III. WOMEN'S HEALTH AND HUMAN RIGHTS SURVEY

Methods

Subjects

Subjects of the PHR survey consisted of female heads of household who could most accurately provide information about the experiences of the entire household over the past two to five years, and a close male relative. An assertive attempt was made to ensure that each respondent was interviewed privately due to the sensitive nature of questions asked. Of the 726 female household representatives of the original sample, 724 participated in the study (response rate: 99.7%). The 724 households included 417 women and 249 men currently living in Afghanistan, 201 Afghan women and 102 men who had recently migrated to Pakistan, and 106 women and 90 men in the process of returning to Afghanistan from Pakistan.

Of the two household respondents who did not participate, one interview was terminated by the data collector out of fear for personal safety (the respondent's family member was an official in the Taliban regime), and one interview could not be completed because the respondent was too ill. The response rate among male relatives was 81-97%. Among refugees in Pakistan, the only reason for non-participation was the absence of a male relative in widow-headed households. All remaining male non-participants were unavailable due to work responsibilities.

Sampling

In order to represent the views of Afghan women and men with a wide range of experiences and attitudes, PHR randomly sampled women and their male relatives in four separate geographical areas. In Afghanistan, PHR sampled rural and urban households in a Taliban-controlled and non-Taliban-controlled area. The combined population size for the two groups in Afghanistan was 228,662 or approximately 1% of the total Afghan population. In Pakistan, PHR sampled refugees who had arrived in Pakistan within the last two years and another group of refugees who had lived in Pakistan for greater than four years and were in the process of being repatriated to Afghanistan. At the time of the study, an estimated 1.2 million registered Afghan refugees resided in Pakistan [131]

The Taliban-controlled area sampled in this study is, and has historically been, a predominantly Pashtun (ethnic group commonly associated with the Taliban) dominated area (69%). Since 1996, this area has seen no fighting between the Taliban and the United Front. At the time of the study, more than 25 national and international non-governmental organizations (NGOs) were operating in the area.[132] Ten of the NGOs listed specific services for women and girls including obstetrical services, traditional birth attendant training and services, maternal health units and basic health units. There was a hospital wing that was staffed by female physicians and dedicated to treating women. Girls were educated in home schools and public schools that were able to enroll 20% of girls in rural areas, as well as in more traditional religious schools for girls up to age eight years. There were also education (literacy programs, teacher training, and traditional birth attendant) opportunities for women. In addition, four NGOs provide income-generating projects for widows and adult vocational training in this area.

The non-Taliban area sampled in this study is predominantly of Tajik ethnicity (61%) and is located in a relatively isolated part of Afghanistan. Fighting in this area, at the time of the study, had not occurred. This area has approximately five international NGOs working in the areas of health (basic health units for both women and men), schools for girls as well as boys, and income generating projects for women. Schools in the rural areas were supported by one of the international NGOs and again had approximately 20-40% girls enrolled in the classes. The main hospital has a staff of approximately 25 female physicians that see all of the women and girls in both the rural and urban setting. This facility was the only available option for health care and was a two to four hour drive or a two day walk from many of the surrounding rural areas. In order to protect the participants in the study, no additional information about these two areas can be given.

Recently arrived refugees (within the last two years) were all sampled in a refugee camp in Pakistan. These refugees were from Taliban-controlled areas and areas that were involved in armed conflicts. Refugees returning to Afghanistan were sampled at a repatriation center. These families had lived in Pakistan for more than four years and were in the process of returning to Afghanistan under a United Nations High Commission for Refugees (UNHCR) supported repatriation program. These refugees of predominately Pashtun ethnicity left during the Soviet occupation.

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[131] See E/CN.4/1996/64; and United Nations High Commission for Refugees, "Focus: Afghanistan the Unending Crises," *Refugees,* 1997;108:3-9; and US Committee for Refugees, *World Refugee Survey, 2000*; web site: www.refugees.org/world/countryindex/afghanistan.htm.

[132] ACBAR, *Directory of Humanitarian Agencies Working for Afghans*, February 2000.

[133] See United Nations High Commissioner for Refugees, *Afghanistan Mid-Year Report 2000*; Each returnee received US$100, a plastic sheet for emergency shelter and 300 kg of wheat.

According to UNHCR staff, these refugees may have been returning for many reasons including harsh conditions in refugee camps in Pakistan, the UNHCR supported repatriation allotment of goods,[133] or a perceived sense of peace or better life under Pashtun ethnic rule.

