Mental Health Assessment
Ghurian and Zendah Jan districts
Herat Province
AFGHANISTAN

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Esmée de Jong
Medical Anthropologist,
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Country manager: Oliver Mathieson
Operational Director: Marcel van Soest
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Executive Summary

The provision of health services in Afghanistan is of poor quality and patients are openly criticising the care provided at public clinics. This discontent can be attributed to poor patient care from the side of the practitioners and unrealistic or even harmful demands from patients. Health workers do not take sufficient time to take an illness history, do not carry out the complete physical examination required and communicate badly. Patients demand a high number of sophisticated drugs and feel that little attention is paid to their problems. We have to acknowledge that the majority of patients are presenting psycho-somatic complaints. The cure-oriented approach of both the care provider and the patient will not give satisfying and visible results.

Psycho-somatic complaints will overburden the health sector because of the continued demand for drugs and ongoing repetitive visits. The health sector threatens to lose credibility among the patients because too little result will be obtained by conventional curative medicine. It is therefore important to upgrade the quality of care in the health centres, to teach relevant skills and transfer knowledge on mental health issues to nurse students currently in training.

The assessment in mental health problems has identified domestic conflicts to be the main source of distress in women. The study has established a direct link between distress and somatising behaviour. The study has likewise encountered a high usage of the clinic by women wanting to leave the family compound and meet other women. Recognising the importance of the health clinic as a social gathering point for women and the somatisation of their psychological problems, services need to be adapted accordingly.

Other causes of stress and (social) dysfunctioning are related to the difficult economic circumstances, the long period of warfare, current political pressure and people’s specific living practices (e.g. purdah related depression, somatised as ‘general body pains’). In order to cope with the different stressors in life, many coping styles can be identified among Afghans. Islam serves as the most important source of relief to both men and women. The religious leaders, the mullahs, play a very important role in solving problems, correcting behaviour and treating mental illness (usually anxiety or sleeping problems). High levels of somatisation coincides with very specific illness behaviour. Illness gives a valid reason for escaping out of everyday routine or misery.

Memories of the war against the Soviets and the fighting among the Mujahideen are blocked (people want to forget). After living under the control of Taliban for the past five years, most people have developed a feeling of resignation with the current situation.

In order to tackle the overwhelming problems in the field of mental health, a number of interventions can be suggested.

- The provision of technical assistance to the female Nursing School in Herat
- the implementation of psycho-social services in Ghurian, Zendah Jan and Khosan clinics
- the implementation of community-based talk groups to start in Zendah Jan

In order for this programme to be carried out satisfactorily, it needs two experienced expatriates. One expat for the teaching position at the Herat nursing school and one for the implementation of psycho-social services in the clinic.
Introduction

Already for quite some time has MSF been concerned about the psychological consequences of armed conflict and social disruption. Through the implementation of integrated mental health services, does MSF hope to add a social dimension to the care provided.

Afghanistan seems to be the classical country for a mental health intervention. The country has been involved in armed conflict since the late seventies, even today fighting continues in part of the country. People are fed daily with stories on the front and continue to be reminded of the horrors of war. Many have lost relatives, or saw their family size reduced considerably due to migration.

When starting the mental health assessment, I met some people being critical of the entire concept. According to them ‘Afghans do not need mental health programmes, they are brave people’. When presenting this statement to Afghan doctors it angered them. ‘Afghans are not brave, they are merely adapting to the situation in the country’. And that’s what they do. At present Afghans prefer to block the memories of the past and try to get normalcy back in their present lives. However, they feel the future looks bleak.

The mental health assessment that has been carried out for MSF-Holland in Herat Province (Ghurian and Zendah Jan districts) has taken place from 6 July until 6 October 1999. It was aimed at identifying traditional coping styles and major causes of distress. Fieldvisits have been made to better understand community dynamics.

The report gives recommendations on possible programming issues and activities.
General Overview

Afghanistan

Afghanistan is characterised by a complex tribal organisation. Although seemingly disorganised, all groups share a common sense of being Afghan and of protecting its values and territory. The tribal organisation is patrilinear, with clans sharing a common male ancestor. Many subtribes have emerged, who will combine forces when security is at stake or engage in internal conflict when a common enemy is missing. However, present regionalisation has exacerbated armed conflict and brought the country’s development to a complete standstill.

The villages in the countryside are organised according to tribal groups. In times of social upheaval, high mobility or insecurity, the tribe has strong social and economic obligations towards its members. Dissolved extended families are reorganised according to the tribe of origin, securing their very survival. Common beliefs and values are shared and transferred within this setting. Tribal cohesion serves as the most important coping mechanism among Afghans.

Human settlement

The climate and geological conditions in western Afghanistan do not favour human settlement. Dry sandy grounds are primarily suited for the production of wheat. The Afghans are utilising an inventive irrigation system to provide year round water to the fields that surround the villages. Most of the water is obtained from natural springs in the mountains or rivers, hence the predominant settlement pattern along the bottom of mountain ranges and alongside riverbeds. Drinking water is obtained from wells in the villages. It is never boiled before consumption. Some mothers claim to start boiling the water when a child is ill.

Joined families live in closed compounds, behind high mud walls. The houses are made of tablets of mud with straw and have a clay layer on the outside. Air holes on top of the houses ventilate the rooms during the hot summer season. They will be closed during the very cold period of winter. Small windows in the rooms stabilise the temperature inside, but introduce insufficient fresh air. Airborne diseases are thought to be frequent (e.g. pulmonary tuberculosis).

Community organisation

Village life centres around the family. Rather than talking about a group of extended families, one can refer to different settlements as having joined families, of the same (sub)tribe. The settlement pattern is patrilocal, with men staying with their families and their wives moving in. Marriages are arranged by the parents. Engagements are celebrated at a young age (as young as 12 for girls) with marriages following some years later. Life within the family is regulated by strict rules of seclusion for women, named purdah (page..).

In the countryside isolated villages function relatively independent from the central Afghan administration. Local counsels of wise men, the so-called ‘shura’s’, are heading the villages and decide on emerging legal, religious and economic matters. All members of the shura must have a say and an unanimous agreement is needed before a decision can be taken. This traditional anarchical decision-taking model can lead to days of discussion, depending on the issue.
The most important men of the village have a seat in the *shura*. Some are members because of their particular religious role or economic position in the community. Others are respected (older) representatives of the diverse joined families.

Traditionally, the landowner (*arbab*) plays a very dominant role. The *arbab* derives his authority from the patron-client relationships with villagers and the division of scarce water. During the last two decades, successful military leaders have in some places replaced conventional leaders (Marsden, 1996). In addition, the invasion of the socialist Soviet army led to the revival of Islam and the strengthening of the Muslim clergy (Marsden, 1996). An increasingly important member of the *shura* therefore is the religious leader, the *mullah*. As the head of the local mosque, he is an important key-figure in the community. In his prayers, the *mullah* communicates information regarding religious matters, politics and social affairs. It is especially in the role of the mullah that political, social and economic life join at community level. In addition, the ability of the *mullah* to cite parts of the Holy Quran makes him an important spiritualist (in both religious and health matters).

The villages are linked to a wider administrative organisation and incorporated in a more market-oriented model through obligatory income taxes. On top of that, ten percent of the harvest is handed over to the regional government. Although officially abolished at the beginning of the century, unpaid (forced) labour is common in Ghurian district. Every family in the smaller villages needs to make one male member of the family available for ‘services for the governor’. Special rosters are made, showing the structural, rather than provisional, nature of these practices.

Some villages are made out of a conglomeration of independently functioning joined families, sharing one *shura*. Although belonging to the same ethnic group, these families belong to different sub-tribes. Scarcity of economic and natural resources often leads to internal feuds between neighbouring sub-tribes. During the fieldwork for this research, such tensions were reported in one village.

The bigger villages or towns are important regional centres, that fulfil a function as local market and places of trade. The district is governed relatively independent from the (weak) central government.

**MSF in Herat**

The city of Herat is situated in the north-western corner of Afghanistan. It has been able to establish itself as an important trade centre, because of its good geographical location. Starting in 1995, MSF-Holland started activities among internally displaced people from Badghis Province. The MSF office in the city of Herat supports two projects. The project carried out in the province of Herat is being implemented in Ghurian and Zendah Jan health districts and has been running for almost one and a half year. Next year activities will be extended to Khosan district. Aimed at supporting a local partner in the development of sustainable health care services, MSF is only partly involved in organisational issues (see Ghurian clinic).

A new programme has recently started in Badghis Province. Whereas the Herat programme is implemented in collaboration with a local partner, local ngo’s are not present at the location of the Badghis programme (Bala Morgab).

**Non-governmental organisations in Herat**

A number of international organisations are currently active in Herat Province. Christian Aid is currently funding twenty community based projects, including TBA-training. A new initiative is the shelter for boy orphans (boys without a father) in Herat city. Currently 160 boys, ranging
between the ages of 8 and 20, are staying at the centre for one year. During this time they receive training in calligraphy, tailoring, carpet weaving or shoe making. It is planned to upgrade the centre to a capacity of 200 boys. Seventy-five percent of the students are taken out of existing orphanages, the remaining 25% are selected in the community. Special attention is paid to disabled children. They have not yet enrolled, as travel expenses were not covered.

The Danish Committee on Assistance to Afghan Refugees (DACAAR) is running an extensive water and sanitation programme. Wells and handpumps have been installed throughout Herat Province. All waterpoints are maintained by a ‘water responsible’, who is paid in kind by the community. Married couples have been trained as health educators, to provide information on water treatment and the prevention of communicable diseases.

Ockenden Venture is implementing a community development programme in one of the neighbourhoods of Herat City. Through participatory appraisals, the community is invited to prioritise emerging needs. To break through the male dominated decision making process, women are being trained in community participation. The organisation is in this initial phase still struggling with ways to improve female participation. Education sessions for women are given at different locations to prevent suspicion from the environment. The only employed female community worker of the organisation operates from her own house and tries to move around as ‘anonymously’ as possible.

The Danish Afghan Committee (DAC), is currently supporting one clinic and intends to build three more. The organisation originally started working at Herat hospital, but stopped its services out of disappointment with the outcome of their efforts. DAC is preparing the arrival of a surgical team that is to start minor surgery services at the clinic. In addition, TBA’s are being trained.

Médecins du Monde (MDM) and Merlin originally supported health districts in Farah (MDM and Merlin) and Badghis (Merlin) Provinces. Both organisations have pulled out, with only MDM maintaining a small office and supporting some clinics in Herat city.

The International Assistance Mission (IAM) is running several projects. An eye doctor is rendering services at the Regional Hospital, a community development programme is run in the periphery of the city and a women’s mental health programme has been functioning for years now (see next paragraph).

The United Nations are also represented, though at a limited scale. UNICEF is implementing its usual Expanded Programme on Immunisation and will rehabilitate the run-down maternity ward of the Herat Provincial hospital. WHO is supporting the nursing school and is interested in finding counterparts (ingo’s) for the implementation of a tuberculosis programme.

**Mental health activities in Herat**

Kabul always has been the centre of institutionalised care for psychiatric patients. As a consequence, both non-governmental organisations (ISRA, IAM) and United Nations Agencies (UNICEF) have started mental health activities in this city and support the Mental Health Institute and centres for the treatment of drug addicts.

There are no psychologists, nor trained psychiatrists working in Herat. One private doctor, with some years of working experience in the Kabul Mental Health Institute, is seeing some psychiatric patients. There is no mental health facility available in the city of Herat and many patients will be treated for their symptoms by general doctors or other specialists. It is important to note that the institutionalisation of people with mental health problems is not a normal concept in Afghan society. Likewise, counselling services for people with psychological problems have never been introduced. Herat does not have, and never had, psychologists or social workers.
There are reportedly traditional doctors working in the city who work with ‘crazy people’. I did not have the opportunity to visit any of them and do therefore not know what kind of mental health problems they treat.

