Risk factors associated with depression among women aged 18-45 in Kabul, Afghanistan

by

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LIST OF ABBREVIATIONS

ARF  Acute Renal Failure

BHC  Basic Health Center

BPHS  A special package of primary healthcare services developed by the Ministry of Public Health of Afghanistan

BPHS  Basic Package of Health Services

BPSM  Bio psychosocial management

COPD  Chronic Obstructive Pulmonary Disease

CRF  Chronic Renal Failure

IHD  Ischemic Heart Disease

KMHH  Kabul Mental Health Hospital

MoPH  Ministry of Public Health

NHA  National Health Account

PHC  Primary Healthcare Services

PSM  Psychosocial management

UN  United Nations
UNICEF  United Nations Children’s’ Fund

UNODC  United Nations Office for Drug Control

WHO  World Health Organization
DEFINITIONS OF TERMS

Marastoon  A governmental shelter for mental health patients and addicts who have no family and home.

Primary Health Care Services  Basic curative and preventive health services, usually provided outside the hospital by health clinics.

WALWAR  The amount of money, which groom has to pay for bride’s family/in-laws.
ABSTRACT

Background: Currently, it is predicted that 350 million persons experience depression around the globe. It is a common problem among women in less developed countries – especially in war-torn countries. Lack of education, unawareness of their rights, having no authority in engagement, as well as war-related aspects are all risk factors for depression. Consequently, the author designed this research to determine the relation of diverse factors (i.e., war-related, cultural, low education, etc.) associated with depression among women aged 18-45 in Kabul, Afghanistan.

Objective: The objectives were to determine the association of depression with the following factors: (a) war-related factors, (b) some negative cultural practices such as (forced marriage), (c) low and irregular income, (d) living away from spouse and (e) to low education among women in Kabul.

Methods: A cross-sectional study with a total of 200 women aged 18-45 years old was conducted in two hospitals from the 9th of August 2014 to the 25th of August 2014 in Kabul, Afghanistan. The case group was selected from Kabul Mental Health Hospital, and a control group of psychologically healthy women from the same socio-demographic group was selected from the Isteqlal Hospital.

Results: Eight percent of the case and 0% of the control group had a history of forced marriage; the result of the Chi-square test is ($\chi^2 = 9.780$) with a P value = 0.001 (thus, the P value is significant as it is lower than 0.05). A history of arranged and voluntary marriage is seen semi-equally in both groups, and this has had no significant effect on the mental status of these women.
Thirteen percent of women in the case group and 5% in the control group have lost their husbands; the result of Chi-square test is \( \chi^2 = 3.907 \), P value = 0.048 and the P value is significant (lower than 0.05). Seventy-three households in the case group had \( \geq 10 \) members, and 27 households had < 10 members, while 22 households in the control group had \( \geq 10 \) members and 78 households in the control group had <10 members; the result of Chi-square test for household member is \( \chi^2 = 54.351 \), and P value = 0.00. Eight percent of women in case group and 4% of control group live away from spouses; the result of Chi-square test is \( \chi^2 = 1.418 \), and P value is insignificant (0.233). Forty two percent of the case group had education and 54% of control group is also educated. Fifty eight percent of case and 46% participants of control are illiterate, and the result of Chi-square test is \( \chi^2 = 2.884 \), and P value is insignificant (0.089).

**Conclusion:** In this research, depression was associated with war-related and socioeconomic factors such as widowhood, forced marriage, low level of education, and low and irregular income. Efforts should be focused to solve negative cultural practices and war-related factors as well as the creation of a women awareness system to make them aware of their rights. Furthermore, a recommendation is to increase the number of mental health hospitals and regionalize the mental health services.

**Keywords:** Depression, married women, war-related factors, cultural practices, Kabul.
CHAPTER ONE

1 Introduction

The unending war and conflict in Afghanistan has caused endless social stress that has a destructive effect on the mental health of the people. The objective and effort of this research is to identify the association of war-related, cultural and socio-economic problems with depression among women aged 18 to 45 in Kabul, Afghanistan. Furthermore, through this study we discuss some traditional and social norms that have dominated women’s lives in Afghanistan. Particularly, this research examines the relation of low and irregular monthly income, women’s education level, loss of family member(s), as well as forced marriage with the level of stress and possible depressive symptoms among women.

According to a World Health Organization (WHO) survey released in 2012, many individuals suffer from depression around the globe; this is a major “contributor to the global burden of disease”. Currently, it is predicted that 350 million persons experience depression. One out of twenty persons experienced an incident of depression in the prior year; the World Mental Health Survey, which was piloted in 17 countries, indicated the above result. … (WHO, 2012).

Additionally, the World Health Organization (WHO) announced the result for all countries around the world. However, the situation of mental health in Afghanistan and many other war-torn countries is different. According to (Dr Alemi, 2014), the number of patients regrettably increases day-by-day, and based on his anticipation, more than 50% of
the population in Afghanistan has some form of a psychiatric problem. Therefore, Lopes Cardozo and colleagues piloted a nationwide mental health study in 2002, and they stated that 73% of Afghans experience symptoms of depression, 84% have symptoms of anxiety, and 59% of them have posttraumatic stress disorders (Cardozo et al., 2005). Also, the WHO declared in a report focused on Afghanistan’s mental health system, that in 2005 there were eight psychiatrists, eighteen psychiatric nurses and twenty mental health professionals for a population of 27 million (WHO, 2006).

Hence, the World Health Organization disclosed in another report in 2001 that, there are no mental health centers to deliver proper health services, or the existing centers are not well equipped. The latest battles have totally damaged the core psychiatric hospital in Kabul. Only one of four public mental health clinics work, and there is a shortage of qualified psychiatrists in the country. The Afghans have suffered from prolonged mental disorders for decades. Prior findings have declared that 20 to 30 percent of Afghans are suffering from mental illnesses, due to continuous war and domestic violence (WHO, 2001).

Therefore, war and internal conflict have damaged all infrastructures, including the health system, in Afghanistan. Many professionals from all fields immigrated to other countries.

Unfortunately, despite the considerable improvements in the modern world, depression is one of the highest and most usual psychological disorders. According to the World
Health Report 2001, based on “disability-adjusted life years, or DALYs”, depression was the fourth main reason of disability among all illnesses. If the existing tendencies remain, it will be the second-most significant root of infirmity in 2020 (Corey & Sherryl, 2006).

Also, according to Murrray and Lopez (1996), depression is recognized as a main health problem and is a key reason of “psychological and physical morbidity”. It is expected to be the second merely “ischemic heart disease in terms of total burden of disease burden to 2020” (Murray & Lopez, 1996).

However, there are different studies conducted in Afghanistan on mental health that report different results. According to Bolton and Betancourt, generally in Afghanistan the findings on “mental health” have concentrated on the occurrence of “post-traumatic stress disorder (PTSD), depression, and anxiety” (Bolton & Betancourt, 2004). Consequently, Scholte and colleagues reported some percentages from their research, reporting that, in Afghanistan, the occurrence of “symptoms of depression and anxiety” was discovered to be excessive: “38.5% to 67.7% for depression, and 51.8% to 72.7% for anxiety” (Lopes, et al., 2004; Scholte et al., 2004).

This study focused on women’s problems in Kabul, the capital of Afghanistan. Women have suffered more than men because of war and conflicts. According to both Lopes and colleagues and Scholte and colleagues, many researchers have disclosed that females after war in Afghanistan live with worse mental health conditions (such as elevated “anxiety, PTSD” and have followed several “traumas”) than males (such as elevated “anxiety, PTSD”
and several “traumas”) (Lopes, et al., 2004; Scholte et al., 2004).

Based on above research in Afghanistan, many women live in a worse mental health condition than men. Women suffer more than men because the Afghan society is a man-dominated society. In a majority of families, females have no right to be involved in families’ decisions.

According to de Jong’s argument, there are numerous reasons that cause psychological disorders among Afghan females that have been declared; specifically, these are schooling, age, spousal situation, “ethnicity”, surviving tools, and uncertain wages. Revisions have regularly discovered that the learning level have protective aspect for psychological disorders. There are many examples that the low level of education has related to PTSD amongst postwar countries plus Afghanistan (de Jong, 2002).

Furthermore, the USSR invaded Afghanistan in 1979 until 1989. According to Hilton’s argument, after the withdrawal of Soviet forces, the combat continued between the communist party and the resistance parties; the internal conflicts continued for more than 20 years. … All of this turmoil badly affected Afghans, particularly the females. When the communist regime collapsed, the war and conflicts continued for more than two decades (Hilton, 2001). Furthermore, Hilton argues that war and domestic conflicts had their own negative impact on Afghans – especially on women.

During the occupation of the Soviet Union, many Afghans lost their life. Millions immigrated to other countries and tens of thousands became disabled due to land mines.
According to physicians of human rights, during the occupation period, Afghans faced bombing, slaying and a huge number of “landmines”. The Afghan-USSR war caused approximately 6 million immigrants and 1 million deaths. After the Soviet Union retreat, the fight continued until 1996 among Afghan armed groups (“mujahideen”); “tens of thousands” of inhabitants lost their life and “more than half a million” individuals were displaced. The Physicians for Human Rights Report has added that within this time, Kabul, the center of Afghanistan, was continually bombardered and “tens of thousands of landmines were laid” (Physician for Human Rights;, 2001).

Based on a WHO report, due to extended ferocity and diplomatic instability, the majority of people in Afghanistan suffer from mental disorders. Inadequate mental health assistance, the destruction of the key psychiatric hospital in Kabul, and the insufficient mental health facilities are the key reasons for no mental health services in the country (WHO, 2001). As WHO reported in 2001, more than three decades of war and instability caused many problems in different parts of Afghan life. The combat and internal violence destroyed infrastructure, including health facilities.

War and conflicts have destroyed the infrastructure of the country and adversely affected the life of people; especially, war in Afghanistan has seriously affected the women. Women in Afghanistan feel inequality with their men counterparts. In several occasions, they are mistreated and denied schooling, health care, job opportunities and other fundamental “human rights” (Rasekh Z. , Bauer, Manos, & Lacopino, 1998).
This issue was raised in an interview with psychologists. Dr. Emal Safi, the trainer specialist of KMHH, added, “many male-dominated families consider that female is the inferior or second gender”.

Due to a lack of awareness between people about mental health disorders, as well as a lack of mental health facilities in the country, the majority of people who suffer from mental disorders seek remedy in non-medical ways, as Lopes and colleagues stated. Afghan men and women try to get remedy by following the “religious” ways like reciting Muslim’s holy book and doing prayer (Lopes, et al., 2004).

Also, 98 percent of respondents of a survey stated that ‘Allah’ is the only emotive supporter during tension, while household affiliates or colleagues were other supporters (Bolton & Betancourt, 2004; Scholte et al., 2004). Furthermore, 98% of participants in a survey mentioned that Allah is the only supporter during distressed situations, and patients pray and read the holy book (Quran).

As Julie argues, “urban women, accustomed to moving about without restrictions, were devastated by the edicts. Severe depression led to some suicides. International health workers reported a number of women brought to hospitals after ingesting caustic soda – a painful but common means of suicide among women. Cultural stigma and religious prohibitions cause most cases to go unreported; some deaths are recorded as accidental. Depression also plagues men who feel ashamed of their inability to support their families. Some react to the stress by lashing out at their wives and children” (Julie, 2000).
As I had a discussion with psychiatrists and psychologists of Kabul Mental Health Hospital, they stated that suicide cases are reported less, due to different reasons, such as Islamic belief, cultural stigma as well as a lack of information from rural areas about suicide.

Based on another argument (Murray & Lopez, 1996), nowadays depression is known as the main health problem, which causes psychosomatic disorders. After ischemic heart problems, it is estimated that depression would be the second-most burdensome disease by 2020.

