What Matters? Afghanistan Speaks!

November 2025

Mental health and psychosocial support (MHPSS)

Exploring pregnant and lactating women's mental health experiences

"Women don't talk about these problems with anyone because there is no benefit in speaking."

Pregnant woman, Ghor

Introduction

Mental health changes during pregnancy and the post-partum period are experienced by many women. Physiological changes that occur at this time can impact the emotional wellbeing and overall health of a pregnant and lactating woman.

This research explores the pregnant woman's experience, family responses, and the challenges they face. We also try to understand how this change is understood and what are the possible solutions in their everyday practice.

Research approach

The research draws on 42 qualitative interviews with pregnant and lactating women, husbands, and mothers-in-law, as well as mental health experts across seven Afghan provinces, during September and October 2025.

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Pregnant and lactating women's mental health stories

Participants spoke about various mental health issues[1] during their pregnancy and post-partum period. They mentioned symptoms of poor mental health during their pregnancy and after birth, including emotional distress and conflict with family members, particularly mothers-in-law and husbands. Reported symptoms included crying, a loss of appetite, sleeplessness, weaknesses, self-harm, and harm towards the husband or baby. There were reports of people feeling fear during their sleep, as well as isolation, restlessness, anger, feeling upset, irritable, impatient, dizzy, nauseous, aggressive, and dissatisfied. There was also mention of physical symptoms such as headaches, numbness, and anxious wringing of their hands and feet, and body pain.

"…when I was pregnant, I had these problems — I was depressed, cried a lot, became restless, and some days didn't talk at all".

Lactating woman, Badakhshan

Women were also concerned about their upcoming labour, potential caesarean delivery, and the responsibilities of motherhood, as well as distressing thoughts about a lack of family support. Additionally, women experienced behavioural changes such as aimless wandering, pulling out their hair, refusing to share their meals, being in distress, and feeling they were in possession of a jinn (a spirit entering the human body) after childbirth.

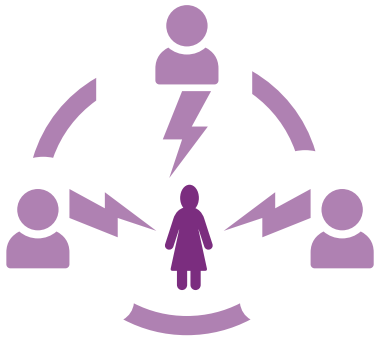
[1] Perinatal mental health refers to the emotional and psychological well-being of women during pregnancy and up to one year after childbirth. Common conditions include depression and anxiety, though more severe disorders can also occur. For further information, see the 'Guide for integration of perinatal mental health in maternal and child health services". Geneva: World Health Organization; 2022: https://iris.who.int/server/api/core/bitstreams/63b2d474-202f-45d8-84fa-e80762ec86cc/content

Untold narratives: women's silent struggles with mental health

Women mentioned that they face stigma when sharing their mental health issues with other people. As a result, they reported keeping their mental health concerns hidden and did not share their concerns with their family members, such as their mothers-in-law and husbands. Reasons for this include being fearful of family conflict, feeling threatened by family members, or feeling a sense of shame.

"Sometimes they even say, 'She has gone crazy,' and look at us as if we are insane. Women don't talk about these problems with anyone because there is no benefit in speaking. People don't understand, and their behaviour becomes even worse".

Pregnant woman, Ghor



Limited understanding of mental health issues

Family members were also reported to lack awareness and have a limited understanding of the woman's mental health situation. Women often experienced an absence of support, such as family members not accompanying the woman to a health clinic to get treatment.

A lack of trust and courage, whilst having low expectations of family members support due to previous negative responses, are other reasons that result in women's silence. Harmful family perceptions, such as viewing women as 'cunning', being 'spoilt', and 'lying', also discouraged communication and contributed to women's silence, often until the situation became severe.

