internally within Afghanistan at the same time as having children of their own.

However, global research regarding Mental Health and Psychosocial Support provides an evidence base inferring a resiliency pattern in psychological response may support a coping strategy in the short term but lead to long-term health issues. Stress accumulation models indicate that significant stressors occurring early in life impact abilities to adjust - leading to long term mental health problems. Where constant changes are experienced, for instance during cycles of displacement, overload can occur leading to a point where adjustment is not possible and psychopathologies such as mood disorders may develop. Therefore – basing MHPSS programming on psychological, may be highly flawed and a fragile basis for effective mental health, as without proper intervention at an emergency phase, overloaded psychological resilience will lead to severe psychological consequences for their long term mental health.

**TRANSACTIONAL RELATIONSHIP OF TRAUMA AND GENDER BASED VIOLENCE:**

One specific trauma trigger in Afghanistan is Gender-Based Violence (GBV). Since 2017, ACF has conducted two separate gender analyses in both Ghor and Helmand province. In Afghanistan, GBV is understood to be a culture, described in terms of antecedents and a need driven set of behaviours. Very specifically, violence against women in particular is the specific GBV that is gradually discussed in all ACF Afghanistan gender based interviews and focus groups; both as a cultural norm and at the same time an urgent issue. One key informant described the core antecedent to violence against women as hyper-masculinity, which, like participation and power in decision making, is one of the issues that is linked to the trauma impact of war.

This risk scape feeds into a mentality of fear, where a man's mind does not allow a woman to be perceived as a person but as an object or property to be honored. Attempts from humanitarian actors, in particular international ones, to address this in the past have targeted women only raising issues of ‘Do No Harm’. As these interventions did not adequately engage men also as decision makers, and focused response on women, these interventions placed women in a precarious situation during and more importantly post intervention when the NGO had left. The evidence for this is seen in the aftermath of women empowerment interventions in the attitudes of community leaders, Taliban spokesmen and national NGOs who are hesitant to include basic gender equality strategies within projects in case this perceived as something in contradiction to Islam itself. It was identified during a gender analysis that where awareness is relatively equal between men and women.
there is an opportunity for balance and potential for development on social issues including but not limited to
gender, implying any intervention wanting to target GBV needs to first target awareness in both sexes.

As well as the aggressive ownership and responsibility described earlier in the Afghani masculinity, violence
against women is also openly discussed as a punishment issued by husbands, mother in law, families or
communities specifically for elopements between young couples who do not have permission to marry. However, for key informants and female participants in focus groups, the woman in these stories is not in a
romantic love story with a tragic ending; rather this elopement is the only escape from a violent unwanted
marriage without resorting to suicide. Historically, cultural leaders would have supported some choice for
women, however because the monitoring mechanisms in community to manage and respond to GBV or other
issues were wiped out through decades of war, women no longer have the access to any form of informed
cultural support. As the case study below highlights, while GBV may be primarily described in terms of violence
against women, it also regularly features forced (and child) marriage, and denial of resources.

CASE STUDY:
Eileen is 12 and arrived at a health clinic with her mother in law. She had acid burns on her mouth, nose,
throat, and stomach and later finds out she has internal scarring. While not openly discussed, Eileen’s mother
in law disclosed privately to the nurse that this damage was a result of a suicide attempt. The hospital staff
had seen these cases before and tried to flush the acid from the system – where it caused further damage to
the throat, eyes, mouth and nose, before Eileen is returned to her mother in law and they go ‘home’. Eileen’s
unborn child was not seen to be harmed at this point. In order to get permission to take her daughter to the
clinic for treatment in the first place, her mother in law first asked her son, Eileen’s husband who is 45
years old, who refused and told his mother to wait and let the girl and his unborn child die. Despite treat-
ment at home with yoghurt as a coolant, the girl’s suffering motivated the mother in law to ask permission
from the girl’s father and with permission from this source, she took her to the clinic. Back at home, Eileen’s
husband questioned her on why she wanted to die and believed her to be in love with another man. He then
stabbed her with a kitchen knife in the abdomen. Her mother in law again treats Eileen with homemade su-
tures, without anesthetic. Eileen moves so much during the suturing that she tears her wounds repeatedly
and they become infected. Finally, Eileen dies. Her mother in law assumed that this infection was the final
cause of death, so there is no blame for her son who tried only to teach this girl how to be a good wife.

