ISLAMIC REPUBLIC OF AFGHANISTAN

Ministry of Public Health

Mental Health Department

National Suicide Prevention Strategy

For

Afghanistan

(NSPS)

February 2016

Dr Bashir Ahmad sarwari

Acknowledgment

First of all I would like to acknowledge all those peoples and organizations, who supported the development of the National suicide prevention strategy, for Afghanistan.

I want to make thanks and much appreciation for The Ministry of Public Health and the Government of Afghanistan which, provide the support during my master and recommend me for such qualification.

I would also like to give my special thanks to Her Excellency Dr. Najia "Tariq", Deputy Minister of Public Health for her great support and advocacy during all process of developing this document especially her chair and participation in the advisory groups.

I want to acknowledge the technical committee and the advisory group for their hard working, and sharing their experience and comments to develop this strategy.

My special thanks to the Mental Health Technical Coordination Committee and to the different departments of Ministry of Public Health for their interest to suicide prevention, sharing the information and attending the meetings.

Also, I would like to thanks WHO, IPSO and Medica Afghanistan for their commitment and providing the technical support during working on this strategy and special thanks to the European Union delegation in Afghanistan and to EPOS, Health Management, who provided the technical and the financial support for this process. It is worth mentioned that I acknowledge the role and efforts of dr. Bashir Ahmad Sarwari, the Director of Mental Health Department, MoPH and to the staff of the department including technical, administrative and auxiliary staff to facilitate the advisory groups and technical committees' meetings, especially Dr. Zahid Sharifi, The National Consultant for Mental Health, Dr.Bashir Ahmad Taseer, M&E Officer of Mental Health Department and to Dr. khesraw Parwiz, Psycho-Social Coordinator of IPSO, also, to Mr. Tajuddin, Mr.Riad and Ms.Arifa the admin officers of Mental Health Department, MoPH. Finally, We I would like to express our appreciation and thanks to Dr. Sayed Azimi and Dr.Ahmed Heshmat, the Mental Health Advisors to the MoPH, Afghanistan, for their support in the development and reviewing the strategy.

Hereby once again I declare my commitment to the government and to the people of Afghanistan, those I may never meet them, but always thinking about them. We will try our best to serve our country and working hard for those people which ever day losing their life.

Dr Bashir Ahmad Sarwari

Abstract:

National Suicide Prevention Strategy for Afghanistan

Suicide in Afghanistan is a public health priority. Afghanistan is a low-income country, emerging from three decades of conflicts. There is high prevalence of mental distress, mental disorders and substance abuse. There are multiple social issues, such as gender imbalance/violence, poverty, obsolete attitudes and customs, rapid social-cultural changes, human right violations, and especially women and children rights. These risk factors contribute to increase the vulnerability of the population for suicide. The relative high rate of suicide in Afghanistan is especially significant as the rates are low in all Islamic countries. Research studies have shown predominance of suicide in women (95%) and in young age people.

There is an urgent need for the country to have a suicide prevention strategy. The strategy has been developed by establishing a multi-sectoral technical/advisory group of different stakeholders from government, NGOs, donor agencies, victim's families, and interested parties. The strategy is based on the following key values, namely, respect for diversities; sensitiveness to socio-culture-religious and gender issues; promotion of the society dignity and respect for the human rights of people.

The six 'Strategic directions' are: involving key stakeholders and creating coordinated inter-sectoral collaboration; providing after care for people making a suicide attempt and their families; improving services for people with mental disorders and psycho-social problems; promoting the safe reporting and image of suicidal behaviour by media; reducing access to the means of suicide and gathering information about suicide rates, risk factor, protective factors and effective interventions.

The National Suicide Prevention Strategy will be initially implemented for 5 years, with an annual evaluation of the action plan to understand the strengths and limitations. Recommendations and suggestions will be incorporated into the next annual plans for effective intervention. A monitoring framework will measure progress in implementing the strategy.

Keywords:

- Suicide
- Women
- Intervention
- Conflicts
- Community

Foreword

Afghanistan is a poor and post conflict country with huge burden of health, Mental Health- psycho-social problems, large risk factors prone people to vulnerability and prohibit them from seeking help such as, gender imbalance, gender base violence, poverty, domestic violence, obsolete attitude and costumes, mental disorders, cultural changes, kinds of human right violation, women and children rights violation and related consequences.

Most of these risk factors contribute to increase vulnerability for suicide and self-immolation, and the situation is going to be worse when, we knew the low level of awareness of people, and the high sigma and even taboo attached to suicide and suicide attempts.

The findings of a survey, conducted in 2006-2007 by Medical Mondiale in three provinces, in Afghanistan, showed that 2300 suicide in the three provinces which 95 % of them were women, and nearly 80% of those were married, and the total mean age of women committing self-immolation was 14-19 (*Medica Mondiale – self-immolation research report 2006-2007 page* 13).

The UN Special Rapporteur on Violence against Women, Professor Dr. Ertürk, stated that Afghanistan faces perhaps the most daunting challenge in terms of Women's rights. She said "poverty, lack of education, and the damage left by decades of conflict are often cited as the prime causes for the current situation in Afghanistan". AIHRC states that, up to 80% of marriages were forced marriages. Against this backdrop of violence, an increasing amount of women are endeavouring to escape the endemic violence in Afghanistan by committing suicide. The trend amongst a growing number of Afghan women is committing suicide by self-immolation.

In 2004, a government delegation was sent to Herat (one of the biggest provinces in south-east Afghanistan) in order to investigate the causes of self-immolation, where the practice was most prevalent. The delegation concluded that self-immolation was due to forced marriages and the violence many women faced. (*Medica Mondiale–self-immolation research report 2006-2007 page* 17)

World suicide report published by WHO, in September 2014, showing that 1200 suicide in Afghanistan in 2012 (603 female and 562 male). (Annex 1 page 80 preventing suicide a global imperative WHO-2013)

Ministry of Public Health started celebrating the World Suicide Prevention Day since 3 years, authority during celebration of world suicide prevention day 2014, declared that the suicide rates is increasing every year since the fall of Taliban in 2001, dough there are no data collection system to collect exact and valid data on suicide, but most of cases of accidents, poisoning and burnt are due to self-immolation and suicide. They added that around 1146 poisoning and 1445 burnt reported only from 5 general hospital in the Capital Kabul in 2013, and around 4466 cases reported in 2014, from the same hospitals (Hospital report 2013-2014-MoPH) , HMIS reports

showing 4136 Burnt cases during 2014, form all primary health care facilities (MoPH-HMIS, 2014).

According to the health staff working in those settings most of cases have been women has been attempted for the purpose of suicide and self-immolation and in response to violence against their person in all its forms (Medica Mondiale 2006)

It was a huge need for the country to have suicide prevention strategy to save life of thousands of young generation specially women. During choosing this topic, I thought a lot for such a topic to do my theses and also to be a part of my country needs, so I preferred to work on drafting a National Suicide Prevention Strategy, as a responsive strategy, publishing suicide report by WHO in 2014, which, provided supportive context for this topic. Also, there are many stakeholders such as WHO, UNFPA, EU, EPOS, NGOs, Civil Society, Sectorial Ministries (such as Ministry of Women Affaires, Ministry of Labour and Social Affair, Ministry of Haj and religious Affairs, Ministry of Education, Ministry of Justice, Ministry of Counter Narcotic and Ministry of Culture and Information), and people from Parliament become interested to, and encourage the efforts toward developing a National Suicide Prevention Strategy for the country.

The start was difficult in such country, where there is no reliable data and evidences. It was very difficult to collect information; however I might start from somewhere, so, I contact HMIS-MoPH, NGOs working in the field of human right, gender based violence and emergency wards of hospitals, and interviewed health staff working with cases, people from community and family of victims to collect the information.

I put this issue in agenda of Mental Health Technical Coordination Committee, MoPH, the member of mentioned committee proposed some nominees from interested parties to establish a technical committee to share with them the information and further process of development of the National Suicide Prevention Strategy.