"During this pregnancy, I am tired and upset and have depression. My mental condition is not good at all, but my mother-in-law says, 'You are just being spoiled and making excuses because you are bringing a child for us.' My mental state is really not good".

Pregnant woman, Ghor

Women reported having threats of getting a second spouse or mistreatment if they gave birth to another female baby.

Family members use offensive terms for women with mental health issues

Harmful or dismissive labels

"Mad" (Lewanai, Deewana), "mental", "lost her mind", "without mind", "mad since childhood" "forever sick".

Cultural or spiritual beliefs

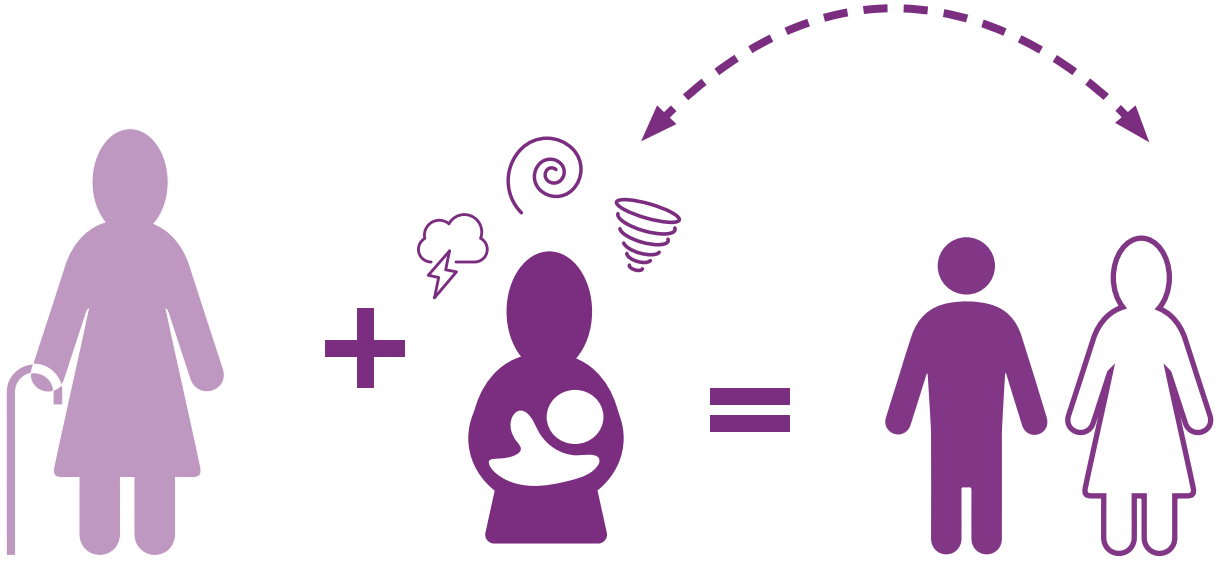
Piryanai or jindi ("Jinn possessed" or "a spirit has entered her body")

Judgemental labels

"Crafty", "naive" (sada), "in love with another person", "foodie"