In the year 2008, the World Health Organization stated that the immobilizing burden of the neuropsychiatric situation is approximately similar for men and women, but the main causative reasons are different. When depression is the main trigger for men and women, “the burden of depression is 50% higher for females than males”. Indeed, depression is the principle reason of disease burden for females in high, middle and low-income nations (WHO, 2008). Corey & Sherryl have stated that the prevalence of depression is higher among women than men around the globe. However, this “gender gap” appears in puberty and continues during maturity … (Corey & Sherryl, 2006).

This thesis is organized into six chapters: the initial chapter concentrates on the introduction of research problems, objectives, questions, and research hypothesis. The second chapter discusses the related literature and studies about depression, especially about the risk factors of depression among women. The third chapter identifies the country
profile and the situation of mental health facilities in Afghanistan, especially in Kabul City. The fourth chapter covers the methodologies and a detailed discussion of tools used to collect data from two groups (case and control) for research. The fifth chapter assigns the findings and results of collected data. The sixth, final chapter focuses on a discussion and conclusion. The bibliography is referenced at the end.

1.1 Research Background

Before the Russian invasion, there were no good and sufficient health services in the country. Unfortunately, the situation has gotten much worse after the Russian invasion with continuous conflicts for more than two and half decades. Afghanistan is one of the countries with the poorest health systems in the world. According to Accera, Iskyan and Qureshi, (2001), the country was classified as 173 of 174 nations of the world in relation to the human improvement guide. The country had the maximum mothers death rate, at 1600/100,000 live deliveries, and the fourth highest below-five death rate in the world. Additional health difficulties include an almost distorted health system, a minor approach to healthcare facilities, even poorer nutrition status, and an even greater death and illness of infectious diseases (Accera J. R. Iskyan K. & Qureshi, 2009).

Based on Accera and colleagues, there are insufficient health facilities and a lack of a proper health systems, including mental health department, to meet the need of people.
1.2 Statement of the Problem

Residents of Kabul city suffer from a lack of mental health facilities. As Dr. Emal Safi, the trainer specialist of Kabul Mental Health Hospital, stated, “Kabul Mental Health Hospital has a total of one hundred beds. But these beds are divided into three separate departments. Forty beds are allocated to substance addicts. Forty beds are assigned for male patients. Twenty out of 60 beds are allocated for female patients. Therefore, these hundred beds are too few and not enough. Now at the time of speaking we have no single reserve bed for an emergency case. If awareness increases about psychiatric disorders, we surely say on that time we will need several psychiatric hospitals”.

“In the 1980s, the Department for Mental Healthcare in the Ministry of Public Health” started to regionalize the mental health care and improve community mental health services. Finally, the Ministry of Public Health built four communities mental health centers in Kabul, but regional stages of the centers have not been opened due to the uprising combat. Numerous mental health specialists and experts immigrated to other countries. Presently, there are no proper mental health services in the provinces. During conflict and warfare, the one and only mental health hospital was totally destroyed in Kabul city. After the establishment of a new government in 2001, a sixty-beds hospital started health services in 2004. There are minor IPD services in the north (Mazari Sharif) and east (Jalalabad) of the country. Only a few provinces have shelter (Marastoon) for those who have no families or homes, as well as for addicted people and those who have major mental problems and no family supports. Lots of Afghans treat themselves with psychiatric drugs and seek remedies
in shrines (Van de Put, 2002).

Based on Van de Put, there is only a hospital, which delivers mental health services. That hospital is the Kabul Mental Health Hospital. The mentioned hospital has sixty beds, divided for male and female. Among all sixty beds, only 20 of them are allocated for women. As mentioned, the hospital provides OPD services, and on a daily basis around 150 to 200 patients come to the outpatient department. Among these OPD’s patients, some of them are required to be hospitalized, but due to lack of beds, doctors only prescribe them medicine.

1.3 Limitation of the Study

There were some technical limitation during the study, and these have been listed below:

- Time limitation. For this research, the research had needed more time.
- Small sample size. As another limitation of this research, for better results the study needed more patients in the case group and more participants in the control group for interview.
- Lack of data collectors was another technical limitation; only one person collected all the data.
- Budget limitation was the last limitation, because there was no extra budget for recruitment of data collectors.
1.4 Research Objectives

The objectives of the research were to find the association of the following different factors with depression among women aged 18-45 in Kabul:

1. To determine the association between war-related factors (losing of husband or other family member) and depression.
2. To determine the association between some negative cultural practices (living in a household with many members, forced marriages, marriage in Baddee).
3. To determine the association between low and irregular income and depression.
4. To determine association of living away from their spouse with depression among women aged 18-45 in Kabul, Afghanistan.
5. To determine the association between the level of education and depression among women.

1.5 Significance of the Study

This research will disclose the factors associated with the risk of depression among women aged 18-45 in Kabul. The findings and results of this study will help policy-makers to include these risk factors in mental health guidelines. The results will help the psychologists and psychiatrists to ask these problems from depressed women in hospitals
and mental health facilities. Moreover, the findings will help the general practitioners to improve their knowledge and include these results in the medical history when women attend health clinics for remedy due to mental health disorders. The findings help the non-governmental health organizations (NGOs) to incorporate these results in their mental health policies as well. The finding will help the Ministry of Public Health to publish these results in its monthly magazine of MoPH (Roghtya/Sehat) for public use as well.

1.6 Hypothesis

This study includes different hypotheses. Each hypothesis is related to a specific area as below;

War-related factors:

1- Loss of husband or family member(s) is associated with depression among women.

Culture related factors:

2- Forced marriage is associated with depression among women.

3- Living in a household with many members is associated with depression among women.

Socioeconomic:
4- Low and irregular income is related to depression among women.
5- Living away from a spouse for a long time (years) is associated with depression among women.
6- Low education is associated with depression among women.

1.7 Research Questions

1.7.1 Main question:

What are the risk factors associated with depression among women aged 18-45 in Kabul?

Sub-question:

1. Does loss of husband or family member cause depression among women?
2. Does forced marriage cause depression among women?
3. Is living in a household with many members associated with depression?
4. Is low and irregular income associated with depression?
5. Does living away from spouse cause depression among women?
6. Is education level associated with depression?
CHAPTER TWO

2 Literature review

The literature review of this thesis will concisely explain the theoretical concept of some risk factors of depression, especially among women. It will briefly discuss the types of risk factors that cause depression among women. Much of the literature defines the family roles, low income, and widowhood as related with depression among women. But there was no literature about forced marriage and living away from spouses.

Firstly, according to (Rees, 1976), in the 19th century the word “depression” has been used by a cardiologist, as he defined the condition depresses the “cardiac function”. After this definition, the word depression has been used more commonly than melancholia. The word depression is wider than melancholia.

Based on the above definition, a majority of those women who face problems have a depressed mode in our society. The problem list includes war-related troubles, financial deficit, family problems, etc.

However, several research studies have disclosed that some women do not attend health clinics to seek remedy for depression, and they do not want to express their emotional problems. Therefore, the number of occurrences and incidence of depression will be underestimated among women around the globe (Deborah, 2013).
Disavowal of “human rights”, disparity between male and female, and ongoing combat are associated with major depression and “poor social function” (Cardozo, Bilukha, Gotway, Wolfe, Gerber, & Anderson, 2005).

In Afghanistan, most of the women who have depression or other mental disorder do not go to mental health clinic or psychiatrists until their health condition worsens. Families and patients do not like to meet psychiatrists due to stigma in society, and some of them go to the shrine and seek remedy in religious practices.

Also, there are not enough epidemiological studies about depression due to wars and conflicts among poor countries. Only few researches have been conducted from 175 countries; based on these studies, 993 Cambodian immigrants have been interviewed on the Thai – Cambodian border. A majority of the immigrants suffered from shortages of food, water, refuge and health service, as well as they complained from indoctrination, enforced employment, loss of family member or contact, and other things … (Mollica R. et al., 1993).

Nevertheless, the Ministry of Public Health of Afghanistan declared in 2010 that two out of three inhabitants have mental disorders due to sustained vehemence, scarcity, joblessness, internal ferocity, and substance dependency (Qaderi, 2014).

In Afghanistan, based on cultural codes in a majority of families, only men work and earn money to support their families, and women do not work outside. Thus, when men become jobless, they cannot financially support the families. This situation causes many problems, and women suffer more from such problematic environments and finally become depressed.
2.1 Family Roles

Galinsky and Bond pointed out, some family functions cause depression among women. … 80 to 90% of married women have main accountability of cookery, spring-cleaning, and other housework (Galinsky & Bond, 1996).

In Afghan society, even in urban area the majority of women are housewives, and they are responsible to do all tasks inside the houses. They take care of their children; prepare food, clean the houses and so on. But men in few families take part in housework and help their wives.

Moreover, research discovered that in those families where men have less participation in housework, it is associated with major depression among working and non-working women. Due to un-involvement of women in family decisions and inaccessibility to family monetary resources, they would sense unimportance and incapability, - predisposing factors to depression (Bird, 1999).

Hence, according to (Andrade et al., 2003), women are more highly susceptible to depression than men, and this fact has been detected through the world by different investigative plans and discussion procedures. Although many researches and investigations found that women are more susceptible to depression then men, a current epidemiologic research that was conducted based on non-clinical individuals, stated that females have two times more vulnerability of depressive disorder than men (Kessler, 2003).

According to (Rasekh Z. , Bauer, Manos, & Lacopino, 1998), Afghan females had absolute extreme “symptoms of depression (97%), anxiety (86%), and clinical PTSD (42%)”. Thus, these data show the high percentage of depression among Afghan women. The main cause of almost
all problems in Afghanistan since 1979 (USSR invasion date on Afghanistan) is war and internal conflicts, which become risk factors of mental disorders among women and men.

Jane (2011) claimed, “During the Roaring Twenties, many American women experienced a rise in their standard of living, and some enjoyed an exciting new sense of freedom. In sharp contrast to this, life was extremely hard for women from poor families, who received almost no support from the government. With the start of the Great Depression in 1929, social problems became very severe, with millions of people unemployed and thousands homeless. Some determined female campaigners devoted themselves to improving the lives of the poor”.

Apter (1995) stated, “Women’s progressive passageways have many significant crossroads, which have been nominated danger points. At each of these crossroads girls and women face the struggle to conform to others' wishes, dreams, and roles for them while remaining true to themselves: outer pressures collide with inner visions. Each of these developmental crossroads has the potential to trigger depression”.

Based on Apter (1995) statement, the first evolution in girls happens in puberty when girls' sexual and social development pushes them into a challenge to please others and remain true to themselves. The second providence of danger point happens as girls inter maturity, fashioning a life away from school and family, often compromising their visions for the sake of socializing freely and openly with some childhood friends and important family members. The third happens between the ages of 25 and 40 when females are working against the ideals of marital and maternity to build a realistic life, frequently balancing needs for relationship with needs for attainment. A fourth danger point happens when females become pri-menopausal in their 40's and ends with the passage through menopause.
A final crossroad happens at around 60 as females start to face the loss of their own strength and health as well as the loss of important affiliations. At this point, the losses of aging present a challenge to a woman's sense of self, as she must adopt weather changes at multiple levels often occurring simultaneously, often taking away all that has been familiar—physically, familial, geographically, socially, and vocationally (Apter, 1995).

2.2 Low Income

In Afghanistan, due to different aspects in majority of families, only men are responsible to work outside and earn money for financial support of families. Hence, when a man who is accountable to earn money and prepare all needs of family becomes jobless, in this case the joblessness becomes a risk factor for scarcity and many other problems, including depression among family members, especially women.

Accordingly, based on research conducted by WHO, those people who live in low income groups or have minor education with critical financial problems such as consequential joblessness, people “who face debt, and those who face hardships” in buying essential needs (such as food for being alive) are highly at risk of mental disorders. … (WHO, 2005).