The committee developed a ToR and action plan, proposed to collect the information from whatever is available, so! I collect research papers from 1969, 2003, 2004, 2006, 2007, 2012 and 2013 e.g. Gobar research on suicide in Afghanistan (Asad Hassan Gobar, M.D., D.P.M., 3 July 1969), Medica Mondiale research (2006-2007) on self-immolation of women in 3 provinces, the research from human right commission office, scattered information from civil society about suicide and the report from the HMIS and hospitals of MoPH, put them in a presentation and present it to the technical committee.

The committee afterward proposed to establish a multi-sectoral advisory group comprises deferent stakeholders from government, NGOs, donor agencies, victim's family, and other interested parties and this advisory group should have 2 sessions, one before drafting the strategy to have their opinion, comments and suggestions and second after drafting the strategy to finalize it.

Fortunately now both; technical committee and advisory group are established and are functional and we got very important information, suggestion from them in a very interested and supportive manner to develop this strategy

Our most efforts spend toward a gender sensitive strategy based on the afghan value and socio-cultural context to be acceptable and affordable by Afghans, though still suicide is a criminal act by Sharea (religious law) but efforts has been done in this strategy to decriminalize suicide on future to open a window for help seekers. Though de-criminalization of suicide is not highlighted in this strategy but the result of six strategic directions may provide the context for de-crimination of suicide on the future.

I hope that this strategy after review by faculty member will be acceptable by Ministry of Public Health of Afghanistan as a national strategy, and hereby I expect faculty member to review it deeply and provide me comments and suggestions toward finalization of this strategy.

I am sure after such process the strategy will save life of thousands of Afghans, which still waiting for such a hand to give those help and support

Acronyms

AFRO	Afghanistan Future Research Organization
AIHRC	Afghanistan Independent Human Right Commission

AKDN	Agha Khan Development Network
ANDS	Afghan National Development Strategy
BHC	Basic Health Centre
BPHS	Basic Package of Health Services
CHC	Comprehensive Health Centre
CHS	Community Health Supervisor
CHW	Community Health Worker
DDR	Drug Demand Reduction
DH	District Hospital
DRC	Drug Regulation Committee
DRD	Disability and Rehabilitation Department
DSM-IV	Diagnostic and Statistical Manual of Mental Disorder-IV
EMRO	Eastern Mediterranean Region
EPHS	Essential Package of Health Services
EPSC	Emergency Psycho-Social Counselling
EU	European Union
GoA	Government of Afghanistan
HF	Health Facility
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMIS	Health Management Information System
HN-TPO	Health-net, Trans-cultural psychiatry organization
HNSS	Health & Nutrition Sector Strategy
HP	Health Post
HR	Harm reduction
ICD-10	International Classification of Diseases 10
IEC	Information, Education and Communication
IPSO	International Psycho-Social Organization
LRP	Learning Resources Package
MH	Mental Health
MHH	Mental Health Hospital
MHT	Mobile Health Team
MH & SAD	Mental Health and Substance Abuse Department
MoW&A	Ministry of Water and Agriculture
MoCN	Ministry of Counter Narcotic
MoH & RA	Ministry Hajj and Religious Affairs
MoI	Ministry of Interior
MoI & C	Ministry of Information and Culture
MoJ	Ministry of Justice
MoLSA	Ministry of Labour and Social Affairs
MoPH	Ministry of public health
MoUD	Ministry of Urban Development

MoWA	Ministry of Women Affairs
NGOs	Non-governmental Organizations
NMHS	National Mental Health Strategy
PFA	Psychological First Aid
PH	Provincial Hospital
PHC	Primary Health Care
PHD	Prison Health Department
PPHD	Provincial Public Health Directorate
PS	Psychosocial Counselling
PTSD	Post-Traumatic Stress Disorder
RH	Regional Hospital
SC	Sub-Centre
SEHAT	System Enhancement of Health Action in Transition
UNAMA	United Nation Assistance Mission for Afghanistan
UNFPA	United Nation Fund for Family and Population
USAID	United State Administration for International Development
WB	Word Bank
WHO	World Health Organization
M&E	Monitoring and Evaluation

Contents

Introduction

Although there are few publications regarding suicide in Afghanistan, some studies have been conducted during 1955-1965 and their findings lead to the following conclusion:

(a) With a suicidal rate of 0, 25 cases per 100,000 population per year, Afghanistan was at that time the country with the lowest ratio, reported in the world.

(b) The variations across time in incidence of suicide greatly depend upon cultural factors such as people's deep religious believes, strong family ties and general social structure (Gobar A.H.1970 Suicide in Afghanistan. The British Journal of Psychiatry, 116, 493-496)

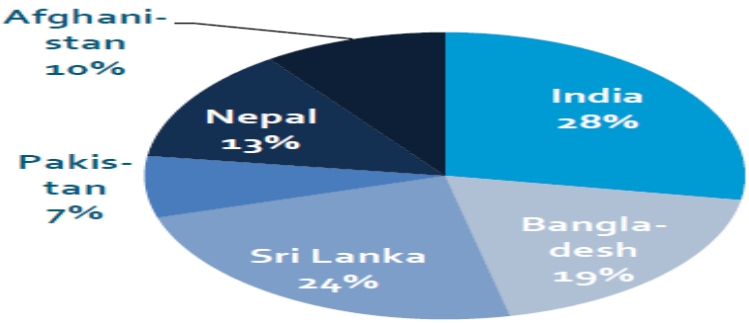
Suicide and homicide cases during ten years in Kabul Province

Year	Suicide	Homicide
1955	2	39
1956	4	43
1957	2	38
1958	4	60
1959	0	29
1960	5	35
1961	2	48
1962	2	54
1963	5	37
1964	4	30
Total	30	413

The start of the violence in the late 1970s led to the migration of many Mental Health professionals. Little is known about the early effects of the war on the Mental Health status and suicide rate of Afghans during the Russian occupation and the armed resistance of the mujahedeen, but during Taliban ruling though there no research on suicide and we can say that this period is a dark time of modern science for Afghans, but it is clearly evident that most coping mechanisms of people were restricted by Taliban extremist regulations and in result the risk factors of mental disorder and suicide increased amongst population at risk.

In a study of south Asian countries (Oct 2013, HN-TPO), from Afghanistan only one piece of grey literature was included in the review and it was impossible to report trends in means of suicide. The study reported only on suicide attacks as a mean of suicide (specifically, using vehicle or body-borne explosive material). All recorded suicide attacks were done by young men and sometimes even children. These findings cannot reflect all suicide cases, and it is obviously very different suicide from self-immolation through suicide attack.

Figure 3: Documents collected by national consultants



Suicide trend (2000-2015):

Since there are no any data collection system about suicide neither in the Ministry of Public Health, nor in other ministries, the only source of data is represented by some research done by human right commission or NGOs and their main focus is on gender base violence and human rights violations against women rather than suicide.

Medica Afghanistan (an Afghan NGO) which was Medica Mondiale in the past (a German NGO) offers psycho-social support to women survivors of self -immolation cases in Kabul Rabia e Balkhi female hospital, Burnt Unit of Herat Regional Hospital since 2005. Afghan women and girls, continue losing their lives through committing self-immolation suicide (Medica Mondiale 2006)

Evidence in recent years shows that after the fall of Taliban, the number of suicides increasing amongst Afghans every year, At least 184 cases of self-immolation was registered by the AIHRC in 2007 against 106 in 2006.

This phenomenon is feared to be increased further in 2008, women's rights activists mentioned "We have been unable to collect data and information about all incidents of self-burning due to a number of reasons, but overall the situation is not promising" said Homa Sultani, a researcher on the rights of women at the AIHRC in Kabul. The AIHRC in Herat and Kandahar confirmed a marked increase in reported cases of self-immolation.

Country-wide investigations showed that the vast majority of suicide cases in Afghanistan were amongst woman and young girls experiencing physical abuse, according to the United Nations Assistance Mission in Afghanistan (UNAMA), Afghan women experience some of the highest rates of domestic violence in the world. According to UNAMA's mid-year report, cases of violence and self-immolation against women were higher in 2013 than in 2012.