All study participants were selected using systematic random sampling or a combination of systematic random sampling and cluster sampling.[134] Household sampling in Afghanistan was accomplished with the aid of city maps that were divided into sectors and included numbers of households per sector. Sectors (16 of 36) sampled were randomly chosen and a sampling interval (n) was calculated by dividing the number of households in the sector by the number of interviews to be conducted in the area. Rural areas were sampled in a similar fashion after mapping the number of domiciles per village. In both rural and urban settings, a starting household was determined by random number generation and each nth household was interviewed until the entire area had been surveyed.

In sampling recent arrivals in Pakistan, PHR first mapped all tents and mud huts in the new arrival sector of the camp, then conducted a systematic random sample of the entire new arrival section. A sampling interval (n) was calculated by dividing the number of households in the camp by the number of interviews to be conducted in the camp. A starting household was determined by random number generation and each nth household was interviewed until the entire new arrival section of the camp had been surveyed. A similar method was used for sampling families in trucks at the repatriation center. Records were available to determine the average number of trucks that were registered per day at the repatriation center. A sampling interval (n) was calculated by dividing the average number of trucks per day by the number of interviews to be conducted. The start of the line of trucks was the starting point and each nth truck was sampled until the all trucks had been surveyed.

Survey Questionnaire[135]

The survey contained 62 questions pertaining to demographics, physical health status including access to and quality of care, mental health status including symptoms of depression and information on suicides and suicidal ideation, experiences of human rights abuses, attitudes on women's human rights, and the significance of Taliban restrictions on women's human rights. In addition, after the completion of each interview, a close male relative was asked to respond only to the questions on attitudes towards women's human rights. The interviewers (trained health professionals) assessed for major depressive disorder in all female respondents

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[134] Patton, M.Q., *Qualitative Evaluation and Research Methods,* Sage Publications, 1990;169-283.

[135] See Appendix A.

using the PRIME MD,[136] a highly sensitive instrument for identifying individuals with current and past depression.[137]

Physical and mental health perception, health care access and quality, and the effect of Taliban policies on mental and physical well-being, educational and work opportunities "5 years ago" and "now" were assessed using Likert-type scales (e.g., excellent, good, fair, poor). A "decline in" was calculated using a self-reported rating scale (1-5) for "5 years ago" and "now." Human rights opinions were asked of both the female head of the household and a close male relative of the respondent. Opinions were assessed by a response of "agree" or "disagree" with statements concerning human rights.

Regarding their experiences, respondents were asked whether they or any members of their household were beaten, shot, killed, tortured, injured or killed by rockets, sexually assaulted, raped or forced to marry. For each abuse, participants were asked their age, the type of abuse and whom they thought committed the violation.

The questionnaire was written in English and then translated and back translated into both Dari (a widely spoken, official language in Afghanistan) and Pashtu. Eight regional experts in health and human rights reviewed the questionnaire for content validity. The survey was pilot tested among six Afghan women in Pakistan and suggestions were incorporated for clarity of questions and cultural appropriateness.

Interviews

Official permission for the study was granted in each area surveyed and there were no limitations on movement or to surveying. All interviews were conducted in the calendar year 2000 in Dari or Pashtu and lasted approximately 45 minutes. Interviews with participants were anonymous and conducted in the most private setting possible. Verbal informed consent was obtained and participants did not receive any material compensation. Interviews were conducted by local, female, trained health professionals following several days of training and supervision. All questionnaires were reviewed for completeness and for correctness of recording after the interview.

Statistical Analysis

The data were analyzed using STATA statistical software.[138] For 2x2 cross

[136] See Spitzer, R.L., Williams, J.B.W., Kroenke, K., et al., "Utility of a New Procedure for Diagnosing Mental Disorders in Primary Care: The PRIME MD 1000 Study," *JAMA*, 1994; 272: 1749-1756; and Brody, D.S., Hahn, S.R., Spitzer, R.L., et al., "Identifying Patients with Depression in the Primary Care Setting: A More Efficient Method," *Archives of Internal Medicine,* 1998; 158: 2469-2475.

[137] *Id., Brody, D.S, et al.*

[138] STATA 5.0 (Intercooled) for Windows, STATA Corporation, College Station TX.