Low and middle-income countries (LAMIC) are spread out around the world: all Africans, many Asian, South and Central American and East European countries and “the island states of the Pacific”. However, 80% of the world population lives in the low and middle-income countries, and only 6% of the studies on mental health have published in journals’ indexed from LAMIC (Patel V Kleinman, 2003). Additionally, in LAMIC 40% and 50% of mental health care expenses are paid by patients (Murray C, 1996).
Therefore, Afghanistan is one of the Asian low-income countries, and about 36% of its total population is living below the poverty threshold (World Bank, 2010).

2.3 Widowhood

Based on “life course theory”, a difficulty related with missing a spouse (Umberson D & Williams, 2005), and “distress theory” (Holmes. T & Rahe, 1967) (Mastekaasa, 1994), altering spousal position is an important lifetime occasion, which could simply produce tension in a person’s lives. As well as Pearlin stated, “Stressful events can cause stress proliferation, which refers to stressors beyond the original stressor, in multiple dimensions of individuals’ lives. If distress, which resulted from partner loss, is the ‘primary’ stressor, then losing partners’ support, such as emotional, financial, or practical support, could be considered ‘secondary’ stressors. In fact, losing such support can harm well-being” (Pearlin, 1999).

According to the above theories and reality, Afghanistan faced more than three decades of war that caused tens of thousands of widowed. According to Julie, the prolonged warfare caused more than fifty thousand widows only in the capital of Afghanistan. Widows have to work to run their families and lives (Julie, 2000). As well as “Mental disorders are a major health concern in people who have survived bereavement, displacement and loss of livelihoods are key risk factors” (Von Ommeren, 2005).

“Women who have lost their spouses suffer from grief on inconsolable persons have not just makes them upset, but also only makes them feel sad, but also concerned and lone” (Parkes CM. & Laungani P and Young B, 1997).

If a woman loses her life partner forever, she becomes depressed and must live alone. In
Afghan society, in a majority of cases the widowed takes the all responsibilities of her life and her children. As we know, taking of these responsibilities is the second stressor and makes the widowed more depressed.

According to Nolen-Hoeksema and Keita (2003), they “have found it likely that depression in women is influenced by women’s lesser power and status in society. This lack of power makes women more vulnerable to significant traumas such as sexual abuse and sexual harassment” (Nolen-Hoeksema, 2001).

As we know, in Afghanistan the majority of women are illiterate housewives, and a majority of them do not know about their rights. They are powerless, and even they cannot take part in family decisions. Thus, such unawareness and lack of education make women most vulnerable to mental disorders, especially depression.

“Psychological distress is more common with the women who fulfill more than half of the childcare responsibilities, but it is not found at higher levels among women who always do more than half of the housework” (Rivieres-Pigeon et al, 2002). Those women who are satisfied from their spousal relation have a lesser chance of depression (Saenz R Goudy W J & Lorenz, 1989). In contrast of this idea, those women who are dissatisfied from their marital relation are highly susceptible to depression in each society, including Afghanistan.

2.4 Poverty

Thirdly, as a part of this, there is a need to understand links between financial deprivation and established etiological factors. Although a correlation between socio-economic indices and depressive disorder has generally been found (Brown G. W & Harris, 1978), the role of poverty
itself remains unclear, not least because of the use of cross-sectional designs (Bebbington P E Hurry J Tennant C. & Sturt, 1984).

The rate of depression in women is typically twice that of men, with several studies reporting variability in the lifetime ratios in different countries. For example, ratios range from 1.6 in Beirut and Taiwan to 3.1 in West Germany (Weissman et al, 1996).

“In some areas of the country, people with mental illnesses are taken to shrines where they are chained for days in an attempt to cure their sickness.” (Salehi, 2010).

Due to lack of mental health facilities and lack of awareness about mental disorders, some people take their mentally ill family members to shrines for seeking remedy at the shrine.

According to Dr. Mahbub-ul-Haq in the “Human Development in South-Asia, 1997” (WHO, 1997), “To be a woman in this region (South-Asia) is to be a non-person”. Afghanistan is a country, located in a region with the same culture and economical situation like other South Asian countries. The situation of women’s lives in Afghanistan is almost the same as other South Asian countries. Finally, based on all accessible data (UNDP, 1997), it concludes, “no society treats its women as well as its men”.

As UNDP announced, there is no society to give same right to their female as male. In Afghanistan, some people think that women are the second gender. As I had an interview with psychiatrists and psychologists, they cleared this issue. Dr. Emal Safi stated, “As we know that, although half of our population are women, but unfortunately some negative cultural practices, especially among male dominated families exist. Therefore, based on those wrong opinions, they consider female as a second or inferior human or gender”.

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More than 50% of the women of the South Asian region live in India. Females in Pakistan, Philippines, or India all face the same difficulties, such as internal and sensual ferocity, sex discernment, deprived schooling and health, and traditional societies. People of these societies have less awareness about using health services, possibly because of different concept of mental disorders in South Asian societies (Jacob et al., 1998).

In Afghanistan, the majority of women are illiterate, as they cannot read and write. Also, the majority of them does not know about their rights or does not have power to ask about their own rights.

Islamic faiths refuse suicide, and patients might not disclose suicidal thoughts simply. When you enquire about feelings of killing, the majority of depressed patients say that they are Muslim and never try this kind of ideas (Dubovsky, 1983). “Although the wish to die is not uncommon among people with depression in Muslim cultures, it usually remains at the level of wishing that God would terminate their life, and does not progress to the wish to kill themselves” (IFakhr el. slam, 2000).

The social situation, one of the most significant factors of health, is described by neediness, over-crowded living situations, joblessness, job uncertainty and inequality, male domination, domestic conflicts and war, all of which cause a lot of problems in a society. Due to these difficulties, men and women become vulnerable to mental disorder, but females are more prone to psychological disorders than males.

“A study showed that women with lower levels of education had an increased risk for psychiatric disorders. Nearly 66% of women and 25% of men suffered from depression and
anxiety disorders” (Mumford et al., 1997). “Violence physical, sexual and psychological is related to high rates of depression and co-morbid psychopathology, including posttraumatic stress disorder (PTSD), dissociative disorders, phobias, substance use, and suicideality” (Roberts et al., 1998).
CHAPTER THREE

3 Country Profile, Mental Health Facilities

This chapter discourses the significant aspects of the country profile and country mental health facilities – especially in Kabul. The aim of comprising this topic is to give a greater perception about the context of the research problem. The country profile mainly focuses on the geography, economy, and population/demography of the selected area. All of these issues influence the delivery of healthcare services.

3.1 Geography

“Afghanistan is a mountainous country with harsh and dry climate” (Dupree, 2011). The total population of the country is about 28.15 million (UN, 2011), about 76% of which is living in rural areas. The GDP per capita is about US$572 (IMF, 2011) and about 36% of its total population is living below the poverty threshold (World Bank, 2010). The war and conflicts that have lasted for more than 25 years worsen the conditions; people suffer from poverty, insecurity, lower availability of resources, and poor public services. The problem is worse in the rural areas” (World Bank, 2010).

Afghanistan has no route to an ocean, and much literature is written about its position. Afghanistan is a country in South Asia, with 652,230 square kilometers of land. It has boundaries with six countries: Pakistan in the Southeast, with a 2,430 kilometer border; Tajikistan, Turkmenistan and Uzbekistan linked in the North with a joint border of 1,206, 744 and 137 kilometers, respectively; Iran in the West with a 930 kilometer border; as well as China, which
has a small border in the North of the country (Dupree L., 2011).

“Afghanistan is a mountainous and landlocked country” situated in the central and South Asia. Approximately half of the country is located at a height of 2000 meters above sea level. The mountains are located in almost all of the land of Afghanistan except in some parts of the northern, central and southern regions (FRD, 2008). “The Hindukush mountains divide the country into three different ecological zones, with different climate, altitude and natural resources” (Dupree L., 2014).

Governmentally, Afghanistan has eight regions, 34 provinces and 394 districts, and each district has several villages (Dupree L., 2014). “The official name of the country is Islamic Republic of Afghanistan (IRoA)”.  

3.2 Demography

According to estimates of the Central Statistic Organization, 25.5 millions people are living in Afghanistan (CSO, 2012); 75% of the people live in rural areas. As reported in 2005, Afghanistan has the largest number of orphans and widows in the globe, 1.6 millions and 1 million respectively (FRD, 2008). Afghanistan also has the youngest residents in the globe. 48% of its citizens are under 15 years and 16% of the inhabitants are under 5 years. “The age distribution” reveals great fertility and mortality rates among the citizens (FRD, 2008). The Ministry of Public Health declared in 2012 that, on average, 7.5 persons live in each household. “Life expectancy at birth was 61 in 2012” (World Bank, 2012).
Afghanistan has different ethnic groups; among all, four of them dominate: Pashtuns, Tajiks, Hazaras and Uzbeks. … Afghanistan’s government has two official languages, which are Pashtu and Dari. About 99% of the population are Muslim (Asia Foundation, 2013).
3.3 Socioeconomic and political context

Since 2002 and the collapse of the Taliban, the new democratic government in Afghanistan has made many reforms with the provisions from the international society (FRD, 2008). “Afghanistan is one of the poorest countries of the world. The national poverty rate is 35.8%” (World Bank, 2012). More than 30 years of combat severely devastated the “economy” and “infrastructure”. … (MRRD, 2012).

The economy of Afghanistan depends on both international support and poppy cultivation (FRD, 2008). The Gross National Income (GNI) per capita was USD 690 (World Bank, 2013).
The government of Afghanistan spent 8% in the health sector as a total percentage of GDP in 2012. The table below shows that the entire health expense, as a percentage of over-all governmental expenditure, was 4.2% in 2012. About 73.3% of families spend on health care by themselves, which is a big burden on the poorest citizens (MoPH, 2012).

![Figure 3-3 GNI per capita](image)

*Source: World Bank*

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total population</td>
<td>25,011,400</td>
<td>27,000,000</td>
</tr>
<tr>
<td>THE per capita (USD)</td>
<td>41.73</td>
<td>55.59</td>
</tr>
<tr>
<td>THE as % of real GDP</td>
<td>10.00%</td>
<td>8.00%</td>
</tr>
<tr>
<td>Government health expenditure as % total government expenditure</td>
<td>4.00%</td>
<td>4.20%</td>
</tr>
<tr>
<td><strong>Financing Source as a % of THE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central government</td>
<td>6.00%</td>
<td>5.60%</td>
</tr>
<tr>
<td>Private</td>
<td>76.00%</td>
<td>73.60%</td>
</tr>
<tr>
<td>Rest of the World</td>
<td>18.00%</td>
<td>20.80%</td>
</tr>
<tr>
<td><strong>Household (HH) Spending</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total HH (OOP) spending as % of THE</td>
<td>75.00%</td>
<td>73.30%</td>
</tr>
<tr>
<td>Total HH (OOP) spending per capita (USD)</td>
<td>31</td>
<td>41</td>
</tr>
<tr>
<td><strong>Financing Agent Distribution as a % of THE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central government</td>
<td>11.00%</td>
<td>11.80%</td>
</tr>
<tr>
<td></td>
<td>75.00%</td>
<td>73.30%</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>Household</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-governmental organizations</td>
<td>5.00%</td>
<td>0.30%</td>
</tr>
<tr>
<td>Rest of the World</td>
<td>8.00%</td>
<td>14.60%</td>
</tr>
</tbody>
</table>

Table 3-1 Health expenditures in total

*Source: MoPH*

Many households are controlled by men (97%), and about 66% of these men are uneducated. Seventy-six percent of females have not attended schools, but if compared with young ladies it is different. 30% of young females (< 20 years) were attending schools in 2010 (MoPH, 2010). About 82% of households cannot reach a health clinic unless they spend about two hours travel time (MoPH, 2012).