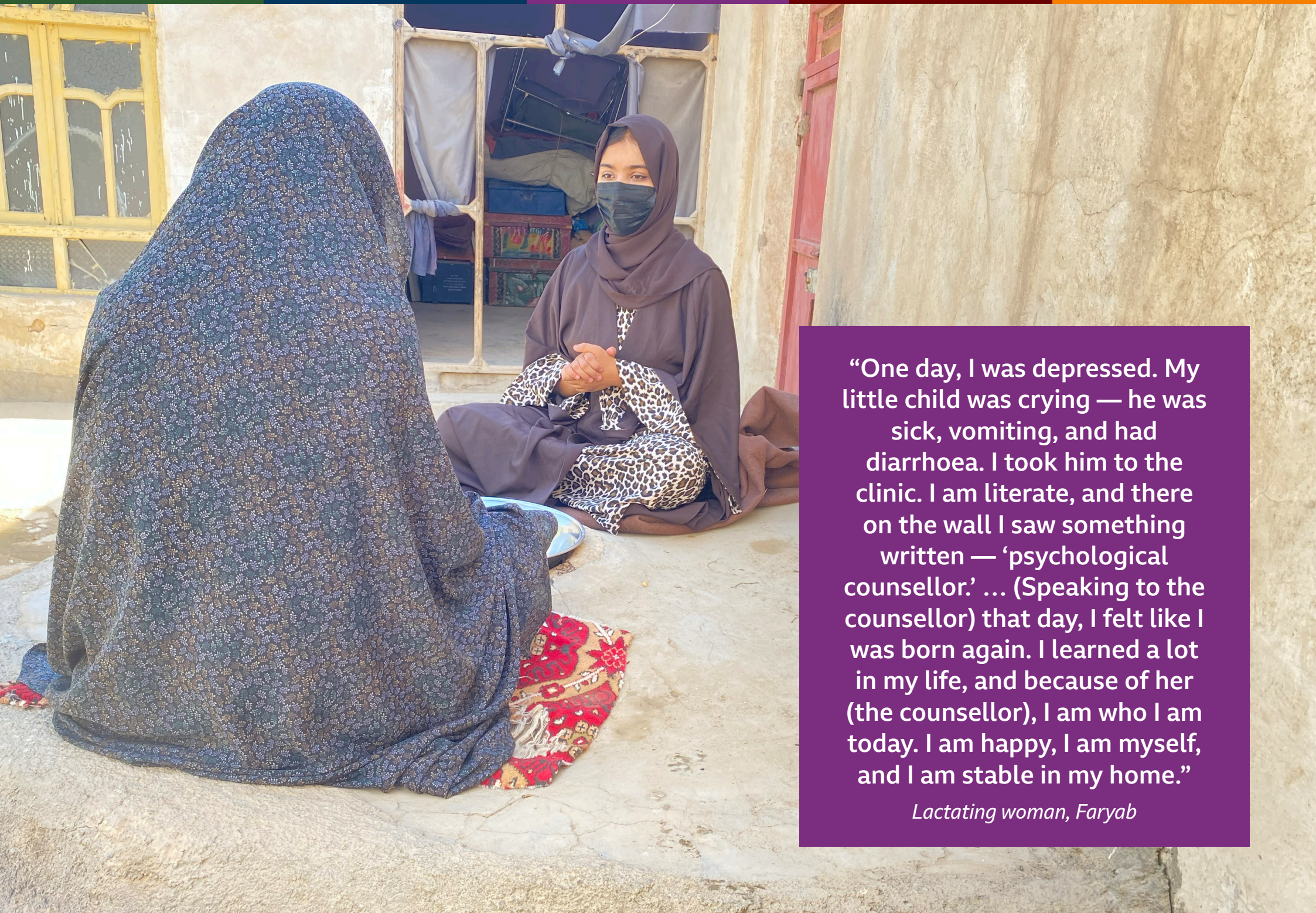
Stigmatizing as dangerous

"A biter who harms herself and other people"



Mothers-in-law sometimes appeared dismissive in their statements, including, "It's a common issue experienced by each woman", "our home needs a second wife for my son because of your conflict and disruptive behaviour". There was also suggestion from them that mental health is a personal weakness; "she can control her behaviour and care for herself. When we were pregnant and delivered births, we did so without accessing proper health care or diets and never acted cunningly or disturbed the family."

However, in our research there were women who went against the norm and were able to share their mental health problems with household members or visiting health clinics and doctors. They tended to be more educated.



"One day, I was depressed. My little child was crying — he was sick, vomiting, and had diarrhoea. I took him to the clinic. I am literate, and there on the wall I saw something written — 'psychological counsellor.' … (Speaking to the counsellor) that day, I felt like I was born again. I learned a lot in my life, and because of her (the counsellor), I am who I am today. I am happy, I am myself, and I am stable in my home."