So, the assumptions, that the real prevalence may be higher than what was mentioned, because of general collusion of silence, taboo and stigma attached to this

issue, as suicide is a criminal act in Islamic 'Sharea' and also in the Afghani civil and criminal laws.

The reactions of the Afghan Government towards suicide issues, has been differ widely. Some condemn the act, pointing to the Islamic belief that: those who commit suicide will go to hell. On the other hand, there have been real attempts at the governmental and para-statal levels to understand the situation. At the same time, AIHRC (Afghanistan Independent Human Right Commission) had undertaking self-immolation research in five provinces in Eastern, Western and Southern parts of Afghanistan, also the United Nations Assistance Mission for Afghanistan (UNAMA) is documenting some cases of self-immolation across the country. The collusion of silence, the general reluctance to address the issue (despite many of the efforts undertaken to date) and the lack of reliable statistics are all encumbrances to understanding the underlying structural roots of the problem. Nevertheless, United Nations' reports have indicated that the endemic violence against women in Afghanistan is often a trigger for self-immolation (UNAMA-2007)

Most factors contributing to self-immolation of women are forced marriages, early child marriages, multiple marriages, lack of societal awareness of women's rights, the psychological impact of 25 years of war, customary practices such as high marriage portion(Tuyana) or (bride price) and family violence are the main risk factor of self-immolation.(AIHRC 2008). However, most of victims were young generation specially women (95%) between ages of 14-19 years old (Medica Mondial 2006).

Celebration of suicide prevention day on September 10th, 2012, 2013 and 2014 provide advocacy and raised awareness to government and parliamentarians, professionals and people to know/understand the magnitude and related burden of suicide. Currently, there are evidence of strong commitment from technical agencies and other stakeholders to support developing and implementing a suicide prevention strategy. These organizations are, High court, general attorney office, World Health Organization (WHO), gender section of United Nation Fund for Family and Population (UNFPA), European Union, civil society and other relevant government Ministries such as Ministry of Women Affairs (MoWA), Ministry of Hajj and Religious Affairs (MoH&RA) and the youth section of Ministry of Information and Culture (MoIC), Ministry of Urban Development, Ministry of Justice, Ministry of Agriculture, Ministry of Education (MoE), and Ministry of Higher Education (MoHE) to start lobby to develop national suicide prevention strategy for the country.

Magnitude of the Problem:

It is difficult or not possible to provide exact figures on suicide and self-harm in Afghanistan, in the absence of national surveillance data on suicide and self-harm. According to the World Health Organization (WHO), the estimated number of suicides in Afghanistan for the year 2012 was 1,205 (males: 562, females: 643), representing an age-standardized rate of 5.7 per 100,000 (WHO, 2014), which is in line with other

countries in the WHO Eastern Mediterranean Region (EMRO) (Rezaeian, 2008), but relatively low in the international context (WHO, 2014). However, across low and middle-income EMRO countries, relatively high suicide rates have been observed among young women and men aged 15-29 years as well as older women and men aged 60 years and older (Rezaeian, 2008). The predominance of Islam and criminalisation of suicidal behaviour may explain to some extent why, reported suicide mortality rates in the EMRO region are lower than in other regions (Khan, 2007; Beautrais, 2006). There is evidence for inaccuracies of suicide statistics due to the criminalisation of suicidal behaviour, i.e. in countries where suicidal behaviour is considered a criminal offence; cases involving suicidal behaviour are often not reported to the police (Khan, 2007).

The HMIS report in 2013 showed 1,146 cases of burnt, 1,445 cases of poisoning and 4,466 cases of only drug poisoning, and data was collected from only 5 hospitals in the Capital Kabul.

A Study of self-immolation by women on 2006 done by Medica Mondiale in three provinces (Kabul, Wardak and Herat) showed an estimated 2,300 women or girls were attempting suicide annually (2006).

According to recent studies, about 1.8 million Afghan women has been diagnosed as depression, due to the massive psychological pressure. Dr. Mohammad Ashraf Rawan, who offers psychiatric support in the northern province of Balkh, said that violence against women and restrictive conditions are potentially fatal.

Cases of self-immolation, hanging, poisoning and exsanguinations were all registered this year. Although they did not go into further detail, Public Health officials said that cases of suicide have increased in Afghanistan.

Suicide amongst men may remain hidden because according to the Islamic beliefs, suicide is a great sin and men with suicide ideation or attempt may divert their belief toward the idea, that: if a person die for the sack of Allah, no one will ask him/her during doomsday and for them heaven is always open so many men with suicidal ideation or attempt are going to die in a purposeful way rather than a condemned way through participation in holy war (JIHAD) or suicide attack either inside Afghanistan or outside e.g. Syria, Iraq and etc. However it is important to take into consideration the positive and negative aspects of religious believes during developing a suicide Prevention Strategy.

The overall underreporting of suicide in Afghanistan is further evidenced by figures from the Health Management Information System (HMIS), showing that in the first 6 months of 2014 approximately 4,136 burn cases from 34 provinces were reported by HMIS, which according to health providers working in these settings, the majority of these cases represented self-inflicted harm or self-immolation.

These figures further convinced the MoPH to prioritise the development of a National Suicide Prevention Strategy.

Objectives:

1. Promote surveillance on suicide/attempt
2. Mobilize the Community to encourage help seekers to receive care, raising awareness, reduce stigma, and apply positive copings & support individual / families bereaved by suicide
3. Increase access of people to receive care at all level of health system
4. Reduce access to means, promote media guide on responsible reporting & creating positive attitude toward suicide behavior
5. Promote integrated, comprehensive & sustainable approaches.

Methodology

1. Technical Group to support to development NSPS
2. Advisory Group, to support & the commitment to implement NSPS..
3. Review the available reports/papers about on suicide e.g.:

• Suicide in Afghanistan, Gobar, July 1969
• Self-immolation of women in Afghanistan MM, 2006-2007
• World suicide report published by WHO, in September 2014.
• Study of South Asian Countries on suicide (Oct 2013, HN-TPO).
• UNAMA's mid-year report, cases of violence and self-immolation against women in 2013 than in 2012.
• AIHRC study papers

4. Drafting NSPS
5. Presenting to Advisor Group for discussions & approval

Important definition:

- Suicide: the act of intentionally killing oneself.
- Attempted suicide: comprises a range of acts where people make attempts to kill oneself which is not fatal.
- Suicidal ideation: thoughts and thinking around to kill oneself.
- Deliberate self-harm: behaviours that may or may not result to serious damage, but are not intentionally fatal.
- Self-immolation: the act of burning oneself with the aim of committing suicide.
- Suicidal behaviour: is defined as, any act that could cause a person to die, such as taking an overdose of drugs or crashing a car on purpose

Vulnerable groups:

- Women especially young girls between age of 14 -19 years, which are most vulnerable due to gender base violence and violence against their rights.

- Drug users: nowadays data showed 11% of general population is using some kind of drugs such as opiates, opioid, heroin, sleep pills or pain killers and hashish (INL Afghan rural drug survey result 2015).
- Returnees and displaced people with facing acculturation.
- Disables, family of martyrs.
- Poor people/ jobless.
- People with mental disorder and psycho-social problem.
- People affected by serious infections such as HIV/AIDS, HBV and HBS.

Happening this strategy:

The areas for action in this strategy is broad and multi-sectorial, so a multi-sectorial strategic plan, should be developed after official approval of the strategy and the development of an annual action plan is needed to implement this strategy. The plan might be developed for 5 years, in first year the activities will be considered according to the priorities and the availability of resources, while, for the second and further years the activities will be selected based on the results of the annual monitoring and evaluation, available information from surveillance and other sources such as HMIS and researches.