In Afghanistan in 2010, two out of five households had electricity. With 83% of areas in the metropolitan and 32% of areas in the countryside, this shows an inequality in the distribution of energy. Drinkable water is necessary for health. “In 2010, over half of all households obtain drinking water from an improved water source – that is, piped water into the home, public taps, tube wells, or protected dug wells and springs. With disparity of around 10% between rural and urban, rural households have less access to drinking water. There was no improvement in basic sanitation until 2010. Only one in five households nationwide has access to improved toilets and latrines, with more than a 50% disparity between rural and urban households, worst in rural areas” (MoPH, 2010).

3.4 Health system

The Ministry of Public Health provides services in three stages (MoPH, 2010). See table 2 for details.
A Basic Package of Health Services (BPHS) for Afghanistan - 2010.

<table>
<thead>
<tr>
<th>Level</th>
<th>Public Health Services</th>
<th>Health Facility type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Health Post (HP), Health Sub-center (HSC), Basic Health Center (BHC), Mobile Health Team (MHT) and Comprehensive Health Center (CHC)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Comprehensive Health Center at district and District Hospital (DH)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Provincial Hospital (PH), Regional Hospital (RH) and National Specialty Hospital (NSH)</td>
<td></td>
</tr>
</tbody>
</table>

Table 3-2 Public health in Afghanistan

*Source: MoPH*

“In the year 2002, Afghanistan had a very low quality health system among poor countries. When the Taliban collapsed in 2002, the new government restructured the health system. The international community supported the Ministry of Public Health to establish an intervening “National Health Policy”, which trailed with applicable strategies like “Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS)” (MoPH, 2011).

The Basic Package of Health Services recommended a “Consultative Group on Health and Nutrition” (CGHN) to properly tackle priority health issues in Afghanistan in rural areas; the Ministry of Public Health improved this package (MoPH, 2010).

There are seven health issues under the Basic Package of Health Services. These are “maternal care including emergency obstetric care and newborn care, child health and immunization, public nutrition, communicable disease treatment and control, mental health,
disability and physical rehabilitation services”, and this package routinely supplies vital medicine (MoPH, 2010). See table 3 for the BPHS facilities.

<table>
<thead>
<tr>
<th>Health Facility</th>
<th>Population</th>
<th>Required technical staff</th>
<th>Maternal and Child health services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health post</td>
<td>1,000–1,500</td>
<td>2 Community Health Worker (female and male)</td>
<td>Family planning (FP), Antenatal care (ANC) and Postnatal care (PNC)</td>
</tr>
<tr>
<td>Health Sub-center</td>
<td>3,000–7,000</td>
<td>2 people (Male nurse and Community Midwife (CMW))</td>
<td>Family planning (FP), Antenatal care (ANC) Postnatal care (PNC) and Skilled Birth Attendance (SBA) Institutional Delivery</td>
</tr>
<tr>
<td>Mobile Health Team</td>
<td></td>
<td>3 people (male Medical doctor (MD), CMW and 1 vaccinator)</td>
<td>Family planning (FP), Antenatal care (ANC), Postnatal care (PNC), Skilled Birth Attendance (SBA) Delivery and referral services</td>
</tr>
<tr>
<td>Basic Health Center</td>
<td>15,000–30,000</td>
<td>5 people (1 community health supervisor, 2 vaccinator, 1 nurse, and 1 Community Midwife (CMW))</td>
<td>Family planning (FP), Antenatal care (ANC) Postnatal care (PNC) and Basic Emergency Obstetric Care</td>
</tr>
<tr>
<td>Comprehensive Health Center</td>
<td>30,000–60,000</td>
<td>11 people (BHC staff + 1 female nurse, 1 CMW, 2 medical doctor (male and female), 1 Lab technician and 1 pharmacist</td>
<td>Family planning (FP), Antenatal care (ANC) Postnatal care (PNC) and Basic Emergency Obstetric Care and referral services</td>
</tr>
<tr>
<td>District Hospital</td>
<td>100,000–300,000</td>
<td>34 people (CHC staff+ 8 nurse (male and female), 2 Midwife, 2 MD (male and female), 1 surgeon, 1 Anesthetist, 1 pediatrician, 1 Dentist, 1 pharmacist, 2 physiotherapist, 4 technicians (2 Lab, 1 x-ray, 1 dental)</td>
<td>Family planning (FP), Antenatal care (ANC) Postnatal care (PNC) and Comprehensive Emergency Obstetric Care and referral services</td>
</tr>
</tbody>
</table>

Table 3-3 BPHS facilities with maternal health services

Source: MoPH - 2010
3.5 Economy

“Afghanistan is one of the poorest countries in the world,” and 36% of the population live under the poverty line. The key problems are joblessness; people have not enough shelters, clean water and electricity”. Around 36% of the population is jobless and live under the scarcity line (World Bank, 2010).

Afghanistan has no stable and proper economy. War during the 1980s and 1990s destroyed the main base of income, which is agriculture, and there are no proper industrial actions. This is because they depend on agricultural products, and have same economical condition. There are some key problems to the economic progress of the country; for example, in 2006, the drug business provided 53% of the Gross National Income (GNI), which was the main illicit economy in the country. The trafficking – mainly across the Durand line with Pakistan – is the other major part of the unlawful economy. (Dupree L. , 2011).

Although the economy of Afghanistan has improved since 2002, this was due to international support along with investment and improvements of agricultural products. Furthermore, this followed four years of drought, but still Afghanistan is one of the poorest countries of the globe. The gross domestic product of Afghanistan at the recent rates was US$ 17 billion and the GNI per head was anticipated to be US$ 572 in 2010 (World Bank, 2010).

Due to nonexistence of a clear registration system and the lack of capability to evaluate the gross domestic product, the gross domestic product of Afghanistan is ambiguous. The fundamental macroeconomic figures have not been obtained correctly. There are some initial sources that express the GDP of Afghanistan in USD as follow: “Afghanistan Central Statistic
Organization (CSO), 18.4 billion; CIA World Fact Book, 17.9 Billion; World Bank Economic updates 10/11, 7.45 billion; IMF WEO Database 9/11 19.38 billion; and UN country profile, 12.853 billion (Kordesman A. H., 2012). The analysis of GDP by different sectors indicates that Afghanistan is an agricultural country.

In the economy of Afghanistan, the agriculture sector contributes 38% of the economy, the industrial sector 24%, and services 38%. On a regional basis, the agriculture ratio is two times higher; in contrast, the western region is 15 times the average. The strict weather of Afghanistan – with droughts, lack of agriculture land, huge young population, different ethnic groups, powerful tribal make-up of the structure and war – have all caused the current economic condition. Afghanistan has about 5 billion USD commerce with other countries. The commerce has been enlarged since 2002.

3.6 Population

Kordesman A. H (2012) stated, there is no clear data about Afghanistan’s “population and demographic information” because of imprecise census. The State University of New York, with collaboration of USAID, from 1972 to 1974 accompanied a “demographic survey of Afghanistan” and used up-to-date techniques. Based on this non-typical survey, they found that the total population was around 10.2 million (The American University , 1986). According to the latter survey about the population of Afghanistan, around 15,551,358 people are living in the country; 85% live in the countryside and 15% live in the urban areas (APHI, 2011). But there is not any precise census after 1979. There are differing data of population from various bases. According to the ACSO yearbook, the Afghan population was predicted to be around 24,485 to 26 million in 2010 and 2011.
Around 22.6% of the Afghan people live in the cities, and the remaining live in the countryside. The age distribution among all population are: “45.9% of population is under 15 years of age, about 50% are aged 16-59 years and only 4.0% male and 3.6% of female can reach 60 year of age or above”. The population of Afghanistan grows annually at an average rate of 3.7%. The population growth in the cities is 2.8%, and in the countryside the population growth is 4.7%. 6.3% of women in Afghanistan have fertility (United Nations, 2011). Annually, the birth rate per 1,000 populations is 45, and the anticipated death rate is 17 per 1,000 population (World Bank, 2010).

Figure 3-4 Population pyramid of Afghanistan

CIA world fact book, 2010
According to other data, around 28.1% of the Afghan population is literate; this is described as 'age 15 and over who can read and write'. The literacy rate for men and women is 43.15% and 12.6%, respectively (UNODC, 2012).

3.7 Effects of war on health

War and internal conflicts had a negative impact on all infrastructures in Afghanistan. Many people have been killed and millions of Afghans immigrated to other countries around the world. Based on several studies, war and domestic ferocity had its own bad impact on people’s mentality.

According to the Human Rights Watch survey, more than two decades of war hugely destroyed all sectors in Afghanistan. Based on estimates, one million people have been killed during fight (Human Rights Watch, 2003).

World Bank (2004) reported, the impact of more than two decades of warfare and ferocity revealed in Afghanistan’s health figures that the country has amongst the poorest health systems in the globe. In the year 2004, the World Bank reported that the “life expectancy at birth is 43 years”, the death frequency for kids less than five years is 257/1000 (fourth highest in the world), and the “maternal death frequency is 1900/100,000 (second highest in the world) (UNICEF, 2005).

3.7.1 Mental Health Status:

The situation of mental health and mental services were the same as many other developing countries in the region. According to (Waziri, 1973), limited “publications” declared that
Afghanistan had same situation in “mental health and mental healthcare” before the war; this was the same as other developing countries in the area.

The Taliban rule of serious “gender” isolation and the rejection of essential human rights to women caused an elevation in the degree of depression and anxiety. The prevalence rate of depression is high among women in Taliban-ordered zones due to their harsh policies (Amowitz et al., 2003).

After the collapse of the Taliban’s government, there has been no significant change in the “mental health” condition of the people. A countrywide study (Lopes Cardozo et al., 2004) and another research conducted in Nangarhar province (Scholte et al., 2004) found that more people suffer from depression and anxiety. The research shows that women are more prone to depression, and two out of three of all women suffer from depression (58.4% and 73.4% in two research separately)…. Based on two research works, there was a precise association amongst “traumatic” incidents and the possibilities of psychological disorder. … (Bolton P. & Btancourt, 2004).

3.7.2 Mental Health in Primary Care

Before the new government in 2002, there was no proper mental hospital in the country. The only mental health hospital was destroyed in the capital of Afghanistan during war, and several mental health experts immigrated to other countries. In 2004, the new Minister of the Public Health Dr. Fatimi announced that mental health is a priority concern (Fatimi, 2004). The Department of Mental Health Care reopened in the Ministry of Public Health in 2005 and began to work; it was the first time to add mental health to general health policies. International donors
funded the government and made decisions to contract NGOs to deliver health services in remote areas of the country.

The “Basic Package of Health Services” has been improved by the Ministry of Public Health to outline the health interventions and accessibility in all districts (MoPH, 2003). The “Basic Package of Health Services” mentioned above has significant interventions in seven priority areas: “maternal and newborn health, child health and immunization, public nutrition, communicable diseases, disability, essential drugs, and mental health”. It is an innovation for a poor country to count mental health as such a major priority.

Decades of combat and violence have caused many mental disorders in Afghan society, and the government validates that there is a precise necessity for mental healthcare. … According to (Ventevogel et al., 2002), the establishment of obtainable, reachable, reasonable and tolerable mental healthcare centers can be able, just based on a key policy, to transfer mental health care from the hospital to primary care services. The government, along with the support of NGOs and donors – particularly the World Health Organization, has begun to combine the “mental health into primary care” (Ventevogel P. & Kortmann, 2004).

3.8 Psychosocial assistance

There were no specific psychosocial support programs in the country. After the establishment of the new government, the Ministry of Public Health, international donors, and NGOs tried to integrate the mental health programs in primary care centers. Due to lack of psychological and social programs, there are clear demands of such programs (Baingana et al., 2005) (Bolton P. & Betancourt, 2004). According to (De Berry, 2004), some NGOs have worked on psychological
platforms, as well as covering those women who were exposed to viciousness. Some NGOs delivered psychological services throughout psychotherapy clinics in diverse area of Kabul or via community-based psychosocial services ruled to the primary care structure.