The International Assistance Mission (IAM) started a mental health programme in the early nineties, when the Mujahideen were in control of the city. With the takeover of Taliban, the programme continued normally. The mental health programme is a community-based programme, working with women only. The major focus is conflict resolution in the family, with a specific emphasis on the relationship between daughter-in-law and mother-in-law. Four local female health workers have been trained in providing training and information to the communities. The local population has been asked to set up talk groups. After two security incidents seriously affected the IAM expatriates, the team temporarily left the city. In order to continue the capacity building of the four female workers, training was provided in Peshawar with the employees flying in. The Herati ministries reacted furious and temporarily closed the IAM project. As of mid-August the programme has resumed its activities again, with the approval of the Herati authorities. However, the starting up is going slowly and many difficulties still have to be approached. Apart from problems with the authorities that seem to affect all programmes, the female workers of the mental health programme have received threats. One of the workers reportedly wishes to leave Afghanistan, the brother of another woman received a visit from a neighbouring Talib challenging his decision to let his sister work for the programme (it is however not clear whether this is related to IAM, the mental health programme or female workers). Apparently the women feel very insecure and have asked IAM for some time to decide whether or not to continue their work.

The programme has another serious problem on operational level. As part of the second phase aimed at making the mental health activities in the community sustainable, training has to be provided to community representatives on conflict resolution. However, these people are refusing to participate in the courses and continue their work, as they want to receive a salary from IAM. It is important to mention that the first phase of the programme lasted five years, which is a long and slow process. No sustainability has yet been achieved.

On several occasions IAM has been asked to support the Regional Hospital in the care of psychiatric patients. Mainly involved in community-based projects, they have always (been able to) refused.

**Ghurian and Zendah Jan districts**

Business is booming for a small group of people, living in the districts bordering Iran. The closure of the border enriches clever businessmen. According to the local population, this increased wealth has led to an augmentation of polygamy practices. More often than before are rich older men marrying more than one wife.

The illegal trade between Afghanistan and Iran has a dark side. Men from very poor families see no other option than to risk corporal punishment, smuggling goods (often opium) from Afghanistan to Iran. If caught, they receive the death penalty by hanging. Even children are used in the smuggling of opium. They are said to at times receive the same penalty when arrested by Iranian police (others say they are imprisoned). One man interviewed at the clinic was in great distress. He was smuggling drugs with his son when being stopped by Iranian police. As his son was the only one carrying opium on his body, he was shot on the spot.

As in all districts in Herat Province law and order is maintained by the Taliban. In Zendah Jan a ‘progressive’ Talib controls the district. In Ghurian, restrictions are more strictly observed. In the adjacent villages life seems to be continuing as usual. However, the composition of the population is not homogeneous. Due to armed conflict and economic hardship, many people left their homes. Most families
settled in Iran or Pakistan. Over the last six years, people have started returning from Iran, as its authorities are pursuing an active repatriation policy. The returnees have experienced a different life style in Iran. Contrary to Afghanistan, women were allowed to work and girls were able to attend school. Even illiterate parents have come to see the advantages of child education. The group of people that has resided outside the country for a long period bring different expectations of life. The social-cultural constellation of the villages is likely to be affected by the many contacts Afghans have had with other tribes (when being internally displaced) or other peoples (as refugees). Women start claiming the right to be (more) self-sufficient and independent and have education (often heard during field research). This may in the future have implications for the population’s fertility pattern, with women demanding greater say in birth control.
Methodology

Throughout the mental health assessment, qualitative anthropological research methods have been used (i.e. field visits to villages, families and communal sites, interviews with key-informants, participatory observation and focus group discussions). In a later phase a base line quantitative survey has been introduced to support the findings of the qualitative research.

After an initial assessment of two weeks (primarily conducted in Ghurian district), the reactions to the mental health assessment were very promising. All health workers interviewed have had experiences with agitated and exited patients. They understood the implications of a mental health intervention and considered such actions important and relevant to their work. Having received this positive feedback, it was decided to visit the Provincial Ministry of Public Health (MoPH) to introduce the assessment and to probe the officials’ thoughts on mental health programmes. The reaction was positive. It was felt that the recent past justified more directed attention to the psychological problems of the local population.

The questionnaire

At the end of the research the General Health Questionnaire (GHQ) 12 has been implemented (Appendix 2). The GHQ-12 can be used to assess social dysfunctioning and distress among the respondents. It identifies basic problems that all people with psychological problems have in common. The preparation of the GHQ has been elaborate. First translated into Dari by a translator, the questionnaire was then translated back into English by a second translator and compared. The final Dari version agreed upon was then typed in the computer. The questionnaire was again looked at by the MSF-translator. Two interviewers, without links to either MSF or CHA were identified and trained during three days of practical on-the-job work. The researcher joined the female interviewer in the Mother and Child clinic and the MSF-translator supervised the interviews in the male section. Only after a new translator started supervising the work in the male section carefully, were mistakes discovered in the questionnaire administered. Two questions out of the original 12 had to be omitted due to mistakes in the answering categories (Appendix 2). By then the female interviewer had finished her target sample of 100 women and the male interviewer had interviewed over 60 patients. Time did not allow for the implementation of corrected questionnaires. The implementation of the questionnaire was stopped immediately after a security incident leading to the temporary suspension of MSF-activities.

The questionnaire has been administered in both the MCH-clinic and the Basic Health Centre. In both buildings a room was allocated, where respondents could be interviewed in private. In the female section, women were informed about the purpose of the questionnaire. Numbers were distributed to 12 women with the question to pass by the interview room on their way out. Numbers were not given to women with very ill children (due to their excitement). Patients were asked to go to other services first, to limit preoccupation’s concerning their consultation or obtaining drugs from the clinic pharmacy. In the BHC, all men were informed before consultation hours about the questionnaire. As at the MCH they were interviewed after consultation. No numbers were distributed at the BHC, since the number of visiting men was low. There was no need to limit the number of men presenting themselves to the interviewer.

During the interviews respondents were asked in more detail about their daily stress and are questioned about apparent contradictions in their answers. This way, an attempt was made to understand people’s reasoning and the place of emotion among Afghans.
fieldvisits

Two villages have been repeatedly visited, (Tajik) Barnabad and (Hazara) Kishmaran. In both villages interviews have been held with families and health workers. In addition, visits have been made to important communal sites. Other villages have been visited less frequently.

It is important to note that the information gathered was treated confidentially, nothing was reported back to shura’s or mullahs. Information was spontaneously given during the interviews, and was never ‘double checked’ in other houses or villages. Information given by different people on separate occasions can be found in the document. When statements were made in only one area or by one person, it is either not used or is marked as non-confirmed information.

The villages Barnabad and Kishmaran are described below to give an idea of the setting of the research and daily village life. After that the health sector in Herat province will be closely examined. Stress in the communities will be addressed, followed by the traditional coping styles and ways to express emotions (social communication). The paper concludes with some preliminary recommendations for the setting up of a programme.

Description of the villages visited

Kishmaran

The village Kishmaran is situated at approximately 25 kilometres south of Ghurian town. It is inhabited by people from Hazara descent. In 1974, the Hazara bought the village from a landlord, who owned large pieces of land in the region. In its high-days, 150 families lived in Kishmaran. At present only 40 families are remaining. Many are living as refugees in Pakistan and Iran. Others are living in the city of Herat, where anonymity guarantees some degree of protection. Those living in the village have settled there at different times. One large family has come as late as a couple of months ago. Being forced to leave Iran, they did not have the means to restart their life in Herat. Since they are Hazara they settled in Kishmaran. Some arrived after the fierce fighting in Kabul in 1996.

Only people owning (some) land are able to stay in Kishmaran. At the outskirts of the village many houses that were in use by landless day-labourers are abandoned. The workers have moved to the city, forced by the difficult economic situation and discriminatory actions from the part of the Taliban.

The land owned by the Kishmaran Hazara is wide-spread. The fields are used for the production of wheat and various vegetables. An elaborate irrigation system provides year-round water. The water is derived from a natural spring in the mountains. At the foot of the mountains a large basin fills during the night. At day-time, the water is distributed to different fields, using a network of small irrigation canals. The arbab of the village is in charge of the water distribution. Once a year, the people clean the canals.

The Hazara used to be a slave people. Used as a free labour force, they earned the reputation of being hard and strong workers. Although abolished at the turn of the century, forced labour continued well into this century (Mousaveni, 1996). Even today, the Hazara village receives visits from the Taliban demanding their services. At times, armed Taliban patrol the village to show ‘their presence’. Two weeks before the assessment team first arrived, all male villagers had been temporarily arrested. They were taken to Herat prison.
This ongoing pressure is visible in the number of stress related complaints in the village. Indeed, an increase in the number of jinn (bad spirits causing illness and misfortune) is reported. According to the shura members, the villagers are under constant strain from daily life and ongoing repression.

The village has a small shura, consisting of the village leader, the mullah and some (three?) older inhabitants of the village. Usually guests arriving are received in a special room, the guest room, in the house of the village leader. They are offered tea and lunch. The guestroom is not used by his family and serves hospitality purposes only.

Barnabad

Barnabad, a village inhabited by Tajik people, is situated on the road from Ghurian to Zendah Jan. Its number of inhabitants is unclear. However, before the war a population census among the male residents counted around 3000 people. Currently some 1000 people have left the village, the majority living in neighbouring Iran. During the bombardments of the Mujahideen many inhabitants went into hiding in Boa, a small adjacent Uzbek settlement. Some parts of Barnabad have been seriously affected. The buildings that were hit have not been rehabilitated. Most families whose houses have been destroyed, moved to Boa. Their decision to do so was primarily influenced by economic difficulties (not having the means to rebuild their property). They admitted to also walking away from bad memories associated with the time of warfare.

The village looks comparatively prosperous. A number of small shops have opened, ranging from a grocers’ to a pharmacy. Most of the shops are owned by demobilised soldiers. Six health workers, trained by the WHO some years ago, provide health services to the local population. Four of them are local teachers. One traditional healer, hakimji, works in the village. She provides herbal remedies for the common diseases (e.g. diarrhoea, nausea). As in the other villages visited, a sharp decrease in the number of traditional specialists is reported. Most have received the WHO VHW-training and have become ‘village doctors’, often replacing herbal treatments with modern medicine.

Barnabad is situated in the catchment area of Ghurian clinic. In case of emergencies, private cars can be rented to transport a patient to the clinic. However, this means of transportation is extremely expensive (around 5 Lac). Others visit the clinic on a donkey.

Barnabad has 13 mosques. Apart from being a place of worship, the mosque is also used for other occasions. On two of our field visits, the mosques were being utilised by outreach vaccinators (from Ghurian clinic). Religious education is provided for children (both boys and girls) by the mullah. The mullahs in Barnabad are also known for treating patients with mental illness, especially those affected by jinn. The mullah encircles them, trying to cast out the evil spirits.

Adding to the spiritual element of life in Afghanistan are the shrines (ziarat). In Barnabad, three important shrines are regularly visited by the locals. Numerous other, smaller shrines, are of importance to a more selected group of people. Apart from being the tombs of important past leaders, the shrines often have a history of strange events or miracles attached to them.