Lactating woman, Faryab

Family dynamics in severe cases

When the mental health of a woman gets worse, family members, particularly mothers-in-law, may initially refer the women to traditional contacts such as religious leaders (Mullah, Agha, Hakim, Mia, Pacha) and shrines. In some instances, they leave the women isolated without treatment or any social engagement, because of her mental health condition.

Traditional treatment of mental health issues

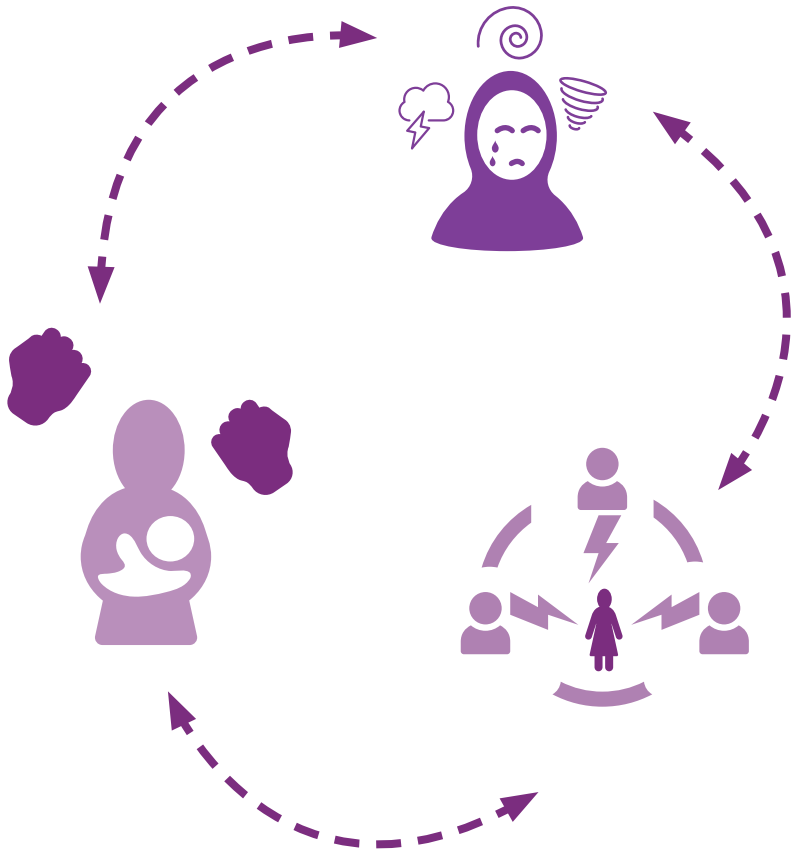
Participants reported seeking support from traditional sources including religious leaders (Mullah, Agha, Hakim), a seer or fortune teller (Pali), and shrines. Some believed that mental health issues occur due to a spirit or ghost, black magic, or evil eyes, so they prefer to visit these traditional contacts for support. These traditional sources are often seen as an accessible option as they are typically located in nearby locations.

Traditional methods to remove the perceived spirit or black magic included practices such as prayer, providing talisman (Taweez) with Quran verses, and writing Quran verses on small pieces of paper, that was then mixed with water for drinking and bathing purposes (Sakht). Other rituals included using Bair tree leaves followed with water for bathing for three days, and smoking paper around the person.

Some other methods included violence, such as hitting the women with a stick, plastic pipe, or whip for removing the spirit from her body. These practices increased the fear and distress of the women and further worsened their mental health condition.

“We were surprised, and her family was also shocked. Some people said she was possessed by spirits; others said she had a mental illness; some said she had been bewitched; everyone said something different”.

Mother-in-law, Nangarhar



The participants mentioned that some religious leaders, seers or fortune-tellers requested money and sheep for removing a spirit or magic from the woman’s body. They believed that some women experienced positive outcomes from visiting these places.