An evaluation of research directed during the Taliban administration has disclosed a great prevalence of anxiety and depression among women. The study of 160 females in Kabul and Pakistan during the Taliban government showed that 42% of them experienced PTSD, 97% experienced great depression, and 86% had “sever anxiety”. A huge majority (84%) of them have confirmed that they lost one or more family members during the fight (Rasekh Z & Bauer, 1998).

In the year 2000, research was conducted by the Physicians of Human Rights to compare the mental health status of the women living under the Taliban regime with the ones who lived in the areas controlled by the government. The prevalence of great depression was high (78%) among females whom live in non-governmental area, and the rate of depression among those females whom live in areas controlled by government was much lower (28%) (Amowitz et al., 2003).

After the invasion of Afghanistan by the United States and its alliances, a national research was performed. This research determined that there was an increase in the rate of depression symptoms (men: 59.1%, women: 73.4%), … Those people who had physical debilities is highly prone to have psychological disorders (Lopes, et al., 2004).

In 2003, a study conducted in Nangarhar province found a high prevalence of depression and anxiety, especially among females. The questionnaire found that females had higher marks on depression (58.4%), the percentage of anxiety among women was 78.2%, and the percentage of
posttraumatic stress disorder symptoms was 31.9% (Scholte W. F., et al., 2004).

Updated research conducted in Kabul found that among those women whom lost their husband, the declared depression symptoms were 78.6% (ARE, 2004). A methodical evaluation of data from Pakistan detected that six different research works randomly selected community sample. The prevalence mean of anxiety and depression was 45.5% for females (changing from 28.8 – 66%) and for male 21.7% (changing from 10 – 33%) (Mirza, 2004). According to (Gustavson, 2004), the great statistics among Afghans in current research might reveal a great rate of psychiatric disorder among Afghan individuals. These point to a debate that the long-term combat and social fragmentation that Afghanistan experienced could have effects on the mental health condition of residents.

Whereas the Ministry of Public Health has documented the elevating significance of developing “mental health care” over all stages of the public health care structure, they also are working to elevate OPD capacity and “outreach at the primary and secondary levels. There is only one mental hospital in Kabul, which has 100 beds: 60 for psychiatric patients and 40 for substance abusers in Jangalak. To make it more complicated, patients come from all over the country to this center for treatment. There are resource deficits that include beds, professional staff, and even a proper system to deliver services for needy patients (International Medical Corps, 2011).

According to WHO, the socioeconomic shortcoming is extremely related to the existence of depression and anxiety conditions. Due to this shortcoming, people may face different forms of such a substantial deficiency. This disadvantage can take many forms, from obvious material deprivation to further sensitive means that replicate a shortage of chances because of minor
schooling, the huge chance of unfavorable living occasions, or extra types of hidden or obvious community discernment (WHO, 2001).

As Stiglitz mentioned, “the performance of the health sector in Afghanistan appears to be in line with the country’s observed economic growth. It is well documented that the investment in health contributes to sustained economic growth and stability. At the macro level, health endowments and investments in health are found to be sound predictors of economic growth” (Stiglitz, 2002).

Based on the World Bank survey, poverty in Afghanistan correlates strongly with both household health and demographic characteristics. The health status and dependency ratio of a household affects its labor supply and earnings. Having a large number of children makes poor households more vulnerable to the lack of maternal and child health services” (World Bank, 2005).

Dr. Abdullah, the Deputy Minister of Public Health mentioned, more than 50% of our people have psychological problems. The cause of all these mental disorders is the three decades of warfare, paucity, immigration and many other community problems in the country (Fahim, 2012).

As Ministry of Public Health announced, that the MoPH added the mental health and psychosocial advising in primary care. Also the Ministry of Public Health has integrated mental health in regional public hospitals. Other responsibility of MoPH is rebuilding the mental health hospitals and worked on the capacity building of its staff. As well as MoPH launched mental health training programs in communities and trained more than 100 trainers to deliver standard trainings for primary health care workers. These are the key actions and “achievements” of
MoPH in the latest years (MoPH, 2014).

Ministry of Public Health has defined mental health as one of the priorities. As a part of the Basic Package of Health Services (BPHS) and the Essential Package of Health Services (EPHS). In order to provide quality mental health services to the population suffering from mental and psychosocial problems. Recently, MoPH and Health Net TPO have trained 32 staff (19 doctors and 13 nurses) from provincial hospitals. Therefore, mental health is integrated in the general hospital, and the psychiatric disorders such as depression, anxiety, psychosis, learning disability, substance abuse disorder, and psychiatry emergency are properly handled (MoPH, 2010).

### HUMAN RESOURCES

#### Workforce and training

<table>
<thead>
<tr>
<th>Health professionals working in the mental health sector Rate per 100,000</th>
<th>Training of health professions in educational institutions Rate per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>0.16</td>
</tr>
<tr>
<td>Medical doctors, not specialized in psychiatry</td>
<td>0.34</td>
</tr>
<tr>
<td>Nurses</td>
<td>0.15</td>
</tr>
<tr>
<td>Psychologists</td>
<td>0.08</td>
</tr>
<tr>
<td>Social workers</td>
<td>0.01</td>
</tr>
<tr>
<td>Occupational therapists</td>
<td>0.01</td>
</tr>
<tr>
<td>Other health workers</td>
<td>0.44</td>
</tr>
</tbody>
</table>

Table 3-4 Health professionals working in the mental health sector

*Source: Mental Health Atlas, 2011. WHO*
CHAPTER FOUR

4 Methodology

4.1 Introduction

I used two methods. One was a qualitative focus group discussion with psychologist and psychiatrists in the Kabul Mental Health Hospital. I discussed with them the different problems the depressed women faced and their experiences threatening women, making the diagnoses. They check depressed women in two different departments, OPD (Outpatient department) and IPD (Inpatient Department).

Based on this qualitative study, I designed a questionnaire and a cross-sectional study in the form of a survey. The survey was done in the form of an interview. I interviewed 100 women whom were depressed. I asked them many questions related to these factors, and I took a control group of women with a similar age and socio-demographic status. The participants of the control group were physically and mentally healthy. I compared the two groups regarding the frequency of theses factors to see if any of these factors are more or less common among depressed women.

The total planned sample size was 220 subjects. Amongst this sample size, 110 were cases and 110 were controls. Therefore, a focus group discussion (qualitative) engaged with psychologists and psychiatrists of the mentioned hospital, including Dr. Aimal Safi, the trainer specialist of psychology department.

This chapter explains the methods to define the approaches to answer the research questions, which were generated based on hypothesis. To analyze the collected data, I applied quantitative
and qualitative methods. Quantitative method describes the numerical data, which were collected through a questionnaire, and qualitative method explains all the information gathered through the focus group discussion in details.

The key themes explained in this chapter are: research area, research design, sample size, permission for data collection and ethical consideration, method of data collection, results and data analyses and methods’ restrictions.

4.1.1 Research Area

This research was conducted in two public hospitals in Kabul city, Afghanistan. The sample of case group (depressed women) was interviewed in Kabul Mental Health Hospital (KMHH) and control group (non-depressed women) was examined in Istiqlal Hospital. Also, a focus group discussion was conducted with psychologists and psychiatrist, including a trainer specialist of psychology in Kabul Mental Health Hospital.

4.1.2 Research Design

A well-known method to investigate the war related and socioeconomic factors associated with risk factors of depression among women aged 18-45 in Kabul, Afghanistan, is cross-sectional method. In cross-sectional study, a group of subjects (individuals who have the disease or outcome of interest) and a group of controls (individuals who do not have the disease or outcome of interest) are identified. The aim of this research was to determine the factors that correlated to depression among women aged 18-45 in Kabul. The case group of this research included married, widowed, and married with spouse away; the control group was the same, but all depressed and those women who had chronic health problem were excluded from the list of
interview. The control group was chosen in the same district of the city to avoid the enormous differences between the socioeconomic conditions of the respondents.

In the case group from the sample size of 110, only 100 responded to the conversation, and 10 of them refused the interview. The preplanned sample size of the control group was 110, and among these only 100 have answered questions while 10 of them rejected. The same designed questionnaire, which had 10 questions, was distributed to both case and control groups, and an open-ended (what are the influence of war related and socioeconomic factors on women mentality?) question prepared for focus group, psychologists and psychiatrist discussed it in details.

4.1.3 Population of the study

According to Central Statistical Office, 2013, “the total population of Kabul province is around 4,086,500. The population of Kabul city is 3,414,100, and 672,400 people live in different 14 districts of Kabul province. Kabul inhabitants live in great different socioeconomic level. But, the numbers of wealthy residents are not too high”.

The study population in Kabul city was selected from two different hospitals in the same district. As mentioned earlier, 100 patients in Kabul Mental Health Hospital were interviewed, and all of these patients were depressed women. Psychologist and psychiatrists had already diagnosed the depression of women in the hospital. The control group, which was selected in Istiqlal hospital, was totally healthy. They come to the hospital for general check-ups, were accompanying their family members, or came to meet their hospitalized relatives.
4.2 Data collection Procedure

A cross-sectional study on two groups of subjects and controls, 200 in total, was conducted in two hospitals in Kabul. The subjects selected at the Kabul Mental Health Hospital. A control group was examined at the Istiqlal Hospital in Kabul. The collection of data started from 10\textsuperscript{th} until 25\textsuperscript{th} of August 2014. The total planned sample size was 220 subjects. Among this sample size, 110 were cases and 110 were controls. The response rate in the case group was 89\%, as well as 89\% in the control group. Accordingly, there was an 11\% non-response in the case group and 11\% non-response in the control group.

4. 2. 1 Data Collection of Case group

The real number of participants in the case group was 100, including patients who had already been hospitalized in the psychiatric ward and those who were coming for follow-up to Kabul Mental Health Hospital during the data collection period. These women had already been diagnosed with depression by the psychologists/psychiatrists at the mentioned hospital according to Diagnostic and Statistical Manual of Mental Disorders (DSM-IV criteria).

Among these 100 patients, 20 of them had already been hospitalized based on severe depression, and 80 depressed women were selected from those who were coming to OPD clinic of KMHH for follow-up and receiving medicine and consultation from psychiatrists. Excluding criteria for the case group (OPD and IPD), were that all newly depressed women, postpartum depressed patients, single depressed women, women above or below age 18-45, and other women have gotten depression due to sever organic health problems (IHD, ARF & CRF, COPD, Diabetes etc.) excluded from the list of interview.
The planned number for the control group was 110 non-depressed women of the same age (18-45) and socio-economic status. The control group was selected in Istitqlal Hospital, which is located near KMHH in the same district of Kabul city. Hundreds of participants responded to the interview in control group, and 10 of them refused the interview.

The questionnaire was designed including 11 questions that cover the war-related and socio-economic condition of respondents. The questionnaire was written in English first, and later translated to Pashtu and Dari, as the majority of respondents are unfamiliar to English, as well as illiterate. Therefore, a face-to-face interview was conducted with every patient, and the purposes of this research and questions have been explained one-by-one to each patient in Pashtu or Dari (two national languages of Afghanistan). All answers have been noted as the same as patients responded, without writing any extra explanation and details. The following are some questions of the questionnaire:

<table>
<thead>
<tr>
<th>Q1. What is your marital status</th>
<th>Married</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Married (spouse away)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Widowed</td>
<td>3</td>
</tr>
</tbody>
</table>

*Tick only one option*

Q2. How did you get marry?
The control group was selected in Istiqlal hospital in the same district of Kabul city. All of those women who have been interviewed came to the hospital for general checkup or seeking remedy for non-serious health problems, or have accompanied a patient or have visited their sick hospitalized relative. Any woman who has history of serious illness (e.g., heart disease, acute or chronic renal failure, liver disease, COPD, diabetes…) or those women were in postpartum stage, and as well as pregnant or any woman which has depressed person in family/household, have been excluded from the list of participants.