The most important shrine of Barnabad is situated in the middle of the village and is surrounded by a high mud wall. In the courtyard grow high pine trees. In the centre of the shrine is situated a small building (with two passages). When passing through the building, a fifteen meter tomb gets visible. On it lies a big tree, the same size as the tomb. According to the locals:

‘...A governor once wanted to cut the huge tree that was standing next to the tomb and use it as fire wood. He appointed a group of men to do the job. The men went to the tomb and stored the
equipment they were going to use. When arriving the following day, the tree had fallen, right on top of the tomb...

The *ziarat* attracts many people. In a little niche in the building, that gives access to the tomb, a number of books with parts of the Holy Quran are permanently available. The *ziarat* is a preferred place of prayer and recitation. Others visit when having health problems. People suffering from tooth ache have hammered nails into the tree, hoping for soon recovery. Infertile women have hung miniature hammocks, made out of cotton, at its roots. Between the tree and the tomb, there is a large number of small clay balls, put there by people suffering from smallpox. People with mental illness also visit the *ziarat*, but accounts on those visits are fewer (probably because they are not leaving anything ‘tangible’).

**Ghurian clinic**

The MoPH clinic in Ghurian is supported by a joint MSF/CHA health project. This project includes, apart from the purely curative services, EPI, a kitchen garden project, a Village Health Volunteer programme and a Traditional Birth Attendant (TBA) training. As part of the project, village health committees are introduced. A School Health Volunteer (SHV) programme recently started (delay in implementation).

At Ghurian clinic an elaborate registration system has been established. Family composition and consultation history are marked on one joint registration card. After taking an a-selective sample of patientcards of one of the districts of Ghurian town, it was found that nearly 50% of the families visited the clinic once, 27% twice and 8% three times\(^1\). The range in the number of consultations is between 1 and 24. The mean is 2.5 and the median number of visits is 2. The 96 family cards analysed recorded 367 children, meaning a low 3.8 children per unit (208 boys and 167 girls, ratio 1.25:1). Interestingly only 4% of the families registered the presence of a second wife in the family. This could imply the provision of important health care to poor families, who cannot afford the widely available private care. It could be an underregistration, as women will only register their husband and own children. Very few widows are registered. In their case the oldest son is considered the head of the family.

All patients visiting Ghurian clinic receive ten minutes of health education (in groups of ten people). Among women, information on family planning is highly appreciated. Other topics (improvement water wells, building and use of latrines) seem to be more outside the scope of the clientele of the clinic. Visiting male patients receive information on topics they are not actively involved in (like treatment safe water). The health education is less appreciated. ‘We want to talk about our daily -economic- problems, not health’. The sessions in health education are rather informative in nature and do not include the participation of the patients.

Daily, thirty patients are admitted to the clinic (30 female section, 30 male section). There is no systematic triage at the entry, all patients are seen by a medical doctor. Many visitors to the clinic will not be seen, as there is a higher demand for services than the precalculated capacity allows. However, one may ask the question whether currently the capacity is used to its full potential. It is correct that thirty patients a morning would allow sufficient time to have a proper consultation with each of the patients. At present, doctors do not take the required time needed though. Consultation hours are deliberately kept at approximately one and a half hours per morning, which results in the health workers not being active for several hours a morning. There are complaints about the inaccessibility of the clinic, with care-seeking people often ending up consulting private doctors in town.

\(^1\) Over the years 1997 and 1998
Afghans are extremely cure-oriented people. Physical complaints, of which many psychosomatic, are thought to require immediate medical attention. Trying to obtain several prescriptions from various general practitioners is common among Afghans. This allows people to buy large quantities of drugs, which is considered necessary to secure a complete recovery. This illness behaviour and subsequent drug consumption complicates the delivery of good quality services. The deviance in proper prescription and preventive services and the demands from visiting patients is enormous.

“At the MCH-clinic in Ghurian a woman came into the room to be interviewed by the team. She sat down on the cushions in front of the interviewers and threw bags with medication she received on the floor. She looked very angry. When asking what was the matter, the Afghan interviewer said the woman was very upset, as she felt not have received the entire dose of drugs needed to cure her sick child. “I have only received two little bags, one holding 5 and one holding 10 tablets”.

At the Basic Health Care wing for men, the same incident occurred. When asked about his sleeping pattern a patient replied:

‘Of course I cannot sleep. What do you think? I have many economic problems! Do you really think I would come here if I were rich? (laughing out loud) If I had money I would go to a genuine doctor and get real medication, not this (he held up three bags of medication he received from the clinic pharmacy)’.

Addressing the problems of drug consumption among patients and (as a consequence) prescription behaviour among medical doctors is a long process, that foremost requires education.

In general, it is important to note that patients have not reported paying for medication at Ghurian clinic, nor have they been asked to return to a consultation of a health worker in the afternoons. People may become regular patients of health workers after visits to the clinic, but this does not follow refusals of the same health workers to treat the people at the clinic. However many patients end up feeling forced to visit health workers privately because of the low threshold of thirty patients a day at Ghurian clinic.

Table 1; the number of patients at Ghurian clinic

<table>
<thead>
<tr>
<th>Month</th>
<th># patients</th>
<th># men (%)</th>
<th># women</th>
<th># under 5s</th>
</tr>
</thead>
<tbody>
<tr>
<td>February</td>
<td>1313</td>
<td>458 (35)</td>
<td>855</td>
<td>364</td>
</tr>
<tr>
<td>March</td>
<td>1265</td>
<td>469 (37)</td>
<td>796</td>
<td>183</td>
</tr>
<tr>
<td>April</td>
<td>1329</td>
<td>555 (42)</td>
<td>774</td>
<td>359</td>
</tr>
<tr>
<td>May</td>
<td>2649</td>
<td>939 (35)</td>
<td>1710</td>
<td>639</td>
</tr>
</tbody>
</table>

Table 2; the number of mental health disorders as registered at Ghurian clinic

<table>
<thead>
<tr>
<th>Month</th>
<th># patients</th>
<th># male adults</th>
<th># female adults</th>
<th># boys 5-15</th>
<th># girls 5-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>February</td>
<td>12</td>
<td>7</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>March</td>
<td>7</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>April</td>
<td>12</td>
<td>2</td>
<td>7</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>May</td>
<td>10</td>
<td>4</td>
<td>5</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Patients who are diagnosed with mental health disorders are referred to Herat Provincial Hospital. Although the medical doctors in the health centers have some knowledge of mental illnesses, diagnosing and treatment skills need serious evaluation. The number of patients presenting psycho-somatic complaints may burden proper health care delivery at the clinic. One doctor estimates that 50% of the
patients could fall in this category, which may be a close approximation. Most cases of agitation among men are thought to be caused by economic pressure, as shows the following case. The doctor of the BHC-facility tells:

'A patient came in with his hands tied to his back. He was still a young men and was accompanied by his father. According to the father, the young men is engaged for three years now. Being a sheep-herder, he is facing difficulties saving for the dowry. He asked his father for financial support, but this the father could not give. He then stopped talking. After three days he started yelling, threatening his family while agitated. The family run scared. When the father told the story, the young men was sitting quietly in the consultation room. After ten minutes he started laughing out loud and singing. He then ran out of the clinic. In the streets, people have been able to stop him. His family has taken him home'.

Among the female patients of the clinic, family conflicts seem to be the most important reason for agitation. They also stress that they find it very difficult to cope with daily poverty. Many complain of having sleeping problems and they say to be receiving sleeping tablets.
Coping Styles

Stress in the communities
When interviewing families, patients and health workers, a common pattern of stress-related complaints have emerged. The causes of everyday stress can be divided in five categories:

1. economic difficulties
2. living environment
3. long warfare
4. political pressure
5. supranatural phenomena

Economic difficulties
Scarce resources and harsh climate conditions make life extremely difficult. Poverty, although influenced by seasonal changes, is chronic.

A major burden on many families is the low number of male members per extended family. During the war some have been killed, others are still fighting in north-eastern Afghanistan. Many men are currently staying outside the country, primarily in neighbouring Iran and Pakistan. The number of productive males in each family has subsequently dropped significantly. With the Taliban decree against female labour in place, the average family income has diminished considerably. Some families do not have male adult to head the family (in which case the oldest son is considered head of the household). Female headed households (in our definition) are amongst the most vulnerable in the country. Without having the mobility nor means to provide their families with their basic necessities. They largely depend on their children for the day-to-day running of the household. Although men recognise the difficulties for adult female sole survivors and feel these women should be supported, the cultural tradition of purdah is prioritised over the need to make exceptions for families in despair.

'I am a widow with ten children. The only male member of the family who can provide us with an income is my sixteen-year old son. He tries to help, but it is simply not enough. I think every day about how to feed my children. I cannot sleep because of the thinking. I have terrible headaches and I sometimes faint. When I think too much I get dizzy. I have pressure on my chest as well.'

After this interview the woman went to the hospital in Herat, where she stayed ten days. She bought three kinds of medication, but could not tell which.

[After your visit]...I have been to the hospital in Herat. There the doctor said that I have a heart problem caused by stress. He told me that my economic situation is causing the stress. He said I would have to continue taking medication. After leaving the hospital I could not stay in the city. I had to return to the village, because of my children. I was not able to buy medication anymore, because it was 12 Lac (±US$ 24,-) and I simply cannot afford that'.

The costs of psycho-somatic or stress related health problems are enormous and heighten the overall stress levels of the poorest.

Living practices
A high number of stressors can be found in the most immediate living environment of the people interviewed. These can be divided in cultural practices and domestic problems. We refer to cultural
practices as customs, values and beliefs that are shared by one people and are handed down from generation to generation. Cultural practices change over time, depending on outside influences or internal tension. It is incorrect to assume that cultural practices are non-adapting entities. When attempting to gain a better understanding of Afghan society and Afghan culture we must pay particular attention to cultural change, rather than continuity.

Recent Afghan history can be seen as a continuous conflict between ‘modernists’ and ‘traditionalists’. The forceful introduction of western-style living by an educated elite encountered much resistance in the traditionally conventional country (Marsden, 1996). As could be expected, new ways of living especially affected cities, though certain towns may have followed in more conservative ways.

Afghan culture is based on a system of purdah, which strictly separates the male from the female domain. The private female domain is closely regulated. The public male domain has seen an increase in behavioural restrictions since the introduction of Taliban rule. Within the concept of purdah, women are the primary preservers of Afghan culture. As mothers, they hand down the fundamentals of traditional belief systems and rules on behaviour. It is an important part of a men’s honour (izzat) to protect a woman from outside influences, that may jeopardise her ability to carry out her main task(s). This strict protection of the female (and family) environment results in narrowly defined codes of conduct and a far going restriction on female movements. In some pockets in the south of Afghanistan purdah is extended to physical segregation of men and women, with women being veiled inside the house. Husbands are not allowed to see their wives and their faces are only uncovered at night.

Furthermore constant internal conflict in Afghan society has shaped the community in such a way, that the seclusion of women is considered the only way to properly protect them. When girls turn 12 years old they are to remain in the family compound. After marriage they will move to their husbands family. Adolescent girls and adult women have to ask permission to leave the family home. Valid reasons are a visit to the tailor, clinic, mosque or the participation in weddings, funerals or circumcision ceremonies. During the day, women may visit neighbouring houses.

Emotional and physical reactions of women living in purdah, range in intensity from minor ‘acts of escapism’ to ‘serious violations’ of purdah rules.

‘When I am at home, I think a lot. I then feel a strong pressure on my chest [starts breathing heavily]. I then quickly take my scarf and run out of the compound. Once I am outside I feel free and I no longer feel the pain’.

In the most extreme cases of deviant behaviour, women can prevent punishment by showing culturally adapted illness behaviour.