TABLE 1.
Respondent Characteristics for Afghan Refugee Women's Health and Human Rights Survey*

Respondent Characteristics	Women in Afghanistan Taliban-controlled area (n=223)	Women in Afghanistan Non-Taliban area (n=194)	Women in Pakistan ≥2 years (n=201)	Women in Pakistan ≥4 years (n=106)
Age, mean (range)	42 (18-80)	39 (17-80)	33 (15-70)	35 (15-70) ‡
Marital Status				
Never Married	25 (12)	1 (0.5)	13 (7)	5 (5) ‡
Married	132 (65)	142 (75)	132 (65)	88 (83) ‡
Divorced	1 (0.5)	0	0	1 (1)
Widowed	45 (22)	46 (24)	56 (28)	11 (10) ‡
Ethnicity				
Pashtun	141 (69)	3 (2)	77 (33)	86 (81) ‡
Tajik	62 (30)	116 (61)	120 (59)	19 (18)
Other	0	69 (36)	4 (2)	1 (1)
Years lived in Afghanistan mean (range)	19 (2-80)	32 (3-80)	28.3 (3-65)	22.7 (2-55) ‡
Years left Afghanistan, mean (range)	NA	NA	1 (0.08-2)	9 (4-25) ‡
Area Lived in Afghanistan				
Urban	117 (52)	103 (52)	99 (49)	59 (56)
Rural	106 (47)	91 (47)	102 (50)	47 (44)
Years of formal education mean (range)	3 (0-20)	2 (0-16)	0.7 (0-12)	1 (0-27)
Occupation				
Homemaker	165 (82)	164 (89)	160 (80)	93 (88) ‡
Tradesman	3 (1)	4 (3)	16 (20)	4 (4)
Professional	17 (8)	12 (6)	4 (2)	3 (3)
Farmer	4 (2)	5 (3)	15 (7)	3 (3)
Student	11 (5)	0	5 (2)	3 (3)

† Data represents £ 10% missing values
* Values are number (percent) unless otherwise stated
† $p < .05$,
‡ $p < .001$

tabulations containing cells with expected frequencies of less than 5, statistical significance was determined using Fisher's exact test; Yates' corrected chi square was used for all others. For cross tabulations with greater than 2 rows, statistical significance was determined using Pearson chi square. Analysis of variance (ANOVA) was used for statistical comparison of means and the Kruskal-Wallis test was used for comparison of medians. For all statistical determinations, significance levels were established at $p<0.05$.

Definitions

Women and men living in the Taliban-controlled area of Afghanistan and refugees who fled to Pakistan comprised the "Taliban exposed" group. Women and men who were living in the non-Taliban-controlled area and refugees in Pakistan for greater than four years comprised the "Non-Taliban exposed" group. Daily activities that may have been affected by one's physical and/or mental condition included: caring for children, cooking, cleaning, going to the market, social activities and work, if employed. Torture, in this study, was defined according to the UN Convention Against Torture and public beatings were considered single episodes of beating of limited duration (less than ten minutes) and intensity.

Results

Data is presented as the range of group averages of the following groups; Taliban exposed 424 (59%) which are represented by the recently arrived refugees in Pakistan 201 (28%) and those living under Taliban rule in Afghanistan 223 (31%); and non-Taliban exposed 300 (41%) which include refugees in Pakistan returning to Afghanistan 106 (15%) and residents in a non-Taliban-controlled area in Afghanistan 194 (27%). The statistical average for each individual group is presented in the corresponding tables. Statistical differences (p-values) represent the differences between the Taliban exposed groups versus the non-Taliban exposed groups.

Characteristics of Afghan Women Respondents

The median age of respondents was 35 (range 15-80) years (see Table 1). Approximately 52% of the women interviewed were from urban areas in Afghanistan and about 48% were from urban settings. Overall, the majority of women were married (65-83%), poorly educated (mean 1.7 years of formal education, range 0-20 years), homemakers (82-89%) and from 13 of 31 different provinces in Afghanistan. Overall, the survey found widow headed households in 10-28% of the women sampled, with the lowest frequency among refugee women returning to Afghanistan. In the random sample, Pashtun ethnicity was represented in 2-81% of the sample and was most common in refugees from Pakistan returning to Afghanistan (81%)

and in the Taliban-controlled area of Afghanistan (69%). Tajik ethnicity comprised 18-61% of the random sample and was most commonly represented among women in the non-Taliban-controlled area (61%) and in the refugees in Pakistan (59%). Of the refugees living in Pakistan, the majority (93-94%) of respondents left Afghanistan because of armed conflict.