The following is the data collection chart of case group, which collected from two departments of Kabul Mental Health Hospital, the outpatient department and inpatient department (Figure 5. 4).
Figure 4-1 Data collection schema
4.2.1 Study Sample

The study sample for this research was selected from two hospitals. The case group was selected from the Kabul Mental Health Hospital in Kabul, and the control group was selected from a non-psychiatric hospital. Based on study design, the samples were selected equally: 110-cases and 110-controls. In the case group, all respondents were depressed, and the control group consisted of completely non-depressed women. There were only 20 beds for women in KMHH, and the remaining 80 beds were divided for male patients and substance addicts. The 80 depressed women were interviewed in OPD (Outpatient Department).

4.2.2 Permission for data collection and ethical consideration

This study was conducted by permission of the research director of MoPH of Afghanistan. I had the signed and stamped letter of my supervisor GHOTBI, Nader. Thus, based on the letter, the director of research contacted the trainer specialist of the psychiatric ward in the hospital of Kabul Mental Health and the Head of Isteqlal Hospital (for control group) through extension.

The trainer specialist (Dr. Emal Safi) and several general practitioners supported my task. They prepared distinct space and chairs in the OPD’s room. Therefore, the study was conducted in both hospitals. Also, based on permission of the director of research, interviews were conducted with 20 hospitalized depressed women in the psychiatric ward of mentioned hospital.
4.2.3 Data collection of Control Group (Interview with non-depressed women)

Based on permission of the research directorate, the data collection was conducted in Istiqlal Hospital. As it has already been mentioned, the data was collected from non-depressed and fully healthy women. All those women who had mental symptoms and any other severe, acute, or chronic illnesses were excluded from the study. Based on research design, the number of control group had to be 110. Thus, during the study only 100 non-depressed women answered the questions, and 10 of them refused the interview due to unknown reason.
CHAPTER FIVE

5 Results and Findings

5.1 Introduction

This chapter describes the result and analysis of the qualitative and quantitative data. The description is organized in two separate parts. First, the qualitative analysis discusses the focus group discussion, and second, the quantitative analysis explains the collected data, which was obtained through questionnaire.

5.2 Qualitative Analysis

This section describes the qualitative method of the research. Therefore, the collected data, through focus group discussion, will be presented in this part. Based on study design, a focus group discussion was arranged with psychologists and psychiatrists of Kabul Mental Health Hospital. Focus group discussion was conducted with a group, which included a trainer specialist of psychology, five general practitioners of psychology and six psychiatrists. Dr. Emal Safi, the trainer specialist, was the head of the group, and all other professionals took part in the discussion. The discussion was open, and I asked about war-related and socio-economic factors of depression among women in Kabul from the members of the focus group. The discussion was conducted in Pashto language, and I recorded all the discussion. Then, I translated it from Pashto in to English.
Mental health professionals (psychologist and psychiatrists) indicated during the discussion in the focus group that widowhood has influence on mentality of the women. They pointed out that we have been facing too many such cases. Based on observation, 30% of group members pointed out that widowhood is a risk factor of depression. They stated that war and domestic conflicts caused huge problems in Afghanistan (Figure 5.1).

The majority of people lost their family members, and tens of thousands of women became widowed. They stated that when illiterate women become widowed and have no supporter, then they face vast problems. They are used to continue their life in widowhood. Members of focus group discussions pointed out that widowhood is a risk factor of depression among women, especially among poor, illiterate, and male-dominated families. Based on their argument that the majority of Afghan families are male-dominated, they do not let the widowed to remarry. As well, they added that most of the widowed even literates do not have any proper extra financial
support from the government or other entities. Therefore, the widowhood from one side and financial difficulties from the other side cause many mental problems, particularly depression.

Also, Dr. Emal Safi, the trainer specialist and member of the panel, talked in detail about the different causes of depression. He added that, based on scientific approach, there are some reasons named bio-psychosocial problems. Some people are prone to depression due to these difficulties. Therefore, if any problems occur during prenatal, natal and postnatal periods, it is highly expected to cause depression. For example, when weak and malnourished pregnant women deliver babies, obviously their newborn children are prone to psychiatric diseases, and we expect that one of these diseases will be the depression.

When children are born in a weak condition and have less body weight, consequently these children have fewer amounts of neurotransmitters. Neurotransmitters are serotonin, dopamine and epinephrine, which biologically perform the neuropsychiatric functions. As well, many children after birth face different problems. Most of them have no access to enough food, thus these children physically and mentally grow up weak. And key reasons are poverty, financial deficit and violence in the families. When a child faces violence in a family, he/she is more susceptible to psychiatric disorders, specifically depression.

5.4 Forced Marriage

Members of focus group discussion (psychologists and psychiatrists) pointed out that forced marriage is the risk factor of depression among women. Based on observation, 28% of mental health professionals during discussion stated that forced marriage is a risk factor of different mental disorders among women in Kabul (Figure 5.1). Also, professionals stated that in some
cases when a father or brother became widower and want to remarry, they then exchange their adolescent daughter or sister to an adolescent boy or old man, despite their daughter or sister whom may dislike that relation. In some cases, families try to earn money by marrying their daughter to a rich old man.

Furthermore, they indicated some causes of forced marriage, which is called BAD/BAADEE. They argued that some families marry their daughters or sisters in BAAD/BAADEE (when father, brother or uncle kills some one due to violence, and, after a while, elders of society come together and try to make reconciliation or peace agreement between two sides. Here, in many cases they exchange or marry their daughters/sisters to the boys of each sides/families. If a side has no female in legal age, they marry their child, even if they are newborn girl, and wait for her to reach puberty)\(^1\).

Hence, mental health professionals added that we have a forced marriage case right now in the ward. She is an eighteen years girl, and the family engaged her in childhood. But now the girl wants to reject that relation, and she faces the resistance of her family. Finally, she became depressed, and now she is hospitalized in the mental health hospital.

Therefore, 28% of group members approved that forced marriage is a risk factor of depression among women in Kabul. They added that we are still in conflict, and male-dominated families do not give the rights of their females.

5.5 Spouse unemployment

The focus group members pointed out that spouse joblessness has direct impact on a woman’s mentality. Professionals talked about the negative impacts of spouse unemployment,

\(^1\) Baad/Baadee definition is the author’s own.
and based on observation, 25% of panel members agreed that spouse joblessness has a direct influence on women and other family members’ mentality (Figure 5.1). They argued that the situation of Afghanistan is different from other countries; it is a developing and poor country. The level of uneducated and unskilled people is high, thus, the majority of unskilled people cannot find regular jobs, and they do not have any extra support from the government.

Therefore, many depressed women come to the hospital, and, after medical history, the doctors find that they have financial problem. The majority of them complain that their spouses are jobless and have no regular monthly income. Thus, psychologists and psychiatrists stated that the spouse joblessness is a risk factor of depression among women.

5.6 Living away from spouse

Mental health professionals pointed out that living away from a spouse is a risk factor of depression among women, and it is a risk factor of depression among men as well. Seventy percent of focus group members stated that living away is a risk factor of depression (Figure 5.1).

Dr. Emal Safi, the trainer specialist of psychology and member of the panel, talked in detailed about this issue, and he added, “certainly, we have many such cases, and those women who acquired depression did so due to this reason. These are the spiritual and psychological stresses, thus, definitely it becomes a risk factor of depression. As we know, each live organism has anatomic structure and physiologic activities. These structures perform all physiologic functions. If any action does not happen normally, this seemed the pathologic status of an organ.” He also stated, “human being needs food, water, oxygen, house and sleep to survive. Besides these needs, sexual relation is important to have reproduction. There are sexual and some endocrine organs responsible for reproduction. Nevertheless, these sexual systems have a proper
time, and that is puberty age. Therefore, when a couple (wife and husband) live away from each other for long time, definitely, this situation cause many problems. The most considerable effect is on sexual desirability for both, and psychologically legal sex is a spiritually support for a wife.”

Some people travel abroad after getting married. These individuals stay there for years. Wives are staying at homes with in-laws. Certainly, this situation causes sexual tension, and sexual tension causes psychological tension. This psychic stress causes depression.

Dr. Emal indicated the main reason of these kinds of travels after wedding: most poor or low-income people travel abroad to earn money. The main reason is a bad custom, which is called WALWAR\(^2\) (this is the amount of money which the groom has to pay for a bride’s family/in-laws). In some cases, this amount exceed 2 millions AFS; that is equal to $20,000 US. Thus, due to this hard custom, a groom has to leave after the wedding to earn money for the debt of his wedding and WALWAR. Finally, the young groom struggles to earn more money and work hard; in the other side, the young bride stays at home for years and faces many problems.

Furthermore, Dr. Safi added, “I have many patients in Saudi Arabia, UAE, Kuwait, Oman and other countries. Many of them contact me through mobile and share their sadness and concerns. They call for consultations, and they have been taking medicines. At the end, I can say that there are many causes, such as living away from family, working hard, and having no contact with wife or children for a long time. Thus, the husband becomes depressed there, and the wife get depression at home.

\(^2\) Italic is author’s word; the definition of Walwar
5.7 Results of Quantitative Part

One hundred women between the ages of 18-45 were enrolled as a case group; this was done in order to study them from various aspects of life and to have a comprehensive research of psychological disorders. From this group, 20 women (20%) were from IPD (In Patients Department) of Kabul Mental Health Hospital, and 80 (80%) of them were from OPD (Out Patient Department) of the mentioned hospital.

A control study group has been selected from the similar socio-demographic group, from the same district of the city, in Istiqlal Hospital. The women, who were selected as control group, were attending the hospital either for the purpose of a general checkup, accompanying an ill family member, or they came to the hospital just to visit their hospitalized relatives. These women were healthy, and they do not have any mental or psychological problem. The response rate was 89 percent in both groups, and 100 percent of the respondents have answered all the questions (Table 5.10).

The following are the risk factors, which cause depression among women, and the result of each factor will be discussed in detailed.

5.7.1 Forced marriage

The result of this study indicates that forced marriage\(^3\) is one of the risk factors of depression among women in Kabul. The data shows that 8% of women were forced to marry; on the other hand, 0% of women in the control group was forced to married. The data also shows that 80% of

\(^{3}\) Mean that when a father or brother marry their daughter or sister in case of Badd/Baddee (explained before), when a father or a brother become widower and wants to remarry then they exchange their adolescent daughter or sister to an adolescent boy or old man despite their daughter or sister dislike that relation, in some cases families try to earn money then marry their daughter to a rich old man.
women in case group and 90% of participants in control group had arranged marriage. Although, 12% women in case and 10% in control group had voluntary marriage.

Based on obtained data, there are no differences between arranged and voluntary marriage in both groups (Figure 5.2). The data in (Figure 5.2) clearly shows that arranged and voluntary marriages do not have any association with depression among women. But the forced marriage is a risk factor of depression among women.

The statistical analysis of data also indicates that forced marriage has association with depression. Categories with difference between observed and expected values make a larger input to the overall Chi-square statistic. In these results, the Chi-square values from each category sum to the overall Chi-square test is \( \chi^2 = 9.78021978 \). The P value is = 0.0017, and the P value is significant (lower than 0.05). It rejects the null hypothesis. It obviously shows that there is an association between depression and forced marriage (Table 5. 1).

Consequently, the main reasons of forced marriage are different in Afghan society, such as (Badd/Baddee (explained before), father or brother exchange their adolescent daughter or sister to get first, second, third or fourth marriage to an adolescent or old person despite their daughter or sister dislike that relation, in some cases families try to earn money then marry their daughter to a rich old man).