‘My wife has a mental problem. When cooking in the house, she sometimes flies the family compound. She just runs out [without the proper clothing]. We [the alarmed (male) relatives] have to search her. She usually is found about 15 minutes later. When we hold her she faints. When she comes to herself, she says she does not know what happened to her’.

Depression due to purdah is somatised as general body pains. The reactions to confinement are often influenced by the relationships between the different members of the household. Girls do not have a say in the marital arrangements that concern them. In Herat province the majority of girls are not even informed, when they are being engaged by her parents. After moving in with her new family, the bride has to

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2 this woman felt she could do this more frequently lately, since for the last 18 months her husband is in Iran
3 this rarely happens to men
struggle for her place in the household. With the female relatives of her new husband living in the same compound, conflicts (especially with the mother-in-law) can easily arise. In conflicts with their husbands or in-laws, the ‘outsider’ is usually left on her own.4

‘I have tuberculosis, for six years already. Doctors have treated me in Iran. After that I was fine. Now it has returned. I have been to the clinic, where I have done tests. They did not do anything.’

‘I am sick. My husband hits me, he does not love me. The rest of his family does not like me as well. He pretends I am not there. I tell him that I cannot make his food, because I am ill. He does not believe me and gets more angry. I need medication, I am ill. He has to believe I am ill, that I cannot look after him and the children’.

Also here, somatisation provides a legitimisation for not living up to expectations, or not being able to (temporarily) cope with the stresses of day to day life.

Another often mentioned cause of stress in the household is infertility.6 The clinic in Ghurian receives daily visits from infertile women. Although presenting other vague physical problems, they admitted in interviews to come to the clinic out of despair with their hopeless lives. All of them have lost their place in the household to a second wife. Often their relationship with especially the mother-in-law is extremely problematic.

Long-lasting warfare

Afghanistan has experienced a long period of warfare. After ten years of Soviet occupation (1979-1989) and three years of ‘disappointing central government’, different groups of freedom fighters took up arms against each other. With the arrival of Taliban forces (young men from the religious schools in Pakistan) in 1994, the war ended in the main part of the country. Currently fighting continues in the north-east of Afghanistan,7 where opposition forces have grouped to fight the Taliban.

Armed conflict has serious consequences for the local population. Often referred to as Post Traumatic Stress Disorder (PTSD), a large proportion of the population may develop a range of non-specific physical and behavioural problems. Often PTSD presents itself in the form of psycho-somatic complaints, thereby burdening the local health structure. In interviews with villagers, exposure to warfare and armed conflict was reported differently from region to region. A major front-line crossed Zendah Jan, a village where people spontaneously mention the war as being at the origin of their problems. However they added that at present economic difficulties are the primary causes for their stress. Some people mention changes of behaviour in people, that may be brought about by warfare.

‘A man in our village, starts running and biting people if he hears a sudden loud sound. We need many men to hold him down. When he calms down he says he cannot recollect what happened’.

During a group interview with women on psychological problems (heavy thinking) in Kishmaran, a woman from Kabul told her complaints and linked her problems with her past war experiences.

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4 the mother-in-law/daughter relationship was identified by the IAM mental health programme as the most pressing problem encountered
5 later she admitted to the tests being negative
6 and, to a lesser extend, not having a son
7 Pashtun people living in Ghurian district receive arms to fight for the Taliban, though some stay in the district. Those who have returned keep their weapons. Arms are thought to be around in abundance.
8 after having been given examples about war-related trauma
'I am coming from Kabul. I was still living there four years ago. There were bombadments. I often have headaches. It’s like somebody has hit me with a stick. After that I have problems breathing, as if somebody is squeezing my throat. I have these sensations especially when thinking about the bombings'.

The shura’s visited mention the existence of stress in relation to warfare, but emphasise the difficult present living circumstances as the most important stressor. However current continued fighting in the eastern part of the country increases tension and rumours in the rest of Afghanistan, affecting people daily. During a shura meeting, one of the people present said ‘[......] we want to forget the war and get on with our lives, but when we hear the news on the radio about the war [big offensive in the east of Afghanistan], we have to think about it again’. The number of rumours are increasing recently, especially since fighting (using guerrilla tactics) has emerged in different pockets around the country. In Ghurian district weapons are being distributed among Pashtun men, who are asked to fight on the front-line.

Political pressure

Following the disruptive eighties and early nineties, the political climate in Afghanistan seems to have calmed down. However, the consequences of the war and internal conflict are still visible and Afghan society is not at all ‘stable’. Still families are waiting for their loved-ones to return home from the battle field. Some mothers are in despair.

‘My husband lost his legs while herding cattle during Soviet occupation. He had to stay inside the house until he died. That same war killed five of my sons. Another son lost his leg. Two of my sons are currently in Kandahar prison. I visited them five times. But over the last six months I have not heard anything from them. One of them was released from Kandahar prison some months ago. He was transferred to Herat prison to be released. I went to the prison, but they would not let me see him. Then, they transferred him back to Kandahar prison where he is now staying. My brother has left yesterday and will try to see them. I do not know what happened to them...’

Whereas women are experiencing much of their stress from factors in their immediate proximity, men are under a lot of pressure from the public environment. Women in distress reported increased spousal abuse. They partially link this violence to the change in behaviour of their husbands. Many men try to avoid leaving the compound due to the strict Taliban decrees on dress code and behaviour and have sometimes even seized to be economically productive.

Extreme political pressure is placed on the Hazara population in the village Kishmaran9. The Tajik village Barnabad also experiences extra pressure, though to a much lesser extend. The city of Herat is in the hands of Taliban since September 1995. There has never been a battle for the city10. Ongoing, seemingly at random, arrests are reported among the Hazara.

Supranatural phenomena

Afghans have an elaborate holistic worldview. Supranatural phenomena, as mentioned in the Holy Quran, are an integrated part of Afghan life. The main spiritual explanations of mental illness and misfortune are jinn and nazar-i-bad.

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9 the Hazara are seen as the potential leaders of a possible uprising
10 rumours are the governor of Herat in Mujahideen time was bought by Taliban, though others mention a possible political split between the governor and the central government in Kabul
**Jinn** are evil spirits and are pictured as invisible people who are omnipresent. An increase in attacks of *jinn* are reported in areas with augmenting tension. Many stories about *jinn* are told among visitors or to discipline children. In interviews at peoples homes, the danger of *jinn* was mentioned frequently.

Cases of *jinn* resemble cases of possession, with people no longer being able to control their body. Some have occasional (partial) paralysis and trembling. Important *mullahs* can cure cases of *jinn* possession (though people refer to *jinn* attacks). The *mullah* has to be very strong, in order to control the evil spirit. He recites parts of the Holy Quran, which can take many hours. In the course of the research *jinn* attacks on females were often reported. Men were less inclined to reveal *jinn* attacks, though taking these phenomena very seriously. Fact remains that in the treatment of mental illness (sudden distress, incoherent behaviour or changes in personality) the *mullah* plays a vital role. People do not visit the clinic when they feel *jinn* are at work, though they may experience other (vague) symptoms simultaneously for which they seek allopathic medical care. In areas where conflict and stress are high (again Kishmaran) the *mullah* has lost his credibility to cure. In areas that have been less effected by the war and where the psychological pressure of life seem to be quite consistent (e.g. Ghurian), *mullahs* are more successful in their curing or ‘exorcism’. Some treat patients for years. One woman interviewed was wearing many amulets (*taliz*), that she had accumulated over the last ten years (all for stress-related complaints). The amulets protect the wearer from *jinn* and *nazar-i-bad*. The same applies for pencil marks around the eyes.

In the interviews with health workers, *jinn* attacks were often not mentioned, and if so it was seen as a phenomenon of the illiterate. A health worker who joined a session with a *mullah* during wartime adds jokingly, ‘when during the ceremony the bombardments restarted, the possessed man was normal again and started running’.

A more innocent phenomenon is *nazar-i-bad*, the evil eye. It refers to people who inflict bad luck on others by envy (e.g. complimenting on a baby, who falls ill after that). To find out who is responsible for the misfortune, seeds are thrown into a fire. Each time, a different name is mentioned. When the seed makes a cracking nose, the person whose name was mentioned is considered responsible for bringing the bad luck. In the village where we discussed the issue, people were only warned of having been ‘discovered’ by setting a little piece of their clothes on fire, though in other villages consequences may be more severe.

**The plight of the Internally Displaced People**

In the review of major causes of stress in contemporary Afghanistan, the specific problems of Internally Displaced People (IDP’s) have not been discussed. Many people are living outside their usual home town or even region of origin. They have received shelter with relatives, local families or are staying in small camps. The few displaced families interviewed feel lost and abandoned. Often possessing very little and having extremely small social networks, they find it difficult to cope with the changes in life. The plight of the IDP’s cannot be heard. As they are hardly integrated in the communities where they reside, they cannot bring forward their message. Their difficulties are not discussed in *shura* meetings as the problems of the community overshadow the importance of finding solutions for the displaced. Hidden behind the walls of the compounds, they remained largely invisible for the research team.

Some of the families interviewed had come from urban environments and have lost income, possessions and status. It is especially among the more wealthy where high levels of PTSD can be found. MSF should focus more on the position and the rights of the IDP’s and the delivery of care to these families. Most internally displaced are living in the city, where they can find jobs in the informal sector and basic protection. It is very likely that among the young children working in the Herati workshops, many are not from the city itself.
Main coping mechanisms identified

In order to deal with stress and pressure, as mentioned above, a number of coping mechanisms are integrated in day-to-day life.

1. religion
2. somatisation
3. resignation
4. expressions of misfortune (women)
5. withdrawal
6. blockage
7. strict enforcement of purdah

Religion

During the years of the Soviet occupation, Muslim fighters took on arms against the unfaithful in a holy war (*Jihad*). In a paper on Afghan children in armed conflict, Dr. Iqbal mentioned the *Jihad* as the most important coping mechanism during wartime. ‘Children learn to participate in the Islamic *Jihad* against the ungodly for which action, whether they die or survive, heaven is guaranteed. This uplifts their morale and enhances the capacity to bear great difficulties and give sacrifice of everything including their lives’ (Iqbal, 1990). Though an important coping mechanism, people seem to be disappointed with the outcome of their sacrifices. Said one health worker, ‘*the jihad was a war against the non-believers, but in the end we did not know anymore who was a believer and who was not’.*

Islam has always been viewed by outsiders as a fatalistic religion. As in other religions, the will of God is seen as ever prevailing and detrimental for the outcome of fate. In daily Afghan conversation, references to the might of Allah are common. Rather than just viewing Afghan culture as a collection of predestined events, the place of religion should be seen as an important coping mechanism. Prayers are an important daily ritual. Men will experience strength through communal prayers in the local mosque, women will pray alone. Women said to especially pray when facing difficulties or feeling sad.

Somatisation

People experiencing stress and continuous pressure are very prone to feelings of physical exhaustion. The psycho-somatic complaints that have been reported repeatedly during the research are sleeping disturbances, pressure in the head (high blood pressure), heavy heart, fainting and running (escapism). Offences against purdah\(^\text{11}\) (usually caused by depression) follow a well-defined illness pattern. People describe the ‘illness’ as having difficulty breathing, followed by running, dizziness and finally fainting. This behaviour is culturally determined and relieves women temporarily from obeying strict separation. Young girls learn to associate this behaviour with the ‘escapism’ of the older women in the household and the acceptance of the male members of the household of this deviant behaviour. I was told by men that this behaviour constitutes a mental illness\(^\text{12}\). Other women are taking on a patient role to relieve them from daily strain (much seen in households with ongoing spousal abuse).