Multi-Sectoral Efforts:

Suicide is not a health problem only, but, it is also a social problem as most of the contributing risk factors are outside of health care system and most of the protective factor are within the cultures and communities, which other sectors are responsible for. So, to treat suicide attempt and improve management of suicide, without intervention from other sectors to reduce risk factors and promote protective factor, we will not be able to reduce suicide rate and to manage the problem properly. The work with governmental and non-governmental sectors, to improve people's life, economy, gender balance, human right promotion, improve mental and psycho-social wellbeing, are fundamental measures, to overcome these challenges. Also, the inter-sectoral collaboration and coordination is crucial as involving other sectors guarantee sustainable and integrated approaches. The most sectors involve in developing and implementing suicide prevention strategy showed in bellow figure:

Link with other sectoral strategies:

1. To ensure that those service and interventions can be implemented in a sustainable manner with the commitment that formalized mechanisms are in place to support extremely marginalized individuals among groups such as the nomads (Kuchis), poorest families, unsupported poor women, unsupported disabled, in particular, mentally impaired, drug addicts, and homeless people, and that they are not denied access to more substantive medical or surgical interventions on account of their socio-economic marginalization (ANDS, 2008, p. 236).

2. To develop a flexible range of integrated Mental Health support and care services at all levels of the health system. Particular attention will be given to specialized counselling for Post-Traumatic Stress Disorder (PTSD) through the training of more community health workers (CHWs) and psychologists and their placement in accessible community health facilities (HNSS, 2008, p. 31).

3. Recognized Mental Health as a priority public health issue. As a direct consequence of the years of conflict, Afghanistan has a large number of disabled and mentally ill people for whom treatment and rehabilitation services need to be developed and for whom assistance will be required in order to re-integrate them into the daily life of the country (Mental Health Strategy, MoPH 2011-2015).

4. The GoA has made a definite and clear commitment to address Mental Health and psycho-social issues with the strategic service delivery statements of a commitment to develop a flexible range of integrated Mental Health support and care services at all levels of the health system (ANDS, 2008, p.241).

5. Hence under government national priority program(NPP) which developed to implement ANDS (Afghan National Development Strategy), HNSS (Health and Nutrition Sector Strategy) there will be an opportunity for implementation of this strategy provided to create strong link with other government priority programs such as Women affair Strategy, Gender and Human Right Strategy, Labour and Social affair Strategy and Policy for the Youth, Mental Health Strategy, policy for Drug Demand Reduction, Harm Reduction Strategy and guidelines, which their main focuses support to women, poor people vulnerable youth, mentally ill patients, and drug users respectively. Thus, this strategy will help to create a bilateral cooperation among every one of them to mobilize their resources and to focus on reduce suicide, self-immolation, and support those ministries to achieve their goals in line with suicide prevention, and provide a context to integrated, coordinated and multi-sectoral measures such as sharing information, reduce risk factor for suicide and promote protective factor to prevent suicide.

Link with other programs and departments:

As far as suicide is not exclusive to one or two programs, and the factors contributing to suicide is broad and risk factors are hidden in heritage of post war society. So all the different programs can play a key role to successful implementation of this strategy and collaborate to reduce suicide rate amongst vulnerable groups. The programmes/departments, which will contribute for the activities are Disability and Rehabilitation, Harm Reduction Program, Youth Programs, Reproductive Health, HIV/AIDS, Health Promotion, Community Base Programs, Drug Treatment Programs, Prison Health Department, Gender and Human Right Programs.

Leading and implementing mechanisms:

The leading role for the implementation of this strategy, will be with Ministry of Public Health, MoPH in close cooperation with the different stakeholders. An annual plan will be developed and the Ministry of Public Health will coordinate the implementation phases. The formed advisory group, under MoPH facilitate inter-sectoral collaboration and provide recommendation to link with other sector strategies and activities. Also, the technical committee inside the MoPH continue working to identify priorities, develop plans and tailoring interventions, conduct monitoring- evaluations and highlight/apply the lesson learns.

At the regional and provincial levels, the different sectors will work closely with (PPHDs) Provincial Public Health Directorates to implement the priorities and facilitate monitoring and evaluation process at the provincial level, highlight lesson learnt and provide feedbacks for next steps.

Monitoring and evaluating progress:

1. Monitoring:

A monitoring framework will be developed to measure progress in implementing the strategy. Monitoring will also allow individual stakeholders to track their performance with respect to the actions they are involved in, and will be the basis for modifying actions to improve their effectiveness.

Progress on the implementation of this strategy will be monitored in various ways, including:

1.1. Routine data collection and analysis by the Ministry of Public Health, using the ICD-10, will track overall progress towards achieving the purposes of this strategy. Trends over time will be measured by three-year moving average data on both deaths by suicide and hospital admissions for suicide attempts. Monitoring will require improvements in the use, efficiency and scope of national coronial data collection and reporting. Trends in suicide data will be reported through the annual *Suicide Facts*, and five-year *Suicide Trends* publications.

1.2. The National Advisory Group for suicide prevention will meet at least twice yearly to review progress and decide what new initiatives should be implemented.

1.3. The Technical Committee for suicide prevention will meet monthly to discuss progress on the implementation of this strategy and ensure that policies and programmes throughout government are consistent and mutually supportive. The committee will co-ordinate reports from government agencies and make recommendations to the Advisory Group for future directions.

2. Review and evaluation:

While it is important to monitor overall strategy progress, it is also important to evaluate its component parts. This includes the implementation of a number of specific policies that span:

a) Improvements in clinical management;
b) Public health initiatives;
c) Community level actions; and
d) Development of culturally specific initiatives.

Evaluating these approaches will require the use of a range of research methods depending on the specific policy and the context within which it is developed. These methods will span the use of: randomised trials for clinical interventions; quasi-experimental designs for population interventions; qualitative studies of policy implementation and process; periodic population surveys to monitor Mental Health and related issues; and culturally appropriate research designs to examine the impacts of policy in different cultural contexts.

Evaluation is particularly important in the area of suicidal behaviour where relatively little is known about the policies and strategies that lead to beneficial results (Mann

et al 2005). It is essential that any new interventions for which there are little evidence will be designed and funded to include an evaluation component.

To support research, data collection and monitoring we need to:

- Build on the existing research evidence and other relevant sources of data on suicide and suicide prevention;
- Expand and improve the systematic collection of and access to data on suicides; and
- Monitor progress against the objectives of the national suicide prevention strategy.

Current context:

The policy of the government of Afghanistan has recognized the need for public health interventions to alleviate psychological distress, trauma, mental disorders, and suicidal behaviour in the general population. However, there are constraints on the provision of basic health and social services and a shortage of qualified Mental Health care practitioners (Waldman et al, 2006). Still large scale interventions are needed to prevent suicide and improve Mental Health.

With the support of the Government of Afghanistan (GoA), a National Mental Health Strategy (NMHS), 2011-2015 was developed. Following extensive consultation with a wide range of stakeholders, the Mental Health Strategy and other programs addresses key priorities with impact on suicide and self-immolation at national and regional levels, these programs comprises the following activities with direct or Indirect impact on suicide:

1. Integration of mental health and psycho-social counselling in primary health care:

1.1. Priority condition has been selected including suicide, self-harm and psychosocial stresses.

1.2. Case identification, referring and follow up are placed in all level of Primary Health Care (PHC) settings such as HPs (Health posts), SC (Sub Centres), MHTs (Mobile Health teams) BHCs (Basic Health Centres), CHCs (Comprehensive Health Centres), and DHs (District Hospitals).

1.3. Availability of basic psychotherapeutic medicines, providing basic Psycho-social counselling (in BHC) and advanced Psycho-Social Counselling (in CHC) level of primary health care settings has been ensured

1.4. A new category by the name of psycho-social counsellors were introduced at the CHC level to provide psycho-social support to those affected by psycho-social problems.

1.5. Standard curricula and learning resources package (LRP) for MDs (medical Doctors), PSCs (Psycho-social counsellors), Midlevel health workers (Nurses and MWs), CHWs-CHSs (community health workers-Community health supervisors has been developed.

1.6. Training for all categories has been conducted, and are ongoing.

1.7. Supervision and monitoring is an ongoing process.
1.8. Placing 8 deliverables in HMIS system, to monitor Mental Health activities/services.