Effects of Official Policies on Humanitarian Assistance and Activities of Daily Living (ADLs)

Only 8-11% of women reported receiving humanitarian aid in the past year in the Taliban-controlled area in contrast to 59% of those in the non-Taliban-controlled area. The most commonly reported humanitarian aid accessed included food, health services and education. Since the study did not include a needs assessment for aid, the potential gap between the individual needs and the provision of services is not clear. However, more than one in every three women surveyed in the Taliban-controlled area reported that official policies interfered with access to humanitarian aid. Other factors are likely to have affected procurement of aid and may include ongoing war in certain areas, lack of roads, distance from villages to aid, which may be primarily be distributed in urban settings, or the unwillingness of male members of the household to allow aid such as education, work or health care for female members of the household. Humanitarian aid in Afghanistan is provided based on acute need. It may be that in the areas surveyed, acute aid was not needed and therefore reports by women of not receiving aid may simply have meant that aid was not needed.

In addition, women in the Taliban-controlled areas reported that Taliban official policies towards women had “almost always” or “always” (59-79%) forced them to restrict their daily activities in public, whereas, women in the non-Taliban-controlled area (73%) reported that the policies had little effect on them.

At the time of the study 75% of women living in the Taliban-controlled area reported wearing the required *chadari* “significantly” or “all the time” in contrast to 85% of women in the non-Taliban area and 95% of recent women refugee arrivals. The high rates of women wearing *chadari* in the non-Taliban area suggests that these women traditionally choose to wear a *chadari*. Overall, women in Taliban-controlled areas overwhelmingly thought the Taliban had made their life “somewhat worse” and “much worse” (94-98%) compared with 32% of women in the non-Taliban-controlled area.

Respondents thought landmine awareness was hampered by Taliban policy in the Taliban-controlled areas (46-47%) and was often reported (39-42%) more of an issue for women and girls rather than men and boys who were able to participate in school where much of landmine awareness education is discussed.

TABLE 2.
Effects of Official Taliban Policies towards Women on Humanitarian Assistance and Activities of Daily Living*

Characteristics	Women in Afghanistan Taliban-controlled area (n=223)	Women in Afghanistan Non-Taliban area (n=194)	Women in Pakistan ≥ 2 years (n=201)	Women in Pakistan ≥4 years (n=106)
Received any form of humanitarian assistance in the last year in Afghanistan	16 (8)	112 (59)	22 (11)	NA ‡
§ Type of Humanitarian Aid Accessed:				
Food	12 (6)	86 (45)	14 (7)	NA ‡
Shelter	2 (1)	8 (4)	2 (1)	NA ‡
Health services	3 (2)	55 (29)	5 (2)	NA ‡
Work	0	23 (12)	0	NA ‡
Education/Training	0	76 (40)	1 (0.5)	NA ‡
Taliban policies interfered with access to humanitarian assistancein Afghanistan	68 (34)	24 (13)	93 (46)	NA ‡
Taliban policies forced restrictions on activities in public in Afghanistan				
"Never" or "Rarely"	25 (12)	142 (73)	19 (9)	NA ‡
"Sometimes"	58 (28)	19 (10)	21 (10)	NA ‡
"Almost Always" or "Always"	120 (59)	24 (13)	159 (79)	NA ‡
Wear a *Chadari* in Afghanistan				
Not at all	40 (20)	16 (8)	7 (4)	NA ‡
A little	11 (5)	13 (7)	2 (1)	NA ‡
Significantly	22 (11)	8 (4)	29 (14)	NA ‡
All the time	130 (64)	153 (81)	162 (81)	NA ‡
Dress code effect on activities of daily living**in Afghanistan				
"Never" or "Rarely"	71 (35)	173 (91)	43 (21)	NA ‡
"Sometimes"	68 (34)	7 (4)	25 (12)	NA ‡
"Almost Always"				NA ‡
or "Always"	62 (31)	9 (5)	130 (65)	NA ‡
Taliban policies interfered with Landmine awareness and education	93 (46)	7 (4)	94 (47)	NA ‡
Worse effect on women and girl's landmine education	86 (42)	3 (2)	79 (39)	NA ‡
Taliban policies changed life for better or worse				
"Much" or "Somewhat Better"	4 (2)	69 (36)	2 (1)	NA ‡
"No Change"	8 (4)	54 (28)	2 (1)	NA ‡
"Much" or "Somewhat Worse"	190 (94)	61 (32)	197 (98)	NA ‡

Data represents £ 10% missing values
* Values are number (percent) † $p < 0.05$, ‡ $p < 0.001$ § May list more than one
** Daily activities included caring for children, cooking, cleaning, going to the market, social activities and work, if employed.