When they find these traditional sources ineffective, some families then refer them to health clinics.

Stigma in receiving mental health and psychosocial support (MHPSS)

Barriers to accessing MHPSS services

It was clear that it was uncommon to visit a health clinic to receive MHPSS services, due to shame, stigma, a lack of family support and lack of access. MHPSS counselling is often wrongly associated with being “mad”, or a sign that a woman dislikes her husband or is judged as “harassed”. Families can feel uncomfortable talking about visiting a health clinic for mental health issues, as they feel it can damage the family’s reputation. These factors all lead to family members preventing women from having counselling.

“Yes, women feel ashamed to go to a mental health doctor. People make fun of them, saying, ‘The wife or daughter-in-law of so-and-so has gone crazy or become mentally ill.’ They also say, ‘Maybe her husband’s family is very bad, that’s why the daughter-in-law went crazy.’ Because of this shame, they don’t take women to health centres.”

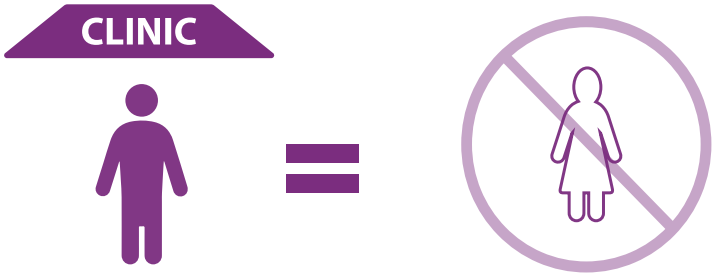
Pregnant woman, Ghor

Apart from the societal and family reasons mentioned above, there is also a lack of awareness of available services, and a shortage of health clinics. Costly treatment via private health professionals can also be unaffordable. Typical challenges such as the distance to health clinics, a lack of vehicles, and transportation costs also prevent easy access to services.

The struggles women face in receiving MHPSS counselling

Women who did receive MHPSS counselling talked of the challenges they faced. They noted a shortage of MHPSS professionals, and that they did not feel properly cared for – this included being referred to as "patients with mental health issues", feeling not listened to or made to feel uncomfortable discussing issues such as harming themselves or their babies with MHPSS counsellors.

A lack of MHPSS professionals, particularly female staff, was also highlighted.



"Yes, there are women in our area who are too shy to go to the doctor and discuss their problems. For example, in the mental health department, the doctor we have is male; we do not have a female doctor. For a woman, going to a male doctor is very embarrassing…"

Husband, Faryab

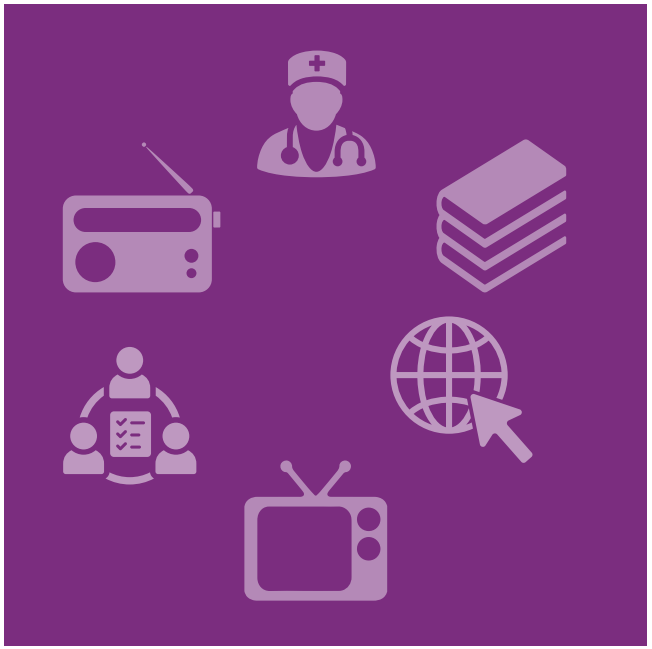
Women felt shame in sharing issues with male MHPSS counsellors, or when their husbands and mothers-in-law were present.

