Challenges and successes

The intervention seems to have had a significant impact on child development (gross and fine motor skills, cognitive skills, language, problem-solving and personal/social development), and this improvement has been sustained. Levels of child stimulation at home have also increased. Most of the mothers (50% came to four or five sessions) appreciated the intervention. According to one psychosocial worker: 'at the beginning [of the project], some people were reluctant to bring their child to the OTP for nutritional treatment but they accepted and continued the treatment after individual or family counselling. Nowadays they thank us for opening their eyes to their child care'. Generally, counselling has made mothers more aware of malnutrition problems, prevention and treatment, parents' roles and responsibilities, hygiene and proper sanitation, proper feeding and access to health services. They also learned about child development, and felt better equipped to make decisions affecting their children.

We could not demonstrate that the intervention had any significant impact on recovery from SAM. Anthropometric measures were not reliable enough, and the intervention was too short to close the gap between SAM and non-SAM children in terms of development. In the opinion of psychosocial workers, facilitating behaviour changes would take more time than was included in the programme: 'there are several factors in the community that we can't change in a short period of time, like girls' education, family support mechanisms, prevention of early marriage, barriers due to cultural factors, lack of economic activities, and the burden of household activities on women'.

Next steps

Psychosocial workers have a vital role in sensitising health workers to the link between malnutrition and child development. In order to retain experience and knowledge among health staff, we trained all 62 auxiliary nurse-midwives working in OTPs and remote birthing centres and five health workers at the Nutrition Rehabilitation Home on the FUSAM psychosocial protocol and basic psychosocial support. Other DPHO representatives and staff as well as those responsible for OTPs received a one-day orientation on the psychosocial intervention programme. We have also provided low-intensity training for health workers at OTP centres in Rasuwa district in northern Nepal in an adapted version of the FUSAM protocol (with very similar content and without additional PSWs). A round of supervision provided additional information on adapting the protocol content and implementation modalities to reflect geographical and socio-cultural differences in the country. This is the first step in scaling up the intervention. There is also a new opportunity for a collaboration with the National Health Research Council (NHRC), which has invited us to join the technical team developing Nepal's first national mental health survey.

Conclusion

The psychosocial component of FUSAM was developed taking into consideration the psychosocial impact of SAM on children, their mothers and their relationships. Interventions were delivered despite numerous challenges and under adverse conditions. It had positive impacts, some expected and others not, and will require further study. In the meantime, the programme is being taken forward and adapted with the support of the Ministry of Health and Population.

The FUSAM project was innovative given the lack of clear national policies or guidelines on psychosocial interventions in nutrition programmes. There are multiple benefits in including a psychosocial component alongside SAM treatment, but the results show that it is unrealistic at this stage to expect psychosocial interventions to address the impacts of SAM.

Karine Le Roch is Research Project Coordinator in Mental Health and Care Practices for Action contre la Faim – France. **Cécile Bizouerne** is Senior Technical advisor in Mental Health and Care Practices for Action contre la Faim – France.

Responding to trauma during conflict: a case study of gender-based violence and traditional story-telling in Afghanistan

Ayesha Ahmad, Lida Ahmad and Jenevieve Mannell

The collapse of the health system during the Taliban regime means that Afghans rely overwhelmingly on health services provided as part of the humanitarian response. The focus is on addressing the physical effects of conflict and violence, rather than the mental health effects of trauma. The World Health Organisation (WHO) Afghanistan Humanitarian Response Plan 2017 describes Afghanistan as 'one of the most dangerous and crisis-ridden countries in the world'.[1] References to the health sector highlight the threat conflict poses to the physical safety and health of Afghans, with a particular focus on infant and maternal health, but there is no mention of mental health. Likewise, the European Civil Protection and Humanitarian Aid Operations (ECHO) overview of humanitarian assistance situates mental health as part of resilience programming, and makes no mention of specific mental health programmes for Afghanistan. WHO's Mental Health Gap Action Programme

1 http://www.who.int/emergencies/response-plans/2017/afghanistan/en/.

2 https://ec.europa.eu/echo/what/humanitarian-aid/resilience_en.

Story-telling interventions could help Afghan women experiencing trauma from GBV.

© Nocem Collado

(mhGAP) is intended to provide training for primary healthcare professionals on diagnosing and treating mental illness, but implementing and sustaining such programmes is challenging in a context of conflict, the stigma and taboo attached to mental illness and a universalised model of trauma that may not be culturally valid.

This article explores the challenges of mental health and psychosocial support (MHPSS) in Afghanistan, with a particular focus on sexual and gender-based violence. We discuss the development of a therapeutic intervention using traditional story-telling for gender-based violence in conflict, drawing out lessons for the role of humanitarian actors in facilitating MHPSS in contexts with very little or virtually non-existent mental health infrastructure. Although the intervention focuses on GBV-related psychological trauma, stories of war and conflict are inescapable, and war narratives and GBV narratives are intertwined. At the same time, war and conflict can produce societal disruption, opening up spaces for social transformation and providing an alternative discourse to channel and transfer stories it might otherwise have been impossible to tell.

Traditional story-telling as a therapeutic intervention for GBV

A staggering 87% of Afghan women are estimated to be affected by at least one form of gender-based violence, and 62% multiple forms. There is a double burden of psychological trauma, both from the surrounding context and within the home. Afghan society is highly gendered; space to openly discuss GBV is extremely restricted, and violence is rarely reported or disclosed and rarely recognised as a crime. The mental health impacts of GBV are heavily stigmatised, and psychological distress is not necessarily interpreted as an aspect of mental health, but instead situated within cultural and religious discourses. Lack of resources for therapeutic responses to GBV are another challenge. For these reasons, psychological interventions for Afghan women experiencing GBV have been extremely limited.