<table>
<thead>
<tr>
<th>Observed</th>
<th>Expected</th>
<th>Chi Square</th>
<th>P</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>0</td>
<td>4</td>
<td>9.78021978</td>
<td>0.00176399</td>
</tr>
<tr>
<td>82</td>
<td>100</td>
<td>91</td>
<td>91</td>
<td></td>
</tr>
</tbody>
</table>
5.7.2 Widowhood

The relation of depression with the loss of dear ones will be discussed later. The percentages of the lost relatives (father, mother, son, brother and sister) are seen semi-equal in both groups. The result of close relatives, except spouse, in the depressed and control groups were {brother; 9% vs 10%, father; 5% vs 7%, mother; 5% vs 18%, sister; 2% vs 5%, son; 6% vs 3%} respectively. Forty six percent of women in depressed group, and 52% women in control group, have not lost any close relatives.

The result of widowhood from both groups shows that 13% of women are widowed in the depressed group, and only 5% in the control group. Also, the statistical analysis demonstrates that the Chi-square test is ($\chi^2 = 3.90720391$). The P value is = 0.048, and the P value is significant (lower than 0.05). It rejects the null hypothesis. The result of Chi-square test also shows that the observed data is statistically different from expected values.

Hence, these data clearly show that there are no associations between depression and loss of
other family members such as father, mother, son, brother or sister. Although, the result of this section indicates that 13% of the widowed were admitted in hospital due to depression. Also, a final research conducted in Kabul among those women whom lost their husband has declared that the depression symptoms were 78.6% (ARE, 2004). The loss of husbands, and subsequent problems in life, have gradually caused depression in the widowed women (Figure 5.3, Table 5.2).

Table 5-2 Widowhood: Observed & expected data, Chi-square test and P value

<table>
<thead>
<tr>
<th>Observed</th>
<th>Expected</th>
<th>Chi Square</th>
<th>P</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>5</td>
<td>9</td>
<td>9</td>
<td></td>
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<td>87</td>
<td>95</td>
<td>91</td>
<td>91</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relation of Lost Relatives</th>
<th>Case Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Mother</td>
<td>1918</td>
<td>13</td>
</tr>
<tr>
<td>Husband</td>
<td>135</td>
<td>6</td>
</tr>
<tr>
<td>Son</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Brother</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Sister</td>
<td>46</td>
<td>52</td>
</tr>
</tbody>
</table>

Figure 5-3 the relation of lost relative of case and control groups
5.7.3 Household with many members

This study shows that those women who are living in a household with many members are prone to depression. The data that was collected for this study was divided into two groups: those women that their household’s members are < 10, and household with ≥ 10 members. The data clearly shows that households in the case group have more members than control. Seventy three households had ≥ 10 members, and only 27 households had < 10 persons in each households in the case group; 22 households in the control group had ≥ 10 members, and 78 households in the control group had <10 members. Although, the Ministry of Public Health announced that “the average number of people in a household is 7.5”. According to (Marine Corps Institute), a family can reach up to 50 members, and these individuals are controlled by one head that they call “father.”

Those women who have a collective family life in a household and are constantly abused verbally by their in-laws (mother and father in-laws, brother- and sister-in-laws) are prone to depression. Verbal abuse is one of the prominent risk factors for women leading to depression. Please pay attention to the given chart, where the bar indicates the percentage in (Figure 5.4).

As well as the statistical analysis, this demonstrates that the result of chi-square test is ($\chi^2 = 54.3517439$); the P value = 0.00, and the P value is significant (lower than 0.05). It rejects the null hypothesis. It also indicates that the observed data is statistically different from expected values. The result of Chi-square is a high number. It shows that those women who live in a household with many members are highly susceptible to depression (Table 5.3).
Table 5-3 Household's members: Observed & expected data, result of Chi-square and P value

<table>
<thead>
<tr>
<th>Observed</th>
<th>Expected</th>
<th>Chi Square</th>
<th>P</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>43</td>
<td>29.03478261</td>
<td>28.03478261</td>
<td>54.3517439</td>
</tr>
<tr>
<td>53</td>
<td>9</td>
<td>29.03478261</td>
<td>28.03478261</td>
<td></td>
</tr>
</tbody>
</table>

Figure 5-4 Number of person in a household

5.7.4 Living away from spouses

The result of this study indicates that those women who live away from their spouses are 8% in case group and 4% in control group (Figure 5.5). Based on statistical analysis, the result of Chi-square test is ($\chi^2 = 1.41843972$), and P value = 0.23366039; thus, it is more than significant value and cannot reject the null hypothesis (Table 5.4). But during the interview with psychiatrists and psychologists, they disclosed that living away from spouses is a risk factor of depression among women.

As Dr. Emal Safi, the trainer specialist of Kabul Mental Health Hospital, stated, “I have many depressed patients whose spouses live in Saudi Arabia, UAE, Kuwait, Oman and other
countries. On the other hand, some male patients have been contacting me through phone and shared their concerns and flirtations. They call for consultations, and they have been taking medicines in a regular basis. As I mentioned earlier, their wives live here in Afghanistan; as a result, both of them suffer and eventually become a prey of depression.

Table 5-4 Living away from spouse: Observed & expected data, Chi-square and P value

<table>
<thead>
<tr>
<th>Observed</th>
<th>Expected</th>
<th>Chi Square</th>
<th>P</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>4</td>
<td>6</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>92</td>
<td>96</td>
<td>94</td>
<td>94</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.41843972</td>
<td>0.23366039</td>
<td>1</td>
</tr>
</tbody>
</table>

Figure 5-5 Percentage of marital status (widowed, spouse away and married)

5.7.5 Educations

The result of this study shows that (42%) of women in the case group are educated, and (54%) of participants in the control group are literate. The percentage of illiteracy in the case group is (58%) and in the control group (46%); there are no big differences between the results of the two groups (Figure 5.6). The result of Chi-square test is \( \chi^2 = 2.88461538 \) and P value = 0.089; it is more than significant value and cannot reject the null hypothesis, thus, both results
clearly indicate that there is no association between education and depression among women in Kabul (Table 5.5).

<table>
<thead>
<tr>
<th>Observed</th>
<th>Expected</th>
<th>Chi Square</th>
<th>P</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>42</td>
<td>54</td>
<td>48</td>
<td>48</td>
<td>2.88461538</td>
</tr>
<tr>
<td>58</td>
<td>46</td>
<td>52</td>
<td>52</td>
<td>1</td>
</tr>
</tbody>
</table>

5.7.6 Education Level

The result and finding of collected data from both the case and the control groups in this study indicate that the education level has its own impact on women mentality. The data precisely shows that those females who have a low level of education are highly prone to depression. The following (Figure 5.7) shows that 1.68% of women of the case group have higher education (Bachelor), and 8.64% of women in the control group have a bachelor degree. The result shows that the percentage of those women who have high school level education is
7.56%, and 15.66% participants of control group have the high school level education. The level of secondary education in case group is 3.36%, and 2.07% women in control group have secondary education. Moreover, the level of primary education among women of case group is 5.04%, and 2.16% female of control group have primary education. Based on researches around the world, there are many examples that the inferior level of learning has relation to PTSD amongst postwar countries plus Afghanistan (de Jong, 2002).

Based on statistical analysis, the result of Chi-square test is ($\chi^2 = 43.5202539$), and the P value = 0.004277 and significant (lower than 0.05). Thus, it rejects the null hypothesis. Therefore, the figures precisely demonstrate that the case group has a lower level of education than control group. Hence, the finding obviously shows that those women who have low education are highly anticipated to be depressed. Finally, low education counted as a risk factor of depression among the case group of this study (Table 5.6).

Table 5-6 Observed & expected data of education level, result of Chi-square test and P value

<table>
<thead>
<tr>
<th>Observed</th>
<th>Expected</th>
<th>Chi Square</th>
<th>P value</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>16</td>
<td>8.75</td>
<td>11.25</td>
<td>13.17652632</td>
</tr>
<tr>
<td>18</td>
<td>29</td>
<td>20.5625</td>
<td>26.4375</td>
<td>8</td>
</tr>
<tr>
<td>8</td>
<td>5</td>
<td>5.6875</td>
<td>7.3125</td>
<td>12</td>
</tr>
</tbody>
</table>
5.7.7 Women’s Occupation

The result of this research did not find any association between women’s job and depression. The following chart and statistical analysis clearly indicate that women’s job does not have any relation with depression. The frequency of women who work as civil servants in the case group is 17%, and 23% of participants in control group are civil servants. There are no huge distinction between these two percentages. Furthermore, 83% of women in the case group and 77% of participants in the control group are housewives (Figure 5.8).

Based on statistical analysis, the Chi-square test is ($\chi^2 = 1.125$), and the P value = 0.28884437; it is more than a significant value and cannot reject the null hypothesis. Thus, the result of collected data and statistical analysis did not prove the association between women’s job and depression (Table 5.7).
Table 5-7 observed & expected data of women's job, the result of Chi-square and P value

<table>
<thead>
<tr>
<th>Observed</th>
<th>Expected</th>
<th>Chi Square</th>
<th>P</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>23</td>
<td>20</td>
<td>20</td>
<td>1.125</td>
</tr>
<tr>
<td>83</td>
<td>77</td>
<td>80</td>
<td>80</td>
<td></td>
</tr>
</tbody>
</table>

5.7.8 Husband’s Occupation

The result of this study shows that the husband’s job has an impact on women mentality. Sixty three percent of women in the case group confessed that their spouses have no job, and 13% of women in the control group mentioned that their husbands are jobless. Additionally, 37% of women in the case group and 87% in the control group answered that their spouses have job (Figure 5.9).
Although the statistical analysis indicates that the result of Chi-square test is ($\chi^2 = 53.0560272$), and P value is $= 0.00$, it is less than significant value (0.05) and rejects the null hypothesis. Therefore, it demonstrates that the husband’s occupation has a high association with wife’s depression. Finally, those women whose husbands have no job are more susceptible to depression (Table 5.8).

Table 5-8 Observed & expected data of spouse's job, the result of Chi-square and P value

<table>
<thead>
<tr>
<th>Observed</th>
<th>Expected</th>
<th>Chi Square</th>
<th>P</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>37</td>
<td>87</td>
<td>62</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>63</td>
<td>13</td>
<td>38</td>
<td>38</td>
<td></td>
</tr>
</tbody>
</table>

![Spouse's Job](image)

Figure 5-9 Percentage of spouse job in case and control groups

5.7.9 Monthly Income

Monthly income of the case group was lower than the control group. The data shows that 43% of women in the case group and 0% of control group have less than 9000 AFs per month.
Thirty one percent women of case group and 7% of control group have 10,000 – 19,000 AFs on a monthly basis. Ten percent of females in the case group and 19% of females in the control group have 20,000 – 29,000 AFs per month. The income of 3% of women in the case group is 30,000 - 39,000 AFs, and 29% of the control group has the same monthly income. No participants of the case and 16% of control have 40,000 - 49,000 AFs income on monthly basis; and 13% of women in the case group and 29% of women in the control group have equal income of more than 50,000 AFs income per month (Figure 5.10).

Therefore, the comparisons of monthly incomes of case and control group show that the majority of participants in the case group have less income than the control group. Thus, it precisely demonstrates that low income has association with depression among women aged 18-45 in Kabul. Here is no need for statistical analysis, because the data clearly shows the big gap between case and control groups.

![Household monthly income](image)

**Figure 5-10 household monthly income**

5.7.10 Living with In-laws

The data of this study demonstrates that 64% of women in the case group live with in-laws, and 35% of women in the control group live with in-laws. On the other hand, 36% of participants in the case group and 65% of respondents in the control group live with their own families.
Hence, the result shows more women live with in-laws in case group than control group (Figure 5.11).