\(^{11}\) e.g. leaving compound unauthorised, leaving compound without proper clothing
\(^{12}\) that they hoped could be cured by a future mental health programme
Expressions of misfortune

Women are using different forms of expressing misfortune. It is acceptable for women in distress to cry and show their ‘weakness’. In many villages it was said to be very common for women to sit together and share their sad stories. When dealing with great distress, often the result of a life full of hardship and therefore primarily seen among older women, story telling is used while showing intense emotion. Women may lament or hold their heads in their hands while loudly pitying their difficult life. Often they cry to Allah and ask for help. During the story telling, periods of relative calmness alternate with outcries of despair.

‘A woman walked into our room nervously (and without invitation) and started telling the story of her two sons that died in Iran. They were caught smuggling and hanged. Suddenly she holds her hands in the air while lamenting, calling out for Allah to look after her sons.’

Another incident occurred the following day.

‘A woman runs into the clinic. She is agitated, confused and looks very frightened. She walks up and down the health education room. When she finally kneels down she holds her head in her hands. She then looks up and calls out loud: ‘Oh, what a terrible thing has happened to me, my five sons have killed a Mujahideen. What can I do?!’

Men do not use the same emotional communication, but will use stories to illustrate their problems and distress. Often they gather outside little shops, where they share tea.

Withdrawal

While implementing the questionnaire we discovered that men have a tendency to withdraw from public life and remain inside their compounds. They fear confrontation with Taliban. They avoid going to the shops as much as possible and are less productive, which increases the economic vulnerability of their families.

Resignation

The majority of the people interviewed felt under a lot of pressure. They refer to the first years under Taliban rule as being extremely difficult. Refugees, coming back from Iran, all talk about the difficulties of integrating in the community and accepting Afghan rules. Literate people emphasise how the new restrictions impede their day-to-day activities. Female teachers and nurses are especially affected, since they had important positions in society and now see their lives restricted to being a mother and wife. Despite the initial disappointments, many feel tired of struggling. Through the years most people have ‘learned to deal with the situation as we face it’. Others just ask ‘what can we do?’. For them accepting the situation is the best solution, adding: ‘we’ll get used to it’.

Blockage

All families have relatives that have been killed, are missing or have been taken prisoner. Especially the male population has suffered from the many years of warfare, when they were active as soldiers or had to protect their compounds from ‘strangers’. Nearly all Afghan men have experienced first degree trauma, meaning that they have directly witnessed or were involved in acts of severe violence. The exposure to inhumane acts of violence has been enormous. The memories associated with these experiences are currently being blocked by the majority of people. Realising the devastating effects the war has had on
their ability to function and think, people (especially men) focus on the daily tasks and difficulties of life. It seems like past war experiences have been ‘placed in the subconscious mind’.

Amongst some others, the period of war and especially the act of being involved in warfare are regarded as ‘good times’. These men showed signs of addiction to violence and the admiration of the grandness of war.

**Strict enforcement purdah system**

Purdah seems to be more rigorously enforced than before. Although based on a (to a certain extend) common culture<sup>13</sup>, the new Taliban decrees are seen as undesired impositions. The new regulations are put in place as strictly executed laws, implemented by a restrictive religious police. The difficulty of having to comply to purdah as described by Taliban is that the moral values are enforced by people outside the family (or tribal) structure. The issue is not whether the new rules are culturally acceptable, but whether it is culturally acceptable to discipline ‘non-compliance’ to the extend to which it is currently done. However, whether acceptable to the population or not, fear for retribution is high. Families that may have allowed their women to enter the public domain (e.g. families of female teachers or nurses) are now (often voluntarily) obeying purdah more rigidly. The ruling of another (for non-Pashtuns) ethnic group adds to the intentional enforcement of purdah. Again, it is important to emphasise that the strict enforcement of purdah does not seem to coincide with Taliban ruling, but with the instable situation in the country.

**Coping mechanisms under pressure**

Some ways of dealing with stress that have been identified, seem to be increasingly suppressed

1. music and dance
2. family outings (picnics)
3. cultural traditions (weddings, entertainment)

Traditional ways of managing stress and misfortune have been curtailed by the current rulers. Behavioural codes are restricting movement and different forms of relaxation are limited to such an extend, that normal ways of relieving stress have become difficult. It has to be noted that in Kishmaran, where people continue to live under pressure, music and dancing is not considered appropriate anymore. ‘We have no reason to sing and dance’.

A very important social event is the picnic, organised at special sites and at sometimes far distances from the village or town. Picnics can last for days and food, music and dance<sup>14</sup> contribute to feelings of joy and happiness. Although not illegal, picnics can turn into big disappointments when the Taliban interfere. Said a man after returning early from a picnic:

‘We did not enjoy ourselves at all. The moment we started making music, Taliban appeared and forbid us to make music or even play cards. So, we just went to sleep and returned home very early that following morning’.

Although picnics may seem small contributors to the relief of stress, this mechanism to let go and gather socially should not be underestimated. It is one of the few occasions for people to break out of the daily routine of village life and contributes to easier and more informal communication. Other social occasions are cancelled, due to anticipated problems.

<sup>13</sup> though many people may correctly argue with me on that
<sup>14</sup> prohibited in public by Taliban
‘Normally we go out into the mountains on every fourth and thirteenth day of the New Year. The Taliban do not allow women in the mountains. We therefore stay inside on these occasions’.

Other important ceremonies continue (e.g. weddings and engagements), at a more limited scale. All gatherings must take place at the houses of the families and music should be ‘carefully used’.

**Negative coping mechanisms**

Some reactions to constant stress are very destructive to both the person in distress and his immediate environment. Negative ways of dealing with pressure may in the end lead to grave conflict.

**Aggression**

Aggressive behaviour is common among people under stress. Aggression can be a result of not being able to channel all ‘negative’ feelings. During the research aggression was primarily reported in the form of spousal\(^\text{15}\) and child abuse (see next paragraph). One woman, when asked to go into more detail, revealed that her husband becomes extremely aggressive after smoking opium.

Others direct their aggression to people in general (usually disrupting social relations in their neighbourhood). In order to prevent acts of revenge, they visit the *mullah*. They are often recognised by their neighbours as ‘people under a lot of pressure’.

**domestic violence**

The most frequently reported stressor among both male and female interviewees is domestic violence. In some interviews, women honestly reported being quick to hit their children and often doing this unnecessarily. They start by describing a physical complaint, which is followed by emotion (anger). The anger then ‘unloads’ in the form of child abuse. They then continue by saying that the child is not easy to handle, in order to get some understanding.

‘Sometimes I get a headache. It starts between my eyes and then it is going round my head. When this happens I get very angry and hit my oldest daughter. When this happens I have the feeling somebody is strangling me and I cannot breath anymore. My daughter is a difficult child. Even my neighbours ask me to better control her’.

Spousal abuse is a big problem in Afghan society. Men are allowed to hit their wives. Among those women reporting the highest levels of stress in the survey, the vast majority is a victim of extreme spousal abuse. Some show scars on their heads.

**Self-destructive behaviour**

There are many reports\(^\text{16}\) of women trying to commit suicide by self-burning\(^\text{17}\). The primarily young women pore kerosene on their chest and light themselves. Most of these cases can be reported back to dissatisfaction with an -upcoming- engagement or to spousal abuse. The female health workers of Ghurian

\(^{15}\) though it has to be noted that hitting your wife is acceptable and commonplace in Afghanistan

\(^{16}\) one doctor said to hear about these cases about once a week

\(^{17}\) the number is likely to be high, but different sources have used examples that may in fact be the same cases. The ‘incidence’ of suicide burning therefor is not clear (and should be more elaborately researched if felt relevant)
clinic pointed out that among young women it is ‘normal’ to threaten with self-burning when upset with their parents’ decisions (comparable to the general ‘I will kill myself-threat’ in western countries). In their opinion burning is the easiest way to commit suicide as ‘all things needed are readily available’. Others add that the woman do not want to die in silence. ‘The young women want to kill themselves out of protest. They do not want to die silently, they want everybody to hear their anger’. The women that try to kill themselves are usually very young. Although some people stated that the self-burning among women is a ‘new’ phenomenon, it is not completely clear when or why it suddenly started. As suicide among women is also reported in other areas, it is likely that this phenomenon already existed. In Ghurian districts (and other districts neighbouring Iran) the incidence is said to have increased due to an augmentation in polygamous marriages and an increase in age-differences (wealthy older men marrying very young girls).

During fieldwork two women were interviewed who inflicted pain upon themselves. One burned herself regularly, and the other hit herself when feeling under a lot of stress.

**Coping styles reviewed**

The above mentioned coping styles are important ways of dealing with distress in contemporary Afghanistan. The way that each of the mechanisms is adhered to, depends largely on the particular village or town and the specific history of its inhabitants. It is important to note that widespread forms of relieving stress, as also used in conventional mental health programmes, cannot be implemented due to Taliban decrees. I am referring to the ban on music, dance, gatherings, picnics and most forms of leisure. Other coping mechanisms, although not always ideal, should be incorporated in the programme as much as possible. In order to determine the areas in need of intervention and the very particular focus of a future programme, we should address (one of) the negative coping styles and aim at correcting this way of dealing with problems.
Emotion and stress

Concepts of distress in Afghan culture

Emotion and distress are concepts that are culturally defined. We cry when we are upset and we laugh when we are happy. When we are afraid we experience how close these two forms of expression are. Do we have to laugh or cry? With the strong cultural relation to emotion and behaviour, it is not surprising that these concepts differ from people to people. We therefor have to make an inventory of Afghan concepts of stress and relief. We have to understand the internal logic of feelings of discomfort and enjoyment. A good example of this ‘different reasoning’ from western societies occurred during one of the interviews in the clinic. A woman was showing strong signs of depression. On the question if she has been feeling a worthless person recently she responded that she very much did. When subsequently asked if she was feeling happy, she stated to feel more happy than before. ‘I have been able to support my family’, was her surprising explanation to this discrepancy.

Having problems sleeping is an often heard complaint. Many patients visit the clinic and the mullah in search of a cure. In the Dari idiom, sleeping and dreams are the same word (i.e. khab didum: I had a dream, khabidum: I slept). This means that careful attention has to be paid to the different meanings, for example between difficulty in getting to sleep and bad dreams. The Dari word for not being able to sleep (the sleep did not take me) is khabnaburd. This will therefor be used in the assessment for problems getting to sleep. The translation of a nightmare proves to be precarious. Having a bad dream, khab bad didum, is not seen as alarming. As a matter of fact bad dreams are seen as warnings, and are therefor considered good. The ‘bad dream’ will therefor not upset a person and subsequently not raise his level of anxiety. So, rather than looking at the interpretation of the dream, we have to focus on the distress the dream causes. The dreamer wishes the nightmare not to return and feels upset when waking up. For this reason the term ‘terrible dream’, khab-e-tersnak didum, is used.

During the assessment, the team was especially interested in talking about depression and dysfunctioning. Basically, we wanted to know more about sad people. In order to make clear to communities what we were referring to, we said we wanted to talk about people ‘who have to think about bad things all the time’. In Dari churt zedan is the direct translation for bad thinking. This expression, together with feshar, meaning under pressure, is therefor used in most of the interviews with families in the villages. In the Hazara village Kishmanan people used the term joosh frequently. This refers to becoming very agitated while thinking. It has become obvious that anxiety is common in the village. All people interviewed said to be feeling under continued pressure and not knowing how to deal with this.