"I saw a person who had such problems. When I advised her to go to a clinic or to a counsellor, she said, 'If someone finds out that I am going to the counsellor's room, they will label me as mentally ill or crazy. That's why I avoid going".

Lactating woman, Badakhshan

Information sources

Women we spoke to received information on mental health from a range of sources, including family members, elder women, peers, women gatherings, vaccinators, health clinics, the radio and TV. Some received information from community awareness sessions, MHPSS counsellors, internet, seminars, traditional healers, educated persons, and women who have experienced mental health issues. The information often covered behavioural changes during pregnancy, depression, and other mental health issues faced by pregnant women.



Recommendations

Based on this research, a key priority is to address the social stigma and shame related to experiencing mental health issues when pregnant or lactating. To achieve this, communication efforts must raise awareness and address the barriers highlighted in the research at an individual, family and community level:-

- **Individual level** – encourage women to take an active role in caring for their mental health and to feel confident sharing their concerns with trusted family members, such as mothers. Raising awareness about the harmful consequences of concealing mental health challenges is essential to encouraging open, supportive conversations.
- **Social engagement** - encourage women with mental health issues to engage in social activities such as participating in women's gatherings and household chores.
- **Family level**- Raise awareness for family members, particularly mothers-in-law and husbands, around mental health issues during pregnancy and the postpartum period. Highlight the importance of family support for women suffering from mental health issues, whilst addressing the harmful and negative outcomes caused by poor family treatment and misperceptions. Promote the relevant referral and treatment sources and encourage family members to provide supportive behaviour with women in terms of care, treatment, nutrition, and rest.
- **Community level** - tackle the shame and stigma in visiting mental health doctors through providing examples of positive stories. Highlight the disadvantages of using offensive terms and visiting traditional contacts.

Another key challenge is increasing awareness and improving the delivery of Mental Health and Psychosocial Support (MHPSS) services.

Health clinics - must actively increase the awareness of their MHPSS services: Communication can help women to understand what MHPSS services are available at health clinics. Also, emphasise the importance of attending MHPSS follow-up sessions to ensure long-term wellbeing.

Efforts can be made to tackle the shame in sharing issues related to speaking to mental health doctors. Clinics can show respect and preferential treatment for women with mental health issues and ensure their dignity and privacy is provided during consultations. Increasing the availability of female MHPSS counsellors is also critical to provide a culturally sensitive environment.

About What Matters? Afghanistan Speaks!

What Matters? Afghanistan Speaks! is a quarterly bulletin which informs the humanitarian community about how people are experiencing issues on the ground. It is part of the Driving Action for Well Being to Avert Mortality (DAWAM) project which aims to contribute to decreased morbidity and mortality in women and girls and high-risk groups including persons living with disability in Afghanistan. The project is funded by the Foreign, Commonwealth & Development Office (FCDO). It is implemented in seven provinces by a consortium consisting of World Vision-Afghanistan, Action Against Hunger (ACF), Action Aid (AA), BBC Media Action, Nai Qala, Afghan Women's Educational Centre (AWEC) and AADA.

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Methodology

Data for this bulletin was collected through 42 in-depth interviews (IDIs) during September and October 2025. Participants included pregnant and lactating women experiencing mental health issues, women without these issues who observed these challenges in others within their community, as well as husbands, mothers-in-law and religious leaders across the project target provinces - Badghis, Herat, Faryab, Daikundi, Badakhshan, Nangarhar and Ghor. Key informant interviews (KIIs) were also conducted with two MHPSS experts from DAWAM implementing partner organisation including Action Against Hunger in Afghanistan.

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