As the first point of contact for women escaping situations of violence, shelters for women, or 'safe houses', offer a key opportunity to mitigate the potential long-term harmful effects of GBV. However, in such a conservative society the idea of providing women with a refuge outside of the family is controversial: there are no government-run facilities, and in 2012 one senior government minister referred to safe houses as 'brothels' housing immoral women.[3] In the absence of government support, the estimated 30 safe houses currently in existence across Afghanistan[4] are supported by NGOs and the UN. The locations of safe houses have to remain secret, and there is a constant risk that the Afghan government will seize control of them.[5]

3 Dean Nelson, 'Afghan Women in Shelters Are Prostitutes, Says Justice Minister', *The Telegraph*, 21 June 2012 (https://www.telegraph.co.uk/news/worldnews/asia/afghanistan/9346779/Afghan-women-in-shelters-are-prostitutes-says-justice-minister.html).

4 'A Safe Place for Afghanistan's Abused Women', *The National*, 27 May 2017 (https://www.thenational.ae/world/a-safe-place-for-afghanistan-s-abused-women-1.67433).

5 'Afghan Women Fear Losing Safe Houses', *BBC News*, 18 February 2011 (http://www.bbc.co.uk/news/world-south-asia-12496381).

The psychological support provided by safe house staff typically involves offering women a consultation with a psychologist. However, this requires the women to disclose intimate details of the violence they have suffered in a context where disclosure as therapy does not resonate with cultural understandings of gender relations, and being identified as a victim of sexual violence is extremely risky for the woman, especially where the perpetrator is an individual of power. As a result, there is an urgent need for alternative approaches to therapy that fit with the local context and effectively address women's psychosocial needs.

My co-researchers and I developed a traditional story-telling intervention to create a way for women to speak about their suffering in a society that silences women's voices. Although women were banned from reciting poetry under the Taliban, story-telling has a significant symbolic role in Afghan culture, with a rich oral tradition of women story-tellers. Talking about violence as a story about one's life provides a means of understanding GBV experiences as part of broader structures of inequality, rather than as an individual responsibility or issue. Similarly, group story-telling provides a potential means for these highly vulnerable women to tell their stories through an act that represents freedom from extreme religious ideology.

The research comprised life-narrative interviews with 20 women who had experienced GBV and were currently residing, either temporarily or permanently, at two safe houses run by local NGOs.[6] A structured story-telling activity using different forms of stories representing GBV was also conducted in a focus group of five women in the safe houses, as well as eight in-depth interviews with staff working for the local NGOs.[7] All activities were recorded, transcribed and translated into English for analysis. The aim of this small study was to identify alternative approaches to interpreting and recovering from experiences of violence grounded in the local cultural context. Using a local researcher with pre-existing links to the safe house where we worked provided for a rich collaboration and dialogue with the women who participated because trust had already been established; the women were happy to be interviewed, although they were clearly informed beforehand as part of the consent process that they could withdraw at any point. The age range was from 18 to 45 years old. All the interviews and the focus group took place in the safe house to minimise the risks to the participants.

As Afghanistan is predominantly an oral story-telling culture and most of the women were unable to read or write, a range of media was used in the focus group. Poetry from well-known contemporary and ancient Persian women poets, such as Forough Farakhzad and Rabia Balkhi, was recited, and a recent media article about the public stoning and murder of Farkhunda Malikzada, a 27-year-old woman falsely accused of burning a Quran, was discussed.[8] Folk stories were also shared. The focus group created connectedness and a sense of shared experience. Although some of the women said that they could not understand the poems because of their lack of education, they felt able to relate to the local researcher's interpretation of them, and the narratives surrounding the poets' lives had contemporary resonance and relevance.

Participants were also asked about a song, poem or story that they recalled from their childhood. This enabled the women to convey their story, or the meaning of it, in a way that did not centre on the violence they had experienced. For example, one woman did not remember any stories from her childhood because there had been no one to tell her stories, conveying a sense of sadness and loss because she had been alone as a child. The woman was nomadic, and instead of recounting a story she remembered being told she spoke about being with her sheep, reminding her of a time in her life without pain or suffering.

Although the women's reflections were violence-based narratives depicting the extent of GBV since birth, the act of story-telling allowed them to bring their own personalities, memories and expressions of hope into the interviews, rather than reducing their lives to a series of violent events. The women were still living through their trauma – there is no 'post-trauma' in this context, and thus the women are constantly connected to their experiences. However, the life-narrative interviews served to tell whole stories that contained more than violence, while at the same time creating an environment where all forms of GBV could be communicated in a therapeutic way. The therapeutic nature of the storytelling was related to the interaction with other people who shared similar experiences, and the relief the women felt from being believed.

This need to be believed was a significant theme throughout given previous negative experiences in telling stories, or parts of stories, relating to GBV to female relatives. Because of the serious consequences of disclosing GBV such as honour-related violence to family members (or anyone for that matter), and the shame associated with GBV, especially sexual violence, it is not safe for women to tell their stories even to female members of their own family. Some of the participants had suffered physical violence at the hands of their mothers and sisters.

Therapeutic outcomes, analysis and future work

As an alternative to Narrative Exposure Therapy (NET), an evidence-based short-term therapeutic treatment for individ-

6 A life-narrative interview is an interview about a person's story of their life to better understand the concepts of suffering and the role of story-telling in responding to trauma.

7 Initially, four focus groups were planned, but due to security concerns only one was possible.

8 Alissa J. Rubin, 'Flawed Justice after a Mob Killed an Afghan Woman', *New York Times*, 26 December 2015 (https://www.nytimes.com/2015/12/27/world/asia/flawed-justice-after-a-mob-killed-an-afghan-woman.html).