Education and Work Opportunities and Opinions

Only 5% of women who left Afghanistan prior to the Taliban reported "no opportunity" and 3% reported "poor" opportunity for education. In contrast, 95% of women currently exposed to Taliban restrictions on education reported "no opportunity" and 1% reported "poor" opportunity for education. Current work opportunities in Afghanistan were reported as "not available" by 78-87% of women exposed to Taliban policies. Over the last 5 years, Taliban-controlled areas noted the largest decline in education (41-73%) and work opportunities (49-63%). Although study participants were largely poorly educated homemakers, the overwhelming majority of women reported education (83-96%) and work opportunities (77-91%) for women and girls as "extremely" or "significantly" important.

Physical and Mental Health

The majority of respondents described their physical health (63-87%) and their mental health (54-85%) as "fair" or "poor." Significantly, a majority (57-86%) of all women attributed their physical and mental health perceptions directly to Taliban official policies towards women, despite years of armed conflict, devastating poverty and underdevelopment. More than 70% of women exposed to Taliban policies met diagnostic criteria for major depression. The majority of these women (65-94%) attributed their symptoms of depression to official Taliban policy compared to only 30% of women in the non-Taliban-controlled area. PHR found a high prevalence of suicidal ideation (65-77%) and suicide attempts (9-16%) among study participants.

Health Care Access and Quality

The number of women reporting "no access" to health care services in Afghanistan increased significantly ($p < 0.001$) over the past five years (i.e. since the Taliban issued official edicts regarding women in September 1996) among women currently living in a Taliban-controlled area (3% five years ago vs. 21% now) or women refugees in Pakistan (2% five years ago vs. 64% now). However, in Taliban-controlled areas, 59% of women reported improvement in access and quality of health care in Afghanistan in the last year. In the non-Taliban-controlled area, access and quality has remained the same in the last year. Sixty to 69% of women exposed to Taliban policies reported restrictions in receiving medical care. Forty-five to 55% of them reported financial limitations as the most common reason. Lack of female medical facilities (25-27%) and not having a *mahram* (male family member escort) (14-19%) were listed as the other most common reasons restrictions on health care access. In the non-Taliban-controlled area, 13% reported financial limitations as the most common reason and lack of a *chadari* (10%) as the second most common reason

TABLE 3.
Reported Changes in Education and Work Opportunities in Afghanistan during the Last Five Years*

Opportunity in Afghanistan Afghanistan Taliban-controlled area (n=223)	Women in Afghanistan Non-Taliban area (n=194)	Women in Pakistan ≥2 years (n=201)	Women in Pakistan ≥4 years (n=106)	Women in
Education Opportunity Currently				
No opportunity	172 (85)	105 (56)	193 (95)	5(5) ‡
Poor	22 (11)	14 (7)	3 (1)	3(3)
Fair	5 (2)	4 (2)	2 (1)	39 (37) ‡
Good	3 (1)	14 (7)	1 (0.5)	55 (53) ‡
Excellent	1 (0.5)	52 (27)	0	0 ‡
Decline in educational opportunities over the past 5 years of > 3 on a 0-5 scale	149 (73)	2 (1)	82 (41)	NA ‡
Importance of educational opportunities for women or girls				
Not at all	0	4 (2)	0	0 †
Somewhat	2 (4)	9 (5)	0	0 †
Significantly	26 (13)	17 (9)	10 (5)	4(4)
Extremely	173 (85)	159 (83)	191 (94)	100 (96)
§ Work Opportunity Currently				
No opportunity	158 (78)	66 (35)	175 (87)	4(4) ‡
Poor	29 (14)	12 (6)	6 (3)	9 (8)
Fair	1 (0.5)	14 (7)	2 (1)	20 (19) ‡
Good	0	15 (8)	15 (7)	69 (66) ‡
Excellent	0	30 (16)	0	1 (1) ‡
Decline in work opportunities over the past 5 years of > 3 on a 0-5 scale	126 (63)	6 (3)	100 (49)	NA ‡
Importance of work opportunities for women or girls				
Not at all	0	1 (0.5)	1 (2)	0
Somewhat	4 (2)	12 (6)	1 (0.5)	1(1) †
Significantly	41 (20)	27 (14)	30 (15)	7(7) ‡
Extremely	154 (77)	147 (78)	169 (84)	95 (91)