Coping with life on a daily basis

The strict separation between male and female living spheres have led to the presence of different stressors in the immediate environment of men and women. The position of women in Afghanistan has been in the centre of international attention over the last years. But how are women managing in their daily lives? And how are men dealing with the current situation?

the daily functioning of women

Women are confined to their compounds, that vary in size and may be very big in rural areas. Most women interviewed are involved in income generating activities, such as tailoring or carpet weaving and
contribute a substantial part of the family income. As such, they are an important economic force in the family. As women cannot move freely and her access to the public domain is limited and indirect (through male relatives only), her ability to be actively involved in trade is absent. This creates a direct dependency on men in her environment. In general, this dependency is accepted, though many women complain about the inactivity of their husbands or their limited business skills.

The daily activities are very important for women. It makes them feel important and helps them cope with confinement and worry. Some women claim to feel very happy when doing their daily work, but to start feeling depressed and locked up when having finished. Often, they leave the compound to visit the neighbour, or walk the street in front of their compound to quickly return. They say to feel better and relieved after doing so. Creating the ability for women to leave the compound and be mobile would diminish enormously their feelings of confinement and loneliness.

The loneliness experienced by a fair number of women is exacerbated by the separation from their parents and brothers and sisters. Many face bad treatment by their in-laws. Mostly regarded as an economic commodity or a servant to the household, little affection or appreciation is shown for their contribution to the household. The bad treatment of women seems to be a vicious circle in Afghan society, with young children witnessing humiliation and verbal abuse by grandmothers, who rule the household. Although a woman should be allowed to see her parental family, some families punish her ‘inactivity’ or ‘sloppiness’ by refusing to let her leave the compound. A considerable number of women visiting Ghurian clinic stated to be having a conflict with their husband’s family about visits to their parental home. At times of increased conflict, they experience sleeping and breathing problems.

A number of female patients visiting the clinic showed intense emotion, because of the refusal of their husbands to go to Herat hospital for treatment, as advised by the clinic doctor. They say their husbands do not consider them ‘sufficiently valuable’ to make big financial sacrifices. Within families with more than one wife the financial contribution diminishes with the increasing age of the woman. Pain and sorrow were also expressed in times of marriage of the daughter. Women often experience the arranged marriages as sad occasions and consider it the selling of their daughters. One woman was very upset because her husband wants to exchange her young daughter with a young girl from another family, whom he wants to marry.

The war in Afghanistan has changed social relations to a great extent. The respect for older people, an important element of family life, has decreased. Some elderly women said to be living in the compound of neighbours after their younger sons stopped supporting them financially. Other women have to find solutions for the absence of men and will have to start functioning independently.

the daily functioning of men

Men are finding it very difficult to cope with the current situation. Being used to controlling the lives of their relatives, they literally defended their compound against aggressors from the outside. Nowadays, the control of their families has largely been transferred to the Taliban. This is regarded as a personal humiliation and a violation of their izzat.

Men regard the pressure from their immediate public environment as increasingly difficult to deal with. Finding it difficult to solve their day-to-day problems, the have a sense of loosing confidence in themselves and their ability to deal with problems appropriately. With men becoming more and more vulnerable, women will have to take on part of the responsibilities of the men. It was striking to see the nervousness displayed by men during the implementation of the questionnaire (in sharp contrast to the women that participated freely without visible limitations). Many men try to withdraw completely from daily life.
Men and Women Compared

Both men and women have a negative perception of the future. Men are pessimistic about the political developments in the country and fear instability in the near future. They do not believe in a stable Afghanistan. Women are fearful for the future of their children.

The results of the GHQ-12 reveals that men feel increasingly pressurised by their environment. For them, this presents a new situation. Whereas men have lost much of their confidence recently, women seem to be able to deal better with stress. Their initial expectations of life differ from those of men. Witnessing the difference in the way men and women are treated in the household from early childhood, women very much reduce their importance to the support of their families and depend on outside appreciation for feelings of happiness. During the implementation of the GHQ-12 it became apparent that women very much feel that their situation has not changed that much. Feelings of distress can be contributed to overall living patterns.

Rapid Participatory Appraisal in the Community

At the beginning of the fieldvisits to the villages, meetings with the local shura’s, were arranged. As representatives of joined families in the village, shura members volunteer a lot of information on the functioning or dysfunctioning of the various households. They have a good inside in interpersonal relations and experience in conflict resolution. This last quality makes the discussions with the shura more beneficial than with health workers or families. Among men, the strictly defined code of honour (izzat), complicates revealing information on problems in the family. The shuras proved to be more open in presenting problems and requests for specific support.

After the initial meetings, villages were visited repeatedly to have a better idea on internal dynamics and to talk with different groups of people. Without explaining what MSF as an organisation thinks are to be considered mental health problems, shuras and villagers were invited to present their own ideas. The causes of mental illness, as mentioned by these councils, are integrated in the above mentioned ‘causes of distress’. Interestingly none of the shuras mentioned the need for income generation in the context of mental health. Economic problems were mentioned as a big problem, but were not considered a natural part of work with people that were ‘having problems with their nerves’.

A number of topics were mentioned as important and as lacking basic support, the number three being:
- family counselling (help for couples with problems, and focus on daughter and mother-in-law)
- normal child development (help in the raising of children)
- grief/bereavement counselling (asked in Kishmaran only)

Communication in the Dark

A mental health programme that targets a large section of the population, and ideally not only patients visiting clinics, is very dependent on the dynamics of communication and the exchange of information. How is information passed, who are the important actors/messengers and how to get feedback?

In Barnabad the social communication in villages could be closely observed. News on the arrival of the research team travelled fast and the women acknowledged hearing many stories about households at the other side of the village, despite them not being able to visit these places themselves. Women are allowed to visit their relatives and neighbours. Other houses can be visited for economic or health-related reasons. People making clothes or carpets at home, receive many potential buyers. Sick patients consult health workers. Visits to neighbouring houses take place during the day, when the men have left the compounds.
The women drink tea together and talk about the events of the village (as told by their husbands and children). When visiting (other) neighbours the following day the new information will be disseminated. During the evenings the family sits together and discusses what they have heard or experienced that day. This again, is information to be used on new visits. This network of social contacts is a lot more elaborate than considered possible at first sight. Information is spread easily and rapidly throughout the community. Basically one can picture the dissemination of information by imagining a number of circles overlapping. Neighbour 1 can visit neighbour 2, who can visit neighbour 3 etc.

As mentioned before, women are allowed to visit relatives. The social networks of families are huge, with ‘far-away’ relatives often being included in the inner circle. This increases opportunities of mobility for some women. Foremost, with the strict regulations on purdah in place, the dynamics in exchange of information exceed to a great extend the social dynamics in the community (i.e. information is freely passed through overlapping networks of contact, whereas visitation patterns are more restricted).

During our visits, one of the health workers sent his brother to represent him as he was too busy. This way the family would stay informed about new developments. Word to mouth information, relatives as major ‘informants’ and networks of social contacts characterise Afghan communication.

Many people listen daily to the radio. Whereas the Taliban have their own radio station (with spoken messages only), Shiites are often tuning in to Iranian radio. A popular broadcasting station is the BBC. The British broadcast a soap-series called ‘New Home, New Life’, which gives people entertainment combined with health education and information on general issues. When asked to young people what they would broadcast if asked, they replied music, educational programmes (requested by the girls) and a programme on the difficulties of teenage girls. The radio is considered very important and extremely influential.
Conclusion and Discussion

Mental health problems, in the form of continued stress, depression and anxiety, are highly prevalent in Afghan society. The constant pressure that people experience jeopardises the effectiveness of existing ways of dealing with day-to-day problems. The consequences for the health sector cannot be overestimated. Psycho-somatic complaints are overburdening a precarious health care system. The consequences for people in distress are even worse. Years of weakness and somatisation often lead to high medical bills and reduced productivity. A high variety of drugs are bought by people with ongoing vague complaints, while others have even been hospitalised.

Stress in the communities is caused by different factors. As Afghanistan is a post-war country, the incidence of PTSD can be considered high. Excessive reactions, thought to be the result of bad experiences during the war, were recorded occasionally. Most stress is related to current economic problems, domestic violence and purdah.

The implications of living in complete segregation, purdah, are difficult to describe. Fact is that living in purdah causes depression in a large section of the women. Adapted illness behaviour and 'discrete escapism' are to prevent women from developing depression. Through specific manifestations of physical non-functioning (running, fainting), the behaviour is placed within a bio-medical model and accepted by the environment. For the sake of ongoing discussions, it is important to mention that in Ghurian district the wearing of the burqa was never mentioned, by any woman, as a problem.

A number of observations need to be made with regard to this assessment. First, the research into mental health problems is taking place at the end of harvest time when people are still making long working days. In these periods, mental health problems (especially PTSD) are less articulately present among the local population. Periods of lesser activity (combined with the long dark winter evenings), will show an increase in overall stress levels.

In all cultures women are seen as the carriers and preservers of culture and are therefore more restricted and confined in their behaviour and movement than men. A good example are catholic women in southern Europe - think Italy- who are the only ones of the family to visit church as a family duty.

With the implementation of the General Health Questionnaire-12 levels of stress among women and men were compared. The final results are remarkable. Men seem to experience a lot more stress than women. Being responsible for the well-being of their family in times of economic difficulties, the safety of the members of the household and enduring political domination by an outside party, men have the feeling to have lost control of their lives. Women face distress due to an uncertain future, especially for their children, and continued family conflicts, partly occurring as a result of stressed relatives. Very simply put, the latter endures stressful situations due to the bad coping of the former.

Working in a mental health programme that addresses issues related to domestic violence, reduced coping mechanisms and oppression means working within the very strict cultural boundaries of Afghan people. Some examples of the cultural rigidity we have come across are:

'A 28 year-old woman feels very upset about not having a future. She was 8 when her father engaged her to a man, whom she saw on that occasion. The then 30-year old man however disappeared shortly after the engagement. Nobody, including his own family, knows what happened to him. She is now waiting for him for twenty years, as she is promised to his family...’
A mother shows her anger with her daughter. Being married for four years, she run away with a lover 24 days ago. The family and her husband are actively looking for her. They think she is in Iran. Her mother was very firm: “she disgraced our family, if we find her we will kill her”...

When trying to address psycho-somatic problems, (male) family members may be inclined to prevent the person from visiting the clinic. It will very quickly be perceived as interfering in a family issue, that is not to the health workers to treat18. A men’s honour will be damaged or attacked if women are approached directly, in an effort to support them in their sorrow or unjust position in the family.

When talking with a patient in the clinic she was asked what kind of activities she does during the day. She responded that she weaves carpets and explained the different kinds of carpets she makes. She brought an example to the clinic at our request. We decided to visit her house to see how she makes them and to buy one. Arriving there her brother-in-law became very angry. “Have you been saying we are poor?”...

My son does not allow me to leave the house and go to my friend. He says I only tell bad things about him and the family.’

In interviews conducted in villages, men refer to deviant behaviour (among women!) as either being a mental illness or the consequence of jinn. When discussing deviant behaviour with women they link this behaviour with domestic violence and in fewer cases to poverty.

In all cases, people leaving the family (house) or not obeying family rules are considered mentally ill. In a country where family ties are tight and problems are solved within the family unit, stepping outside the basic support unit is considered dangerous and foolish.

We have seen that overall stress levels among men are higher than among women. So, why the emphasis on women in this report and probably in the coming programme? Women have been the specific focus of the MSF activities in Afghanistan over the last years. Feeling that the current situation degrades women to a place in the margins, the programmes are aimed at improved communication with women in their environment and in safe locations like health centres. Especially with the reduced accessibility of public institutions (like schools), efforts should be made not to loose sight of half the population of this country.