2. Integration of mental health in the general hospital setting:

2.1. Development of psychiatric wards in Regional and General Hospitals, with outpatient services in all the provincial hospital, with training of staff on suicide risk assessment, aggression management, self-harms, and psychosocial problems.
2.2. A three-years European Union (EU) funded project to improve the quality of services and enhance capacity of staff including training of psychiatrist, psychologists, nurses, social worker, administrative and auxiliary staff on human right driven behaviour toward mentally ill patients and patient with suicide attempts, risk assessment and management of psychiatric cases, was implemented in Kabul Mental Health Hospital.

3. Online psychosocial counselling:

3.1. One online counselling centres and three hotline counselling centres have been established to provide psycho-social counselling for people in need or for who can't access to health facilities (IPSO, AFGA, STATT and AFRO).

4. Psychosocial counselling and legal counselling for women:

4.1. Since 2014 in sixteen shelters, psycho-social counselling and legal counselling is implementing by IPSO and Ministry of Women Affair(MoWA) , 4 of these shelters are located in Capital Kabul and 14 in provinces, where the most vulnerable groups (victims of GBV and family violence) have been protected.

5. Gender base violence and trauma sensitive approach for women:

5.1. Medica Afghanistan (Ex Medica mondiale) provides psycho-social counselling and legal counselling to women residing at the wards for burn patients in the women's hospitals in Kabul and Herat, since 2007.
5.2. Since 2005, staff working in the female hospitals in Kabul, Herat, and Balkh received on-going training on human rights, GBV and trauma sensitive approaches.
5.3. Staff in juvenile centres in Kabul, Herat and Balkh has received training to provide psycho-social support, since 2005. This training has also been implemented for staff working with women residing in prisons in Kabul, Herat and Balkh.
5.4. Community based self-help groups for women have been established including the topics of suicide awareness and education, intervention via psychosocial counselling, and postvention.
5.5. Community interventions such as psycho-social and legal counselling for GBV victims in female gathering places such as Bagh E Zanana in Kabul conducted since 2005.

6. National health strategy for Youth:

6.1. Recommendations for the Mental Health component of the National Health Strategy for Youth, were developed at a panel debate on the occasion of International Youth Day 2014, 12 August 2014.

6.2. Recommendations for preventing suicide among young girls were developed at World Suicide Prevention Day, 10th September 2014.

7. Psychosocial counselling for people diagnosed with HIV/AIDS:

7.1. A HIV/AIDS programme provides psycho-social counselling beside pharmacotherapy to around more than 2000 affected people with HIV/AIDS, HBS and HBV, and for 75 injecting drug users, which are under methadone maintenance therapy.

8. Treatment programme and counselling for drug users:

8.1. The MoPH is providing support for drug users through integrated approach (BPHS, EPHS and Tertiary Mental Health Hospital).

8.2. A vertical MoPH program is providing services for critical and street/homeless drug users in close cooperation with Ministry of Counter Narcotic (MoCN), Colombo Plan (CP) and International Narcotic Board and Law Enforcement of the United State (INL).

8.3. In 2014 MoPH developed 2 additional strategic documents:

8.3.1. Strategic plan for primary prevention of substance abuse.

8.3.2. Community based strategy for treatment of drug users. However, due to the lack of resources, these strategic plans and strategy for community base have not been implemented yet.

9. Emergency psycho-social support in disasters:

9.1. A standard learning resource package (LRP) for emergencies has been developed.

9.2. 92 Primary health care med level health worker trained on Emergency psycho-social support in East province Kunar by support of PU-AMI

9.3. Supervision and monitoring tools for emergency Psycho-Social Counselling has been developed.

9.4. The package is ready to replicate in other provinces at risk of disaster such as earth quick, flood, war and earth slip.

10. Community mental health programmes:

10.1. As part of the Mental Health System, there are community based programmes in Herat and Balkh, which are being implemented by the International Assistance Mission (IAM) and MoPH which is providing out-patient Mental Health Services and psycho-social support for people in need since 2003 (IAM, 2015).

10.2. Psychological first aid (PFA) adapted ,translated and around 300 volunteers from 10 vulnerable provinces in north trained to provide support during disasters

10.3. E Health Programs: a community E health program is running by Agha Khan Development Network (AKDN) in north province Badakhshan especially in far districts and sub-districts where days are needed to reach capital of the provinces such as Darwaz, Wardoj.

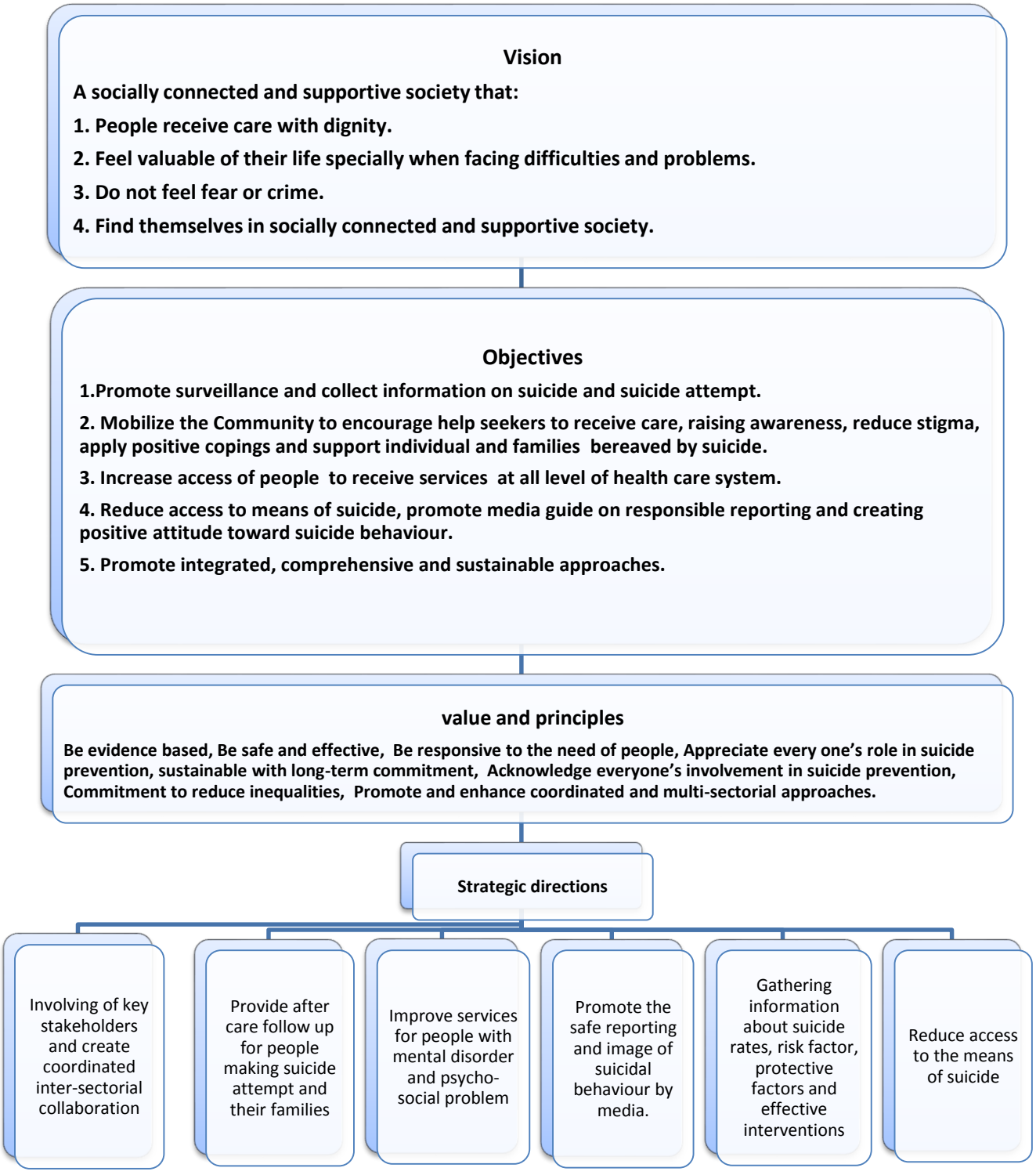
10.3.1. CHWs are trained on Mental Health applied mh GAP messages

10.3.2. Anti-stigma activity are conducted to decrease stigma

10.3.3. An electronic referring are put in place for sever cases

10.3.4. An on line consultation is established to Psychiatrist whenever is needed

Framework:



Value and Principle:

1. The strategy is based on the following key values:

- Respect for diversities (tribes, clans, nationality, languages, believes and geographical area).
- Sensitive to socio-culture-religious and gender issues.
- Promote dignity of society.
- Respect human right of people.
- Acceptable.