* Values are number (percent)
Data represents £ 10% missing values
† $p < 0.05$, ‡ $p < 0.001$
§ Did not include responses if respondent was a student

for limited health care access. Mental health services in Afghanistan were reported as "not available" by a majority of women in the Taliban-controlled area (57%) and refugees in Pakistan (80%). Forty-four percent of respondents in the non-Taliban-controlled area reported that mental health services were not available.

Attitudes Towards Women's Human Rights

More than 90% of both women and men respondents agreed that women should have equal access to education, equal work opportunities, freedom of expression, legal protection for women's human rights, participation in government, and the inclusion of women's human rights issues in peace talks (Table 6). Approximately 80% of both women and men agreed that women should be able to move about in public freely and that the teachings of Islam do not restrict women's human rights. Seventy-five percent of women and men expressed that women should be able to associate with people of their choosing. More than 50% of women and men agreed strict dress codes are not appropriate. However, there were statistically significant differences of the appropriateness of dress codes between women and men in rural or urban settings. Women and men in rural areas expressed that dress codes are not appropriate less frequently than women and men in urban areas (23% vs. 30%, $p = 0.01$). With respect to freedom of association, more women in rural areas felt that it was appropriate to restrict the freedom of association than did women in urban areas (14% vs. 10%, $p = 0.007$). In addition, women in rural areas expressed less agreement for legal protection of women's human rights (48% vs. 50%, $p = 0.002$) and women and men in rural areas both expressed less agreement than urban women and men about women's participation in government (44% vs. 50%, $p = 0.02$).

There were no significant differences between rural and urban views of human rights with regard to equal education and work, freedom of expression and movement, agreement that Islam does not specifically restrict women's human rights, and that women's human rights issues should be included in peace talks.

Physical Abuses

Overall, 36 (5%) of respondents reported one or more personal experiences of abuse. The abuses included beating 8 (22%), being detained for more than 24 hours 3 (8%), sexual assault 1 (3%), rocket injury 2 (5%), and gunshot wound 1 (3%). Torture, forced marriage, or rape was not reported by any of the participants. Of the reported abuses, non-adherence to the Taliban's dress code for women accounted for 2 (5%) of the incidents reported. Two (5%) of respondents reported being detained for more than 24 hours for being unaccompanied by a male chaperone in public. Other reported abuses included being forced to leave one's homes

6 (40%), burning of one's homes or village 7 (19%), war 2 (13%). The remaining 6 (40%) of women either had no response to the question of abuses or listed the abuse as "other" but did not specify the type or reason for the abuse.

The vast majority of all abuses were reportedly perpetrated by Taliban forces 34 (92%). Forces of the *mujaheddin* and/or United Front were reported as the abuser in only 2 cases (5%). In the case of rocket injuries, it was not possible to ascertain the identity of the reported perpetrator.

Comments on Survey Findings

Taliban restrictions on women's freedoms have largely precluded effective representation of women's perceptions of the degree to which violations of human rights by the Taliban regime are responsible for declines in women's health and well being. Although previous reports on women's health and human rights in Afghanistan provide insight into the suffering of Afghan women, such studies have been limited to non-probability samples of women living in Kabul.[139] This study was designed to assess the perceptions of the effects of Taliban restrictions on women's health of a broad spectrum of Afghan women who have lived or are living under Taliban rule, as well as women living in non-Taliban-controlled areas.

Since individual attitudes and experiences may be influenced by a number of social and political religious factors, PHR's population-based assessments of health and human rights concerns cannot be generalized to all Afghan women and men. Taliban official policy is inconsistently enforced in different areas of the country, thus making generalizations even more difficult. However, in this study, random sampling of a considerably large (235,312) and diverse population provided effective representation of the communities sampled. Also, the study was designed to describe the health and human rights situation and concerns of Afghan women, not to compare differences with men or among specific sample groups or to test hypotheses. Therefore, attribution of health and human rights outcomes to specific factors is limited.

Despite these limitations, PHR's findings indicate that Taliban restrictions on women's human rights have had a profound effect on Afghan women's health and are inconsistent with overwhelming support for women's human rights among Afghan women and men in the sampled population.