Fortunately, the problems encountered among women are considered problematic by both women and men alike. Accessibility to those women that are facing domestic problems may be easier, when put in a health context (a context that was very much accepted during the research). We should use this opportunity with both hands.

Accessibility to the male domain is normally easier, because of the free and unlimited mobility of men. However, concepts of male honour stand in the way of easy access. I suggest targeting the women through the programme to finally end up analysing the situation in entire households. Links with violent or disfunctioning spouses can more easily be made when the well-being of an entire household is assessed, rather than the functioning of the head of the household only. It needs emphasising that a mental health programme primarily targeting domestic violence in Afghanistan will be confronted with serious cases of PTSD among the local population. The programme needs to be very sensitive to this possibility and should formulate ways to address this syndrome. Indeed, during the research it became clear that some cases of domestic violence could be directly linked to PTSD.

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18 which was also the reaction of an important shura member in one of the villages visited. ‘All your drugs and doctors cannot reduce the stress under the people’..
SWOT MODEL

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Opportunities</th>
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<tbody>
<tr>
<td>The organisation MSF:</td>
<td>- mental health services are not available, but very much needed</td>
</tr>
<tr>
<td>· is seeking to better understand the influences of social disruption on the Afghan population (advocacy)</td>
<td>- many mental health problems are identified</td>
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<tr>
<td>· has increasing experience in the field of mental health in non-western societies</td>
<td>- positive (initial) reactions from local and regional authorities</td>
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<tr>
<td>· has capacity (organisational and technical) to implement mental health activities</td>
<td>· the community requests very specific support</td>
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<tr>
<td>The community:</td>
<td></td>
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<tr>
<td>· states to have a high number of people that are in distress</td>
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<tr>
<td>· feels high need for support of depressed and ‘sad’ people</td>
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<tr>
<td>· has reacted with keen interest during mental health assessment</td>
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<tr>
<td>The health sector:</td>
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<tr>
<td>· has acknowledged a great need in the field of mental health</td>
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<tr>
<td>· admits to not being able to properly treat people with psychological problems</td>
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<tr>
<td>· feels psycho-somatic complaints are important part of complaints shown at clinic</td>
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<table>
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<tr>
<th>Weaknesses</th>
<th>Threats</th>
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<tr>
<td>The organisation MSF:</td>
<td></td>
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<tr>
<td>· has little institutional knowledge on the cultural framework of the country they are working in</td>
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<td>· does not have activities that are community-based</td>
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<td>· does not have a communal participatory approach to its programmes</td>
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<td>· implements through local partner and is dependent on capacity and willingness partner for amendments</td>
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<tr>
<td>The community:</td>
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<tr>
<td>· is sub-tribe oriented with a strong view inwards at the own family, limiting communal activities and solidarity</td>
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<td>· will very quickly want compensation</td>
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<tr>
<td>The health sector:</td>
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<tr>
<td>· fears overburdening</td>
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<tr>
<td>· may increase somatisation-oriented behaviour</td>
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<td>· will have to face more criticism from patients when trying to tackle somatisation (reduction in medication distribution)</td>
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<td>· no sustainability</td>
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<td>· relationship with local partner discontinues</td>
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<td>· weak structure/personnel in project to integrate mental health</td>
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<td>· extreme poverty hampers the programme in more advanced stages</td>
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<td>· security situation deteriorates</td>
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<tr>
<td>· rigorous impediments on women’s involvement (both on the part of beneficiaries as staff members)</td>
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33
- is cure oriented only
- offers no referral possibilities
RECOMMENDATIONS

On the basis of the study a number of interventions can be formulated. Our concerns have two dimensions:
1. somatising behaviour and subsequent overburdening health sector
2. pressure and tension within the family (family violence, isolation), causing the majority of psycho-somatic complaints

To tackle both issues, complementary programmes can be suggested with the objective of:
1. improving the institutional capacity to recognise and deal with mental health issues through the transfer of knowledge
2. improving the ability of the health sector to manage psycho-somatic illness
3. installing community dynamics that will provide tools to deal with stress and behavioural problems, in particular
   3a. support women in finding ways to deal with purdah related depression
   3b. support depressed women in child-rearing practices

Level One:
Support to the female Nursing School in Herat

Suggested activities:
1. organise a workshop for nurses working in health clinics in Herat Province and nurses from Herat Regional Hospital
2. define needs for refreshers courses for nurses (using the outcome of the workshop)
3. upgrade the nursing curriculum (with feedback of the workshop)
4. teach mental health, communication skills and quality of care to nursing students
5. provide student positions at MSF/CHA supported clinics for work experience
6. provide technical support through:
   * the setting up of a medical library at the nursing school OR
   * the creation of a committee in control of a free budget, to be allocated to the purchase of medical books, medical equipment or teaching aids

Assumptions:
- MSF is not looking for institutional capacity building
- MSF will actively lobby for other organisations to offer student practice places in their clinics
- MSF gives technical assistance and can work within the setting of the nursing school

Level Two:
The implementation of social services at Ghurian, Zendah Jan and Khosan clinics (and Badghis?)

Suggested activities:
1. integrate mental health issues in the health education sessions at the MSF/CHA supported clinics
2. establish a ‘talking room’, offering social services under the auspices of trained social worker
3. train Village Health Volunteers in giving information on depression and stress-related aggression
2.4 train Village Health Volunteer in listening skills and give clear criteria for the identification of depression and stress

Assumptions:
• MSF is satisfied with implementing a social service that addresses clear needs, without any elaborate treatment being offered

Level Three:
The setting up of women talking and self-help groups in one pilot village

Suggested activities:
3.1 identify key women in the community (often the ‘wives of’)  
3.2 organise two-weekly health meetings with women in the community  
3.3 introduce child-rearing practices during meetings  
3.4 start basic training of women, preferably with basic level of education  
3.5 include child-in-conflict related issues in the curriculum of School Health Volunteers

Assumptions:
• MSF is satisfied with small-scale activities from the clinic  
• MSF feels comfortable with a pilot outreach-activity

Staff needed:
Nursing school: one expat teacher, psychiatric nursing background  
   one translator (full time)  
   one secretary  
Minimum time expat required: 6 months

Clinic and outreach: one expat social worker with psychiatric background  
   one female and one male social worker per clinic  
   one translator (full time)  
Minimum time expat required: 1 year

Advised literature for use while developing curriculum School Health Volunteers, Village Health Volunteers and training community key-figures:

- UNICEF handbook on children in conflict (already translated in Dari)  
- section on mental health in book ‘Where women do not have a doctor’

Rationale:
In order to improve the capacity of the health sector to properly manage cases of psycho-somatic complaints and other forms of (minor) mental disease, an improvement of the general quality of care is vital. The best time to intervene and teach is at the beginning of people’s health careers, when routine and demotivation are not yet blocking eagerness to learn and a need for certain skills to develop. Before setting up an intervention at the female nursing school in Herat, practical day-to-day problems need to be identified, both in the field mental health and quality of care (planning and organisation clinic,
communication skills, relation care provider and patient). During a workshop with all nurses working in the clinics, these needs can be identified. After defining training needs, the curriculum of the nursing school can be upgraded and implemented. An expat should provide teaching at the school and look for the opportunity to train a teacher in mental health and quality of care (though this last topic should be optional) or supervise the teacher in place.

The student nurses should receive extensive practical support, that MSF would be able to give in the MSF/CHA supported clinics. Students can be selected who are from the clinic town.

In the clinic, more attention should be given to patient/care-provider relationships and the psychosomatic nature of many of the complaints presented. During health education sessions, issues related to depression, child rearing difficulties, (social) dysfunctioning and problematic drug use can be addressed. A social worker should always be present at the clinic and provide people with the ability to talk about their daily problems and understand the underlying causes of their ill-feeling.

From the clinic outreach work can be conducted in the community. I suggest started small scale with so-called health sessions, since women are only allowed to officially gather when discussing health-related topics. After meeting key-women in the community, the contacts can be extended and partly be organised ‘underground’.
IMPLEMENTATION

Some observations when implementing a third line intervention

- maintain a very narrowly defined framework within which you want to move
Make sure the programme has a clear objective, strict boundaries of activities and a logic ending that nobody can dispute.

- play the role of technical advisor only
I suggest to separate any possible material intervention from the purely technical input. Building capacity through the transfer of knowledge is a very directive programme.

- set up criteria for possible additional support
When additional support is asked and considered relevant to the programme (e.g. the setting up of a medical library at the nursing school), the decision-making process should be clear and transparent. In order to not become involved in conflicting interests a fund can be set-up for the sole purpose of purchasing books, medical material or teaching aids. A committee can be founded that can decide on how to spend the allocated budget, following clear guidelines and without further MSF interference.

- keep in constant contact with the authorities (boards) on progress made and time remaining before the end of the programme
Monthly reports or quarterly overviews of activities, restraints and remaining programme issues clarify the activities of the organisation and make additional information available on future planning. It gives the boards the opportunity to plan activities in accordance with MSF presence and prevents frustration due to incoherent programmes.

- clarify the end of the programme
When keeping strict programme lines, the end of the programme can be clearly marked. Time schedules and action schedules should remain upgraded.

Some observations when implementing activities at clinic level

- involve existing staff at the clinic
In order to tackle psycho-somatic complaints, all health workers have to be able to recognise patients with psychological problems or at least create an environment that invites people to come to the clinic and feel important and taken seriously. Sit with health workers and ask their input on how to better organise services and improve the communication with patients.

- add few local staff
Close supervision is imperative in obtaining a good level of functioning. In order to optimise output, the number of people supervised should be minimised. In addition, limit local staff to keep the paying of salaries in proportions.

- closely define the role of each participant
Mental health can be a difficult programme. The concept of mental health is not always clear to people and patients do not receive drugs or other incentives. The health workers of the programme have to have a
good picture of what they do, why, and have confidence in the positive outcome of the intervention. Defining the role of the health worker makes sure its still relevant and in tune with popular demands.

**Some observations when implementing a community-based mental health programme (over a long period of time)**

- **use other organisations active in the village area**
  Before introducing the organisation or programme (to a new area), it is advisable to make an inventory of national or international organisations already working in the village or town and their subsequent reputation. Non-governmental organisations can facilitate the arrival and use their social network to introduce MSF as a reliable partner to be taken seriously. In some of the visits to the villages, shura’s mentioned being visited by many important delegations of various agencies, without ever seeing them again. Though welcomed because of their resources, foreign organisations are primarily regarded as unreliable. Thus, explaining to the local population what a non-governmental organisation is, what humanitarian aid is and what an international ngo, in particular MSF, can and cannot do should be improved.

- **map the village you are going to work in**
  Make a good inventory of the village or area you are going to work in. Not only look at infrastructure and demographics, but try to understand the local dynamics. Who is in charge? Is it the shura leader or is it that one man who always speaks in the name of the shura? What is the position of the local religious leader? Can he be regarded liberal? What families are important in the village and why? Which families are very vulnerable? Try to find answers together with the local community.

- **contact shura’s**
  Introduce the programme (and MSF) carefully to the traditional and administrative leaders. Normally the shura, the local council of wise men, is the first to be informed about the intention of starting activities in their community. The size and involvement of the shura is very much dependent on the village in question. Shura’s have a relatively large autonomy and can be useful discussion partners. Do not overestimate the role the shura can play in a programme, but build up good relations with the members.