2. All activities in this strategy should be guided by the following principles:

- Be safe and effective.
- Be evidence base.
- Be responsive to the need of people.
- Acknowledging every one's role and involvement in suicide prevention activities.
- Sustainable with long-term commitment.
- Priority to the vulnerable groups.
- Promote and enhance integrated, coordinated and multi-sectorial approaches.

Strategic directions:

1. Involving of key stakeholders and create coordinated inter-sectorial collaboration.
2. Provide after care follow up for people making suicide attempt and their families.
3. Improve services for people with mental disorder and psycho-social problem.
4. Promote the safe reporting and image of suicidal behaviour by media.
5. Reduce access to the means of suicide.
6. Gathering information about suicide rates, risk factor, protective factors and effective interventions.

1. Strategic direction 1: Involving key stakeholders and create coordinated inter-sectorial collaboration:

This strategic direction is very important because Afghanistan is developing and implementing national suicide prevention strategy for the first time, hence a coordinated inter-sectoral collaboration is vital to identify the priorities, select intervention create coordination amongst different stakeholders and advocate for successful implementation of strategic plan, as still suicide is a criminal act by SHAREA law, civil and criminal law so more advocacy is needed to decriminalize suicide act.

Areas for action:

1.1. Identify key stakeholder from governmental and the non-governmental sectors, including parliamentarians, civil society, human right activist, media and donor agencies, to create advocacy toward suicide prevention.
1.2. Create a coordination mechanism of stakeholders for successful planning, implementation, monitoring and evaluation of the National Suicide Prevention Strategy. Ministry of Public Health have the responsibility of leading and facilitate inter-sectoral coordination and mobilize resources from different stakeholders, also MoPH will lead successful implementation including planning, monitoring and evaluation.
1.3. The stakeholders will provide advocacy, fund raising and effort toward decriminalization of suicide; the politicians from higher authorities such as cabinet, parliament houses and president house, will increase the importance of suicide prevention by their support.
1.4. Raise awareness and enhance commitment of governmental and non-governmental sectors including political and parliamentarian circles to mobilize resources and encourage authority to revise legislation/criminal law to recognize suicide as non-criminal act.
1.5. Identify priorities for prevention of suicide: A technical committee should be established by stakeholders to start working on priorities. These priorities should be selected based on comments from technical and advisory groups which comprises all governmental and non-governmental sectors, and based on information from monitoring and evaluation reports.
1.6. Identify the roles and responsibilities of deferent sectors such as Ministry of Public Health(MoPH), Ministry of Women Affairs (MoWA), Ministry of Labour-Martyr and Disables and Social Affiar (MoLSA), Ministry of Hajj and Religious Affairs (MoHRA), Ministry of Justice (MoJ), General Attorney Office (GAO), Ministry of Interior (moI), Ministry of Urban Development(MoUD), Ministry of Water and Agriculture(MoW&A), Ministry of Counter Narcotic (MoCN), Drug Regulation Committee (DRC), International Technical Agencies such as WHO, UNFPA, UNODC, EU, USAID, AIHRC and media to take responsibilities toward successful implementation of suicide prevention strategy at the capital and provincial levels.

2. Strategic direction 2: provide care and follow up for people committing suicide attempt:

This strategic direction will help to mobilize the community and health care system, human resources including users and families to provide support for those making suicide attempt. Also, will support follow up and after care, crisis intervention and postventions. The key role of community leaders and influenced person such as religious leaders' psycho-social counsellors, health workers, teachers, police and other influenced persons are crucial for early identification, follow up and after care.

Areas for action:

2.1. Provide human right driven support and after care services for people committing suicide, care should be available to nearest places, where people are living.
2.2. Community leaders and gate keepers such as religious leaders, teachers, police, and primary health care workers including, psycho-social counsellors and community health worker, community health supervisors should receive orientation to provide guidance and referrals for help seekers and encourage them to receive care.
2.3. Mobilize the community organizations and civil society to play positive role to provide information for people at risk and encourage them for positive self-care and effective copings.
2.4. Improve coordination and cooperation with civil society, NGOs, disability and rehabilitation services working within community to provide psycho-social and legal counselling services in female gathering places such as BAGH e ZANANA (Female garden in Kabul), women shelters for victim of GBV, female juvenile centres and female jails and identify such places to improve access.
2.5. Establishing after care supportive groups/self-help group within the community to improve self-care and create learning environment to reinforce positive copings.
2.6. Provide individual and family support for suicide attempt and those bereaved by suicide and for their family.
2.7. Improve in-patient and out patients services with follow up in the burning unites and emergency wards of general hospitals to provide quality of emergency services.
2.8. Promoting crisis intervention for prevention and postvention proposes.
2.9. Improving quality of services in a sustainable and human driven manner.

3. Strategic direction 3: Improve services for people with mental disorder and psycho-social problems:

Though Afghanistan started integration of Mental Health and psycho-social services in primary and secondary health care since 2005 and improved the quality of services in tertiary Mental Health hospital since 2012. There are still huge need to scaling up the integration process and improve the quality of services. The changes are needed at the policy level and also at the service delivery level to respond effectively in favour of patient with suicidal behaviour, self-harms, mental disorder for early identification, effective interventions, proper and effective treatment and care, management of common and severe mental disorder including substance abuse and psychosocial problem in a less stigmatic way are crucial.

Areas for action:

3.1. Revise/change Mental Health strategy and plans to be in line to provide quality of human right driven services for instance, early identification, treatment/intervention and bio-psycho-social management of mental and substance abuse disorders e.g., depression , mania, psychosis, anxiety disorder especially post-traumatic stress disorder (PTSD) and obsessive compulsive disorder (OCD), personality disorder which are the most disorders contributing to suicide.

3.2. Improve links between community and health care system to support people with mental disorder and suicidal ideation-behaviour about utilization of Mental Health and psycho-social services.

3.3. Scaling up integration of Mental Health and psycho-social counselling in primary health care to respond properly to those experiencing sign and symptom of mental and substance abuse disorder:

- 3.3.1. proper training for all primary health care work force to deliver proper treatment and intervention;
- 3.3.2. Revision of the training curricula for all staff categories of primary health care, to be sensitive to gender and strengthened part of suicide management;
- 3.3.3. Ensure the continuous supply of psychotherapeutic medication especially antidepressants;
- 3.3.4. Improving quality of services for people with mental disorders;
- 3.3.5. Expand accessibility through availability of service at all primary and secondary level with functional referral system;
- 3.3.6. Increase number of female psycho-social counsellors within primary health care settings to improve access for women and remove cultural barriers; and
- 3.3.7. Develop/revise guidelines, procedures and standards.

3.4. Establishment of functioning and equipped psychiatric units in the general hospital:

- 3.4.1. The staff of psychiatry units, should be trained to build up their knowledge and skills to deal with suicide attempts, those bereaved by suicide, assessment and bio-psycho-social management of suicide attempt and
- 3.4.2. Respond to referral from primary health care and other community centres including private sector.

3.5. Provide integrated Mental Health and psycho-social services in specific units such as causality units, burning and emergency unit of general hospitals.

3.6. Improve Care for marginalized groups such as:

3.6.1. Strengthening the GBV-psychosocial units in regional hospitals to provide legal, psycho-social and medical care for those people at need of such services, and

3.6.2. Referral link between these unites and judicial system should be functioned.

3.6.3. Promote community programs for displaced people especially for women, disables, young and adolescence inside camps and villages,

3.6.4. Community health workers(CHWs), community health supervisors(CHSs) from health care system or other programs support people at risk of mental and substance use disorder,

3.6.5. A referral system to connect them to primary health care system should be established.

3.7. Strengthening the non-pharmacological aspect of current model of treatment for drug users, such as motivational counselling, individual and family support, follow up and after care after leaving the drug treatment centres, relapse prevention program, vocational training and occupational opportunities are vital with support from other sectors.