As dialogue within each focus group elaborates further on what GBV actually translates as, incidents of denial
of resources, violence and the inferred sexual assault and rape that led to the pregnancy in the above case
study, are perceived to be very different to the sexual assault against young boys. This latter type of sexual
assault is tentatively raised by participants through story telling. Anecdotes of wealthy men who engage in
bacha bazi describe ‘beautiful young boys’. These boys are described as status symbols for the War Lords,
and while sexual assault is never defined or discussed, narratives regarding the beautiful boys then shifts to
highlighting that within the Quran where there is clear Islamic punishment against men who have sex with
other men. The assault is implied further because these men who do it because they cannot be with a woman
due to their lifestyle. However, for male participants in focus groups, men assault young boys because they
neglect their Islamic study, which would teach sexual patience. For men, all Sexual GBV (SGBV) is linked to
other men moving away from Islam either consciously or unconsciously through ignorance.

For women, at the community level, household resources are the prime triggers for GBV; with specific reference
to socially acceptable mobility for different gender groups. Where water needs to be accessed at a well, and
wood needs to be collected from the mountainside, women are only given permission to complete these
household chores with a mahram or at night where the risk of being seen by other men is understood by

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4 This is a local term that literally translates as child play.
the husband to be reduced considerably. However, this nighttime movement is community knowledge and it exposes women to the risk of SGBV because they are unguarded with fewer people to witness the attack at night.

Overall, SGBV and GBV are grounded in systemic fear; male fear and in part the female fear of consciousness raising. Women may become aware of their rights, but that does not necessarily translate to an overnight transformation on their thinking, beliefs and consciousness.

**RECOMMENDATIONS:**

The prioritization of developmental needs, in addition to the provision of water, shelter and food, is an important feature within emergency and humanitarian response. Just as nutrition, has immediate impact on development observed physically in stunting and wasting, as well as short and long term cognitive developmental delay, mental health impact on development can be similarly physically observed through behavior and perspectives, significantly from the perspective of familial welfare. The latter not least can be observed simply through a lack of attention to personal care. Under the Action Against Hunger Mental Health and Care Practices (MHCP) model, this lack of care is well identified to also lead to malnutrition in the carer and in the children under their care.

However, despite the clear links between psychological trauma and both physical and psychological development, particularly in children, provision of mental health and psychosocial support within many humanitarian responses, particularly Afghanistan, is severely lacking. Humanitarian actors, working in Afghanistan, are dealing with multiple cases of trauma and GBV on a daily basis, but currently lack in many cases the technical expertise or resources to address these issues themselves. This situation is further compounded by the lack of technical capacity within the Afghan Health System and the lack of specialist mental health actors in many areas leaving humanitarian organisations without appropriate referral pathways.

Therefore, in order to more effectively address Mental Health and Trauma in Afghanistan we recommend:

- Mental Health and Psychosocial needs of conflict-affected people in Afghanistan must be taken into account during the current revision of the Humanitarian Response Plan across all sectors.
- Emergency Actors, including partners of the ECHO-funded Emergency Response Mechanism should be integrated Emergency MHPSS and Psychological First Aid into their interventions.
- All Psychosocial responses should be funded for a minimum of one year to enable community acceptance necessary to adequately address mental health needs, integration within other sectorial responses and to contribute to a national understanding of the developmental impact of psychosocial impact on human functioning as much as malnutrition.
- Development actors must provide both funding and technical resources to invest in health system strengthening to support the establishment of and access to psychosocial support in health facilities and capacity building at the biopsychosocial medical model stage.