Additionally, the statistical analysis indicates that Chi-square test is ($\chi^2 = 16.8216822$), and P value is $= 0.00$; it is less than significant value (0.05) and rejects the null hypothesis. Thus, it shows that living with in-laws is highly associated with women’s depression. Finally, those women who live with in-laws are more vulnerable to depression (Table 5.9).

Table 5-9 Observed & expected data, result of Chi-square and P value

<table>
<thead>
<tr>
<th>Observed</th>
<th>Expected</th>
<th>Chi Square</th>
<th>P</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>64</td>
<td>35</td>
<td>49.5</td>
<td>50.5</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>65</td>
<td>49.5</td>
<td>50.5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Living with in-laws</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living with in-laws Yes</td>
</tr>
</tbody>
</table>

64 | 36 | 35 | 65

Case Group | Control Group

Figure 5-11 Number of women who live with in-laws and those who live with own families
Table 5-10 Univariate analysis shows the distribution and association of war related and socioeconomic factors with depression among women aged 18-45 in Kabul, Afghanistan.

<table>
<thead>
<tr>
<th>Items</th>
<th>Patients, ( n = 100 ) (%)</th>
<th>Control, ( n = 100 ) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 - 24</td>
<td>18 (18)</td>
<td>11 (11)</td>
</tr>
<tr>
<td>25 - 29</td>
<td>22 (22)</td>
<td>27 (27)</td>
</tr>
<tr>
<td>30 - 39</td>
<td>27 (27)</td>
<td>32 (32)</td>
</tr>
<tr>
<td>( \leq 45 )</td>
<td>33 (33)</td>
<td>30 (30)</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>79 (79)</td>
<td>91 (91)</td>
</tr>
<tr>
<td>Married (Spouse Away)</td>
<td>08 (8.0)</td>
<td>04 (4.0)</td>
</tr>
<tr>
<td>Widowed</td>
<td>13 (13)</td>
<td>05 (5.0)</td>
</tr>
<tr>
<td><strong>Marriage Type</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arranged</td>
<td>80 (80)</td>
<td>90 (90)</td>
</tr>
<tr>
<td>Forced</td>
<td>08 (8.0)</td>
<td>00 (00)</td>
</tr>
<tr>
<td>Voluntary</td>
<td>12 (12)</td>
<td>10 (10)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>42 (42)</td>
<td>54 (54)</td>
</tr>
<tr>
<td>No</td>
<td>58 (58)</td>
<td>46 (46)</td>
</tr>
<tr>
<td><strong>Education Level</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bachelor</td>
<td>04 (1.68)</td>
<td>16 (08.64)</td>
</tr>
<tr>
<td>High School (10-12Y)</td>
<td>18 (7.56)</td>
<td>29 (15.66)</td>
</tr>
<tr>
<td>Secondary (5-9 Y)</td>
<td>08 (3.36)</td>
<td>05 (02.07)</td>
</tr>
<tr>
<td>Primary (1-4 Y)</td>
<td>12 (5.04)</td>
<td>04 (02.16)</td>
</tr>
<tr>
<td><strong>Job</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Civil servant</td>
<td>17 (17)</td>
<td>23 (23)</td>
</tr>
<tr>
<td>House wife</td>
<td>83 (83)</td>
<td>77 (77)</td>
</tr>
<tr>
<td>Monthly Income (Afs)</td>
<td>Yes (%)</td>
<td>No (%)</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------</td>
<td>--------</td>
</tr>
<tr>
<td>&lt; 9000</td>
<td>43 (43)</td>
<td>00 (00)</td>
</tr>
<tr>
<td>10,000 - 19,000</td>
<td>31 (31)</td>
<td>07 (07)</td>
</tr>
<tr>
<td>20,000 - 29,000</td>
<td>10 (10)</td>
<td>19 (19)</td>
</tr>
<tr>
<td>30,000 - 39,000</td>
<td>03 (03)</td>
<td>29 (29)</td>
</tr>
<tr>
<td>40,000 - 49,000</td>
<td>00 (00)</td>
<td>16 (16)</td>
</tr>
<tr>
<td>≥ 50,000</td>
<td>13 (13)</td>
<td>29 (29)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Spouse Job</th>
<th>Yes (%)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>37 (37)</td>
<td>87 (87)</td>
</tr>
<tr>
<td>No</td>
<td>63 (63)</td>
<td>13 (13)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Living with in-laws</th>
<th>Yes (%)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>64 (64)</td>
<td>35 (35)</td>
</tr>
<tr>
<td>No</td>
<td>36 (36)</td>
<td>65 (65)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relation of lost relative</th>
<th>Yes (%)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brother</td>
<td>09 (9.0)</td>
<td>10 (10)</td>
</tr>
<tr>
<td>Father</td>
<td>05 (5.0)</td>
<td>07 (7.0)</td>
</tr>
<tr>
<td>Husband</td>
<td>13 (13)</td>
<td>05 (5.0)</td>
</tr>
<tr>
<td>Mother</td>
<td>19 (19)</td>
<td>18 (18)</td>
</tr>
<tr>
<td>Sister</td>
<td>02 (2.0)</td>
<td>05 (5.0)</td>
</tr>
<tr>
<td>Son</td>
<td>06 (6.0)</td>
<td>03 (3.0)</td>
</tr>
<tr>
<td>No</td>
<td>46 (60)</td>
<td>52 (52)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Persons in a household</th>
<th>Yes (%)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 10</td>
<td>73 (73)</td>
<td>22 (22)</td>
</tr>
<tr>
<td>&lt; 10</td>
<td>27 (27)</td>
<td>78 (78)</td>
</tr>
</tbody>
</table>
CHAPTER SIX

6 Introduction

This chapter describes the discussion and conclusion & recommendations of the study. The description is organized in two separate parts. First, the discussion part and second is conclusion & recommendation part.

6.1 Discussion

This study is the first study to examine the association of women’s depression with war-related factors (e.g., losing a husband or other family member), some cultural practices (e.g., living in a household with many members, forced marriage, marriage in Baddee), low and irregular monthly income, living away from spouses, and having a low education in Kabul, Afghanistan.

The finding indicates that widowhood is clearly related with depression. This is possible because living without a spouse forever (in Afghan society fewer widows get married after widowhood) is difficult and can make this woman further susceptible to depression.

Although, based on prior theories – such as “life course theory”, a difficulty related with missing a spouse (Umberson D & Williams, 2005) and “distress theory” (Holmes. T & Rahe, 1967) (Mastekaasa, 1994) – it is apparent that altering spousal position is an important lifetime occasion, which could, in turn, simply produce tension in a person’s life.

Another factor that is divulged through this study is the reality of living in a big joint family without a proper social system. Living together in a big household is a usual and traditional
system in Afghanistan. Hence, women who live in such a crowded household are likely susceptible to oral quarrels and sensitive abuse by in-laws. This contrasts with other countries, where people have their individual life or even a social life with the promise of protection of each individual’s rights.

The pronouncements, which we gained by conducting two separate categories of Case and Control Groups, designate that more women in the Case Group live with in-laws than in the Control Group. Furthermore, the statistical analysis through Chi-square test and P value found this to be associated with depression.

Forced marriage is another major problem and risk factor of depression among women in Afghanistan. The results show that there are many cases where women are forced to marry, since they do not have any other options. They are obliged to obey the orders of her/their father or brothers, which in most cases lead to depression.

Dr. Emal Safi, the well-known trainer and psychology specialist of Kabul Mental Health Hospital, stated, “As we know that half of our population are women, but unfortunately some negative and unacceptable cultural practices, especially among male dominated families do exist. Therefore, based on those wrong opinions, they consider female as a second or inferior human or gender”. Dr. Emal Safi added, “in these families women are oppressed, expose to family violence, and even they do not have a choice or a will of their own”.

Based on data, low and irregular income is another risk factor of depression among women in Kabul city. Results from both the case and control groups show that in the case group, many women have a low income; also, a majority of them mentioned that their husbands are illiterate
and they do not have any vocational skills. Furthermore, there are limited opportunities to find a regular and permanent job. Thus, most of the depressed women are from those families whose income is less than 200 USD per month. Those who become depressed relate to very poor families, and they earn less than 200 USD per month.

While the comparison is made between two researched groups, the data clearly shows that low monthly income is a risk factor of depression among women.

Another risk factor of depression among married women is living away from their spouse. We explained all of its aspects above, however, I would like to add that the most considerable effect, which is on sexual desirability, comes due to the imbalance of sexual hormones. As we all know, every single human needs to have legal sex on a regular basis throughout their lives in order to stay and spend a normal life.

The above situation is due to the lack of work or job opportunities in Afghanistan. In order to have a decent life, men have to travel abroad to earn some savings; besides, there is a dark side of some cultural constraints, as the family of the wives’ side ask for some money called WALWAR\(^4\) (the amount of money which a groom has to pay for the bride’s family/in-laws). In some cases, this amount exceeds 1 million AFS (20,000 USD).

Dr. Emal Safi added, “due to this difficult custom practice groom has to leave immediately after wedding to earn money for the debt (if any, and in most cases, yes, they have) of his wedding and WALWAR. Finally, the adolescent groom struggles to earn more money and work hard; on other side, the young bride stay at home for years and endure many problems”.

\(^4\) *Italic is my word; the definition of Walwar*
The last risk factor, which was recognized through this study, was education level. The results from both groups indicate that those women who have low education levels are more prone to depression. There is no other previous study done to find out the relation of depression with the low level of education in Kabul. Therefore, instead of comparing the present generation with the previous one, we are comparing two study groups in the research.

Based on the findings of this study, we can easily see the result that a percentage of those women who have low education are more prone to a higher risk of depression than those who have high and higher education in control group.

6.2 Conclusion and recommendations

This research perceived a major and significant relationship between a number of risk factors and depression among women. There were some factors such as war-related (e.g., losing a husband or other family member), economical (e.g., low and irregular monthly income), education (e.g., low level of education) and even cultural negative habits (e.g., living in a household with many members, forced marriage, marriage in Baddee). They will continue to exist as long as the government or family does not have any proper handling systems.

This research defines that we need to concentrate on some fundamental rules of our life and make a strong and proper system common to handle some bad and chronic issues in a better way in our society.

These results point to both a vital plan and policy suggestions at the same time, and they
should be in the form of taking some major steps to stop war and conflicts, bad and unacceptable traditional principles, and other such problems. Some other suggestions would be educating the society and increasing the awareness level in various branches of life.

The government should create more job opportunities for people inside the country as well as support widows through local entities. They should work and raise people’s awareness about the significance of female rights. Women by themselves should make progress to gain knowledge about their rights and communicate with their families – especially with their in-laws – in a more proper way.
REFERENCES


MoPH. (2014). *National Mental Health Strategy*. MoPH.


APPENDIX

Questionnaires:

Risk factors associated with depression among women aged 18-45 in Kabul, Afghanistan

09/08/2014

Mohammad Muhsen

Email: mmh.afghan@gmail.com

mohamh13@apu.ac.jp

QUESTIONNAIRE: TO COLLECT DATA ABOUT RISK FACTORS OF DEPRESSION AMONG WOMEN IN KABUL MENTAL HEALTH HOSPITAL
## GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Q1. How old are you?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q2. What is your marital status</th>
<th>Married</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Married (spouse away)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Widowed</td>
<td>3</td>
</tr>
</tbody>
</table>

*Tick only one option*

<table>
<thead>
<tr>
<th>Q3. How did you get marry?</th>
<th>Voluntary</th>
<th>Arranged</th>
<th>Forced</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q4. Do you have education?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Q5. What is the level of your education?</th>
<th>Primary</th>
<th>Secondary</th>
<th>High school</th>
<th>Bachelor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q6. What is your job?</th>
<th>Housewife</th>
<th>Civil servant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
This is the end of the interview. Thank you very much for assisting us with this research. Remember that your answers will be kept confidential.