- **be very specific on programme input and expected output**
  In many post-conflict countries with poor infrastructure and an unstable market, aid delivery is regarded by the local population as synonymous for the injection of capital. Afghanistan is by no means different. In fact, showing the intention to support a community and help its people is considered a clear agreement that resources needed are going to be provided.
  In its attempts to discuss activities with local shura’s, MSF has been confronted with expectations from the community they cannot, and have not agreed upon to, fulfil. Therefor:

- **put all agreements on paper and make sure contracts with the communities are well thought through and clearly written**
  Try to formalise as much as possible (even when at times, you may find a shura without literate people). This does not only increase clarity towards recipients, it also improves the institutional memory of MSF. Many assessments have been carried out and will undoubtedly continue to be carried out. With a (high) turn-over of staff, MSF knowledge on issues discussed with the communities and solutions offered disappears, making the organisation vulnerable for ‘fake’ promises. During the research, many shura’s and villagers claimed to have reached agreements with aid organisations19 (statements that were of a highly doubtful nature).

19 e.g. on the building of clinics in their villages and the distribution of drugs
- **introduce yourself to the religious leader and involve him in programme**

The religious leader (*mullah*) has become increasingly powerful through the years of warfare. His influence is significant. Approaching a *mullah* for intended activities is a must, if it were just for the mobilisation of the community. However, *mullahs* can be very conservative elements in their communities and can hamper the implementation or further continuation to a great extend. Therefore, collaborate with mullahs and acknowledge their position in the community. Try to find out more about his reputation. Integrate him in the programme activities, to the extend that is beneficial to the programme (think also about his role after MSF withdrawal).

- **use male Village Health Volunteers**

With the vast majority of the women in the villages being illiterate, male health workers may be used for communicating with the community (e.g. *shura/mullah*), the exchange of information and the education of families in matters related to the mental health programme. Men have better access to the different extended families and can play a more corrective role towards other men. With men being as dominant as they are in Afghan society, their position should be used to change behaviour from ‘the inside’.

- **set up female shura’s**

*Shura’s* are local councils of wise men. There are no women represented in the local councils. As a result, problems reported in the community are not necessarily prioritised in the same manner by the female population. Simultaneously, solutions suggested by the *shura* may not be the most suitable for women. Women define their problems differently, and have other solutions to offer. Installing female shura, to provide a discussion forum for women could help bring forward problems in the female community. (Note however that female shura’s will be very difficult to establish in Pashtu villages)

- **work within the setting of women’s illiteracy**

Programmes aimed at women should take into consideration that the segregated worlds of men and women have led to a low accessibility of education for women. The vast majority of women cannot read nor write and will have a very basic understanding of the world surrounding her. Programmes aimed at women should excel in simplicity, without lowering output expectations.

- **use the available media (BBC?)**

Radio is an important medium of exchange of information. Taliban have their own radio station, broadcasting the news and prayers only. The Farsi-speaking population listen Iranian radio and the BBC. The soap-opera ‘New Life, New Home’, produced in collaboration with Afghan refugees in Peshawar, is very popular among the local people interviewed. Issues treated in the mental health programme would have a big boost if also being addressed in the radio broadcasts.

- **be very precise on exit strategy**

No programme can run forever and no smooth exit can be guaranteed. However, formulating how to end the programme, diminish support and hand over to the local population, should receive as much attention (if not more) as the implementation of the programme. How do we want the villages to continue working, how do we envisage our role and how can we prevent a relationship of full dependency? How much time do we want to be present and how to scale down physical presence?

- **continuously monitor the (unwanted) consequences of the intervention. DO NO HARM.**

The activities implemented should benefit the recipients. In the female oriented programmes, there is a thin line between harming or improving the position of women. A mental health programme, because of its very specific nature, has to balance all its activities continuously.

- **take time to implement a programme**
A badly implemented programme will require much time and energy to correct, if even possible. Therefore, have patience during the implementation phase. Take all steps considered necessary to prevent future conflict with authorities, local villagers, health workers or beneficiaries.

- **remain realistic, this is more honest for community and the beneficiaries**
A mental health programme can be one of the most difficult programmes to work in. The needs are overwhelming and everybody seems to be traumatised and having good reasons for feeling that way. Feelings of helplessness can be overwhelming and can easily lead to promises you normally do not want to take.

- **prevent burn-out of most active community members**
Debrief active local staff or volunteers frequently. Adjust programme output and expectations to their capacity. Try to go through problems and solutions found.
MSF Holland - Afghanistan

Terms of Reference
Mental Health Specialist

1. Summary

Starting Date: 18th March 1999

Duration of visit: 6 weeks

Locations: Herat, Ghurian, Peshawar

Candidate: Female Mental Health Professional
Non-Muslim, preferably Persian/Farsi speaking (Pashtu a bonus) Non British or US passport holder
Preferably experienced in NGO work in developing world
Fluent in English

Overall Objective: Assess the possibility of MSFH starting a mental health component as part of the services provided within existing programmes in Ghurian and in the future in Zendeh Jan and Badghis.

Specific Objective 1: Define the major mental health problems of the target populations with particular focus on women.

Specific Objective 2: Define the normal coping mechanisms of the community.

Specific Objective 3: Understand the framework within which MSF Holland projects operate.

Specific Objective 4: Visit the IAM mental health program in Herat.

Specific Objective 5: Define which mental health services could be offered within the framework of our ongoing programs.

Specific Objective 6: Assist in the development of a mental health project proposal.
2. Background

Afghanistan has been at war in one form or another since the Soviet invasion of 1979. Since the departure of the Soviets in 1989 there has been a protracted civil war between various mujahedeen factions. The latest of these to emerge, the Taliban, have swept to power since 1994 and now control 90% of the country. The Taliban have imposed an extremely harsh and unparalleled form of Islam in the areas under their control. Men must grow beards, cover their heads, attend prayers, refrain from listening to music, dancing, watching TV and playing cards. They may have no contact, no matter how professional, with women outside their extended families. While things are hard for the whole population, it is undoubtedly women who are affected most by Taliban rule. They must now live in ‘Purdah’, confined to their homes for the most part. When they do leave their homes to attend to essential tasks they must be covered in a ‘Burkah’ and accompanied by a relative. Girls may no longer be educated and women may no longer work outside the home. The only exception to this rule is in the health sector, where women may still work, albeit in a limited capacity. Female health workers may provide care for female patients only and can have no professional contact with their male colleagues. They may not receive formal teaching or training other than that provided on the job by other women.

It should be noted that the imposition of Taliban rule, while seriously impinging on the lives of the educated, urban classes, has changed little in the lives of many of the rural poor. Many, especially the Pashtuns of Southwest Afghanistan, have lived under similar, self imposed constraints for generations.

The current circumstances in Afghanistan and an increasing amount of anecdotal evidence point to a probably huge incidence of unmet mental health needs in the communities in which we work, particularly among women:

- Country in ‘chronic conflict’ for almost twenty years and the subsequent problems of trauma, bereavement, internal displacement, poverty, uncertainty etc. that that brings severe restrictions to the lives of many women living under the Taliban
- High percentage of patients presenting to our clinics with ‘total body pain’ and other symptoms suggestive of somatisation
- Increasing admissions to Herat Burns unit of women who have set fire to themselves
- 60% of female respondents to an MSF survey reported being the victim of domestic violence
- Respondents to the same survey reported an average of 3.6 of a possible 5 mental health symptoms:
  - Sad 85%
  - Worry 84%
  - Poor sleep 60%
  - Poor Appetite 49%
  - Crying: 78% reported crying often in the preceding month
- Personal stories of staff and patients
- Response to mental health program by IAM in Herat

3. Objectives of the mental health consultancy:

MSF Holland is currently running primary health care programs in west and Southwest Afghanistan. The target populations are 120,000 people living in two districts of Oruzgan province, (now handed over to our local Afghan partner NGO but still being monitored and supervised by us) 150,000 people living in three districts of Herat province and 7000 IDPs in Shaidai Camp in Herat City. Each district has an MCH unit (mother and child health) and a separate clinic for men. In addition we provide village-level services through traditional birth attendant training, village health workers/volunteers, village health committees and outreach EPI. We are currently not providing any mental health services as part of our programs and would like to address that issue. To this end we need the input of a mental health professional to assess the situation and advise us on an appropriate course of action.

Overall Objective:
Assist the MSF Holland team in establishing mental health services in their ongoing programs in Ghurian and in future Zendah Jan and Badghis.

Specific Objective 1:
Define the major mental health problems of the target populations

**Activities**
- Review the available literature
- Consult professionals working in the mental health field in Afghanistan
- Review the experiences of MSF expats and national staff
- Consult widely with health workers
- Interview patients
- Interview TBAs, VHC members

**Specific Objective 2:**
Define the normal coping mechanisms of the community

**Activities**
As specific objective 1

**Specific Objective 3:**
Understand the framework within which MSF Holland projects operate

**Activities**
- Visit Shaidai and Ghurian programs and in particular see consultations, health education sessions, TBA training and village health committees in action
- Discuss the constraints, do’s and don’ts of health service provision in Taliban Afghanistan

**Specific Objective 4:**
Visit the mental health program of IAM in Herat.

**Activities**
- See the program in action
- Review training curriculum/methods
- Review the program
- Interview participants
- Interview providers
- Identify strong and weak points, successes and failures
- Advise MSF on the suitability of possible future co-operation in Ghurian

**Specific Objective 5:**
Define which mental health services could be offered within the framework of our ongoing programs.

**Activities**
- Identify services which could be offered within the MCH units and clinics
- Identify possibilities for including mental health topics within health education sessions
- Identify possible roles for TBAs, VHWs and VHCs in mental health care
- Identify other ways in which we could develop mental health services
- Advise on culturally appropriate goals and methods

**Specific Objective 6:**
Assist in the development of a mental health project proposal.

**Activities**
- Identify human resources required both local and expatriate
• Advise on the training program required
• Advise on training and other resources required
• Assist in the definition of objectives, activities and indicators
• Advise on the monitoring and evaluation of such a project

Date: 16th February 1999
Helen O’Neill, Herat
APPENDIX 2

General Health Questionnaire 12

The ten valid questions (with subsequent answering categories) analysed during the assessment are:

HAVE YOU RECENTLY:

1. been able to concentrate on whatever you are doing?
   better than usual/same as usual/less than usual/much less than usual

2. felt that you are playing a useful part in things?
   more so than usual/same as usual/less useful than usual/much less useful

3. felt capable of making decisions about things?
   more so than usual/same as usual/less so than usual/much less capable

4. felt you could not overcome your difficulties?
   not at all/no more than usual/rather more than usual/much more than usual

5. been able to enjoy your normal day-to-day activities?
   more so than usual/same as usual/less so than usual/much less than usual

6. been able to face up to your problems?
   more so than usual/same as usual/less able than usual/much less able

7. been feeling unhappy and depressed?
   not at all/no more than usual/rather more than usual/much more than usual

8. been loosing confidence in yourself?
   not at all/no more than usual/rather more than usual/much more than usual

9. been thinking of yourself as a worthless person?
   not at all/no more than usual/rather more than usual/much more than usual

10. been feeling reasonably happy, all things considered?
    more so than usual/about the same as usual/less so than usual/much less than usual

Invalid questions:

Have you recently:

- lost much sleep over worry? (Original question 2)
- Felt constantly under strain? (Original question 5)
APPENDIX 3

Female (N=136) / Male (N=64) comparison of the outcome of the General Health Questionnaire, carried out in Ghurian clinic.

Have you recently been able to concentrate on whatever you are doing?

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Have you recently felt that you are playing a useful part in things?

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Have you recently felt capable of making decisions about things?

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Have you recently felt you could not overcome your difficulties?

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Have you recently been able to enjoy normal day-to-day activities?

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Have you recently been able to face up to your problems?

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### Have you recently been losing confidence in yourself?

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### Have you recently been thinking of yourself as a worthless person?

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### Have you recently been feeling reasonably happy, all things considered?

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