3.8. Improve services including counselling for people affected by HIV/AIDS and HCV and HBS.

3.9. Strengthening/expansion of community Mental Health services and online or hotline services, E health and follow up for those people cannot access primary health care.

4. Strategic direction 4: Reduce access to the means of suicide:

Evidence reveals that majority of suicide attempts, suicide, self-harm and self-immolations contributes by pesticide such as organophosphates fuel, and drugs especially sleep pills, though there are no evidence about using arms and poisonous gases of cars for such proposes. There are no evidence that suicide cases occurring due to these materials, because of the strong stigma related to those acts and penalties which threats the relatives and families, will kept it hidden from the eyes of police, health providers and criminal justice system.

Areas for action:

4.1. **Pesticides:**

4.1.1. Ratifying, implementing and ensure about forcing of international convention on hazardous chemicals and wastes.

4.1.2. Measures to remove local and traditional pesticides form agriculture and traditional practices.

4.1.3. Regulation on sale and safe storages of pesticide such as organophosphates and other local and imported products.

4.1.4. Measures to reduce the toxicity and fatality of pesticides.

4.2. **Minimize access to medication and other available pharmaceuticals contributing to suicide :**

4.2.1. Encouraging the adaption of regulation on safer prescription of medications and other lethal pharmaceuticals.

4.2.2. Control use of local remedies such as opium and other productions.

4.2.3. Strengthening the regulation for drug marketing and sale by retailers.

4.2.4. Encourage drug regulatory committee (DRC) to adapt drug estimation based on the need under national and international regulations.

4.2.5. Legalize import of under control drugs such as opioid, benzodiazepines and other drugs to reduce smuggling

4.2.6. Restriction on import of unlicensed, cheap and smuggled drugs.

4.2.7. Restrict street vendors.

4.2.8. Legalise traditional useful medicine.

4.3. **Fire arms:**

4.3.1. Improve legislation and regulation for restriction of firearm such as procedures for obtaining license, waiting period for purchase.

4.3.2. Enforcing of safe storage of firearms in households.

4.3.3. Education of community on fire arm regulation and hazards.

4.4. **Poisonous gases:**

Though there are no evidence to use poisonous gases in suicide by people, however the following measures are recommended for further cautions;

4.4.1. Promote safety measures to reduce the toxicity and lethality of motor vehicles such as quality of imported benzene,

4.4.2. Strengthening regulation and procedures for importing second hand vehicles, changing period for vehicle old engine and measure to reduce car traffic in cities and crowded cities.

4.4.3. Promoting community education on use of raw Charcoal during winters.

4.5. **Building and bridge designs:**

Though there are no evidence to jump from height buildings for the purpose of suicide, however the following measures are recommended for further cautions

4.5.1. Promoting clear guideline of local governorates to improve measures and regulation on safe urban and bridge designs

4.5.2. Promoting regulation for restriction of possibility of jumping form height buildings markets, institutions, Macrorayans, business centres especially in capital Kabul and capital of the regions.

4.5.3. Promote regulation on safety measure for water walls (especially in rural area)

4.5.4. Increase education and regulation on river water especially when crossed from towns and populated areas.(especially in north province of Badakhshan)

4.6. **Minimize hazardous use and misuse of household gases and fuel:**

4.6.1. Safety measures for indoor use of gas and fuel to be developed and disseminated especially in south-east region (Hirat, Ghor, Nimroz)

4.6.2. Encouraging community education of hazardous use and misuse of gas and benzenes especially in south-east region(Hirat, Ghor, Nimroz etc)

4.7. **Students, drop out from higher education:**

4.7.1. Improve the environment and quality of learning in school and universities.

4.7.2. Promote measures to reduce school drop-out.

4.7.3. Promote measures to reduce concur drop-out.

4.7.4. Establishment of stress counselling programs for students.

4.7.5. Involve family/parents of students.

4.7.6. Promote sports/music, football, volleyball, and other competition for students.

4.7.7. Encourage higher education system to increase the chances to absorb more students.

4.8. **Enhance awareness and promote alertness of families and communities toward suicide**

4.8.1. Enhance community and family awareness regarding availability and hazardous use of means for suicide.

4.8.2. Community vigilance about suicide attempt by means and availability of possible emergency responses.

5. Strategic direction 5: Promote the safe reporting and image of suicidal behaviour by media:

Media has important role to demonstrate fascinating reports and portrayal of suicides especially reports from suicide of important ones such as journalist (Balkh-August 2015), failed lovers (burned oneself in Kabul Street June 2015) which might copycat by others. The important role of media in line to turn from inappropriate and irresponsive report to responsive and help seek oriented manner is vital, also media plays key role to raise awareness and reduce stigma attached to suicide, mobilize community to be supportive and encourage higher levels such as parliamentarians and government officials to decriminalize suicide in favour of new policies and practices.

Areas for action:

5.1 **Promote work with media/social media to provide safe reporting and encourage people to use positive copings in a way to decrease stigma attached to suicide:**

5.1.1 Media support:

5.1.1.1 Training of media reporters on suicide to prevent copycat, decrease stigma and promote help seeking behaviour, in the same time provide guidance to referral.

5.1.1.2 Develop and disseminate media guide on suicide.

5.1.1.3 Monitor the coverage of information and guidance.

5.1.1.4 Support media with new information on suicide.
5.1.1.5 Promote the role of media for prevention and postvetion.

5.1.2 Social media support:
5.1.2.1 Improve online counselling through trained psycho-social counsellors for those who can't access to health facilities and for those in need of urgent help.
5.1.2.2 Improve hotline counselling through trained psycho-social counsellors to provide urgent support.
5.1.2.3 Improve informative websites with availability of appointment to chat.
5.1.2.4 Encourage media to participate in awareness campaigns and stigma reduction.
5.1.2.5 Encourage role of mass media for advocacy.

6. Strategic direction 6: Gathering information about suicide rates, risk factor, protective factors and effective interventions:

Reliable Information and realistic data is scarce in Afghanistan, most of information comes from other surveys and research especially mental health, substance abuse, gender-based violence and human right agencies. Gathering information from different sources during implementation and after implementation of this strategy, will help policy makers and practitioners to tailor proper and effective policies and interventions, based on evidence and according to the needs. Research, monitoring and evaluation are the important approaches to get realistic and valid information. HMIS, surveillance and reports from hospitals and other facilities plus reports from other sectors such as Ministry of Women Affair (MoWA), Ministry of Interior (MoI), Ministry of Hajj and Religious affair (MoHRA), Ministry of Labour-Social Martyr Affair (MoLSA), Ministry of Urban Development(MoUD), Ministry of Justice(MoJ), Ministry of Water and Agriculture (MoWAC), Civil Society and Afghanistan Independent Human Right Commission (AIHRC) will help to effective interventions and evidence based policies.

Areas for action:

6.1 **Establish surveillance system to gather information about suicide and suicide attempt:**
6.1.1 Establishing integrated surveillance system to collect regular information about suicide and suicide attempts in Afghan context.
6.1.2 Establishing regular data collection and information system on suicide attempt, self-harm, self-immolation and suicide from different organizations working with suicide vulnerable groups.
6.1.3 Promote Identify people at risk of suicide and possible risk factors.

6.2 **Research:**
6.2.1 Promote Conducting researches on prevalence of suicide, effectiveness of interventions and find the gaps and barriers.

6.2.2 Researches to identify problems and responses of the need of different ethnic groups of Afghan society such as Pashtoons, Tajiks, Uzbiks, and Hazaras communities.
6.2.3 Researches to promote evidence based interventions.
6.2.4 Provide recommendations and suggestions to policy makers and planers to overcome barriers/challenges and find best practice approaches.
6.2.5 Promoting data analysis system to find the weaknesses and the strengths of the National Suicide Prevention Strategy.

6.3 **Registration and reporting:**

6.3.1 Establish a functional, reliable registration and reporting system from the level of health facilities to hospitals to collect information on suicide and suicide attempt, self-immolation and other types of self-harm.

6.4 **Monitoring and evaluation**:

6.4.1 Establish a monitoring and evaluation system for the implementation of national suicide prevention strategy.

6.5 **Reports from other sectors:**

6.5.1 Establishing a system of data collection from other sectors such as Ministry of Women's Affair (MoWA), Ministry of Hajj and Religious Affair(MoHRA), Interior Ministry (MoI) ,Ministry of Education (MoE), Ministry of Higher Education (MoHE), Ministry of Labour and Social Affair(MoLSA), Judicial system will be helpful.
6.5.2 Encourage Involvement of human right activists and Civil Societies in sharing the information
6.5.3 Involve civil society and NGOs whom their programs are contributing to suicide prevention.

Coordination Mechanisms:

Coordination plays a vital role in implementation of any program especially in implementation of National Strategy for Suicide Prevention, as most of risk factors are in other sectors and within the society. Coordination will help to mobilize resources from other sectors and encourage them to take proper measures to reduce suicide, such as measures in building height plazas, markets and etc. or measures in education system and regulations in agriculture to restrict the means. The following coordination mechanisms are proposed by this strategy at deferent levels and for deferent purposes:

1. Stakeholder meetings (national coordination mechanism).
2. Advisory group meetings (inter-sectoral collaboration).
3. Technical committee meetings (public policy level meetings).
4. Sub group working sessions (intervention and best practice sessions).
5. Provincial and regional inter-sectoral meetings on the implementation of National Suicide Prevention Strategy at the regional and provincial level.
6. Annual evaluation and monitoring workshops.

Implementation:

The National Suicide Prevention Strategy will be explained by a related strategic plan with specific actions, targets and responsible actors based on the priority and availability of resources. It will be for 5 or more years based on stakeholders decision and resources with an annual evaluation of the action plan. This will help to continue to next year, while challenges and barriers will be assessed by policy makers in annual bases and gaps will be identified at the end of the annual implantation plans. The new recommendations and suggestions will be incorporated into the next annual plans for effective intervention. A monitoring framework will be developed to measure progress in implementing the strategy. Monitoring will also allow individual stakeholders to track their performance with respect to the actions they are involved in, and will be the basis for modifying actions to improve their effectiveness.

References:

World Health Organization (2010), country profile- Afghanistan, Ministry of Public Health(MOPH) Afghanistan, (2005), the essential Package of Hospital Services for Afghanistan. (Ed. MOPH), PP. 1-52, Kabul, USAID http://moph.gov.af/Content/Media/Documents/EPHS-2005-FINAL29122010164126629.pdf

World Health Organization, WHO-AIMS Report on Mental Health system in Afghanistan, pp. 1-19, Kabul: WHO and MOPH http://www.who.int/mental_health/who_aims_country_reports/en/

Van de Put W., Addressing Mental Health in Afghanistan, The Lancet, Dec 2002, Vol.360 pg. S41

Hasrat-Nazimi W., (2013) Afghan women escape marriage through suicide, DW-Society, 18.04.2013, ed Sarah Berning, http://www.dw.de/afghan-women-escape-marriage-through-suicide/a-16750044

Majidy T, 2013, Women Comprise 95 percent of suicide in Afghanistan: Officials, Tolonews.com, Wednesday 11 September 2013, http://tolonews.com/en/afghanistan/11886-women-comprise-95-percent-of-suicides-in-afghanistan-officials

Nahiz, K. (2008) Afghanistan: Self-immolation on the rise among women. In *IRIN*: IRIN, the humanitarian news and analysis service of the UN Office for the Coordination of Humanitarian Affairs. http://www.irinnews.org/report/80236/afghanistan-self-immolation-on-the-rise-among-women

Khan M. M., Mahmud S., Karim M. S, Zaman M., Prince M., (2008), Case-Control study of suicide in Karachi-Pakistan, The British Journal of Psychiatry 193, 202-405, doi: 10.1192/bjp.bp.107.04206Khan, http://www.ncbi.nlm.nih.gov/pubmed/18978322

M. M. and Reza, H. (1998), Gender Differences in Nonfatal Suicidal Behavior in Pakistan: Significance of Sociocultural Factors. Suicide and Life-Threat Behavi, 28: 62–68. doi: 10.1111/j.1943-278X.1998.tb00626.x http://www.ncbi.nlm.nih.gov/pubmed/9560167

Khan, Murad Moosa; Reza, Hashim, The pattern of suicide in Pakistan, Crisis: The Journal of Crisis Intervention and Suicide Prevention, Vol 21(1), 2000, 31-35. http://psycnet.apa.org/psycinfo/2000-07829-004

Ghafarian Shirazi H. R., H. M., Zoladl M., Malekzadeh M. (2012) Suicide in the Islamic Republic of Iran: an integrated analysis from 1981 to 2007. *Eastern Mediterranean Health Journal*, 18, 607-6013. http://www.griffith.edu.au/__data/assets/pdf_file/0003/499350/Suicide-ResearchVol8.pdf

Mohammadi, M.-R., Ghanizadeh, A., Rahgozart, M., Noorbala, A. A., Malekafzali, H., Davidian, H., Naghavi, H., Soori, H. and Bagheri Yazdi, S. A.

(2005), Suicidal Attempt and Psychiatric Disorders in Iran. Suicide and Life-Threat Behavi, 35: 309–316. doi: 10.1521/suli.2005.35.3.309 http://onlinelibrary.wiley.com/doi/10.1521/suli.2005.35.3.309/abstract

Shooshtary M. H, Malakouti S. K, Bolhari J., Nojomi M., Poshtmashhadi M., Asgharzadeh Amin S., Bertolote J. M. & Fleisschmann A., Community Study of Suicidal Behaviours and Risk Factors among Iranian Adults, Archives of Suicide Research, 2008, Vol 12 (2), PP 141-147, DOI:10.1080/13811110701857475 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3939979/

Murray R. (2012), Self-immolation among Afghan women rises as UN pushes country to take action against violent crimes, NY Daily News, DECEMBER 13,2012 http://www.nydailynews.com/news/national/self-immolation-afghan-women-rises-article-1.1219570#ixzz2fdvP99xG

Afghan Public Health institute, Ministry of Public Health, Central Statistics Organization*, et al* (2011), Afghanistan Mortality Survey 2010. Kabul. Afghanistan. Calverton. Maryland. USA. Jaipur. India. Cairo. Egypt. APHI/MopH, CSO, ICF Macro, IIHMR and WHO/EMRO. http://moph.gov.af/Content/Media/Documents/AMS2010FinalFullReport14122011142624269553325325.pdf

Gobar A.H. (1970) Suicide in Afghanistan, *The British Journal of Psychiatry*, 116, 493-496,http://bjp.rcpsych.org/content/116/534/493

Campbel E. A. & Guiao I. Z, Muslim culture and female self-immolation, Health care for women International, 25: 793-782, 2004, Taylor & Francis Inc,

Morre U., 2010, War Not Cause of Self-Immolation Suicides in Afghanistan, UN Dispatch, http://www.undispatch.com/war-not-cause-of-self-immolation-suicides-in-afghanistan

Raj a, G. C., Silverman J. G, 2008, Driven to Fiery Death- The Tragedy of Self-immolation in Afghanistan. The New England J of Medicine, 358, 2201-2203

Mental Health and childhood adversities: a longitudinal study in Kabul, Afghanistan. Panter-Brick, C[1], Goodman A, Tol, W, Eggerman M., http://www.ncbi.nlm.nih.gov/pubmed/21421175

HN-TPO, Suicide in south Asia: a scoping review of published and unpublished literature final report Oct, 2013, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4299381/

Outcome report: inception workshop National Health Strategy for Young People 2015 – 2019, 3 September, 2014 Kabul-Star Hotel.