Although enforcement of the Taliban's official restrictions on education for women and girls may vary on local levels, the vast majority of girls and women reported having no access to education or access to religious

[139] See Rasekh, Z., Bauer, H., Manos, M. & Iacopino, V., "Women's Health and Human Rights in Afghanistan," *JAMA*, 1998; 280(5):449-455; and Physicians for Human Rights, *The Taliban's War on Women: A Health and Human Rights Crisis in Afghanistan*, 1998.

TABLE 4.
Physical and Mental Health of Afghan Women*

Health Status	Women in Afghanistan Taliban-controlled area (n=223)	Women in Afghanistan Non-Taliban area (n=194)	Women in Pakistan ≤ 2 years (n=201)
Perception of Physical health in the last year			
Very good or good	26 (13)	70 (37)	39 (20) ‡
Fair or poor	177 (87)	119 (63)	169 (80) ‡
Perception of Mental health in the last year			
Very good or good	30 (15)	87 (45)	27 (14) ‡
Fair or poor	173 (85)	104 (54)	173 (85) ‡
Reported "significantly" or "extremely" to Taliban's affect on physical health	141 (69)	121 (63)	174 (86) †
Reported "significantly" or "extremely" to Taliban's affect on mental health	142 (70)	108 (57)	164 (81) ‡
Major Depression (> score of 5 on the PRIME MD)			
Within the past 2 years	80 (39)	43 (23)	176 (88) ‡
Currently	158 (78)	53 (28)	146 (73) ‡
*Reported "significantly" or "extremely" to Taliban's affect on symptoms of depression†	135 (65)	58 (30)	191(94) ‡
Suicidal ideation			
Within past 2 years	68 (33)	35 (20)	176 (87) ‡
Currently	132 (65)	31 (18)	155 (77) ‡
Suicide attempts	33 (16)	18 (9)	18 (9)
Reported "significantly" or "extremely" to Taliban's affect on suicidal ideation or suicide attempt	44 (22)	4 (2)	118 (58) ‡

* Values are number (percent)
† $p < 0.05$
‡ $p < 0.001$
§ Of women with criteria for major depression

schools for primary education.[140] Furthermore, both women and men overwhelmingly indicated that education for girls was important (more than 90%), even though the majority of female participants in this study were poorly educated (mean 1.7 years of formal education, range 0-20 years).

[140] E/CN.4/Sub .2/2000/18.

TABLE 5.
Health Care Access and Quality in Afghanistan*

Health Care Access or Quality in Afghanistan	Women in Afghanistan Taliban-controlled area (n=223)	Women in Afghanistan Non-Taliban area (n=194)	Women in Pakistan ≤ 2 years (n=201)
Reported no health care services			
5 years ago	7 (3)	54 (28)	5 (2) ‡
Now	43 (21)	36 (19)	129 (64) ‡
Access to health services in the Last Year**			
Decline ≥ 3 on a 5- point scale	8 (4)	17 (9)	0 (0) ‡
Remained the same	42 (21)	118 (64)	14 (7) ‡
Improved ≥ 3 on a 5- point scale	31 (15)	4 (2)	119 (59) ‡
Reported restrictions on receiving medical treatment in the last 2 years	121 (60)	42 (22)	138 (69) ‡
Reason for Restrictions on Health Care Access §			
No chadari	11 (5)	19 (10)	34 (17)
No Mahram	29 (14)	12 (6)	39 (19) ‡
No female medical facility	54 (27)	6 (3)	51 (25) ‡
Financial	112 (55)	25 (13)	90 (45) ‡
Not able to see male physician	19 (9)	7 (4)	31 (15) †
Doctor unable to perform adequate exam	9 (4)	3 (2)	8 (4)
Denied treatment due to gender	11 (5)	2 (1)	25 (12) ‡
Reported "no access" for women to mental health services in Afghanistan	115 (57)	84 (44)	161 (80) ‡
Quality of health services in the Last Year			
Decline ≥ 3 on a 5- point scale	19 (9)	3 (2)	21 (11) ‡
Remained the same	37 (19)	111 (59)	21 (10) ‡
Improved ≥ 3 on a 5- point scale	19 (9)	6 (3)	12 (6) ‡

Data represents £ 10% missing values
* Values are number (percent)
** Could also answer "did not seek treatment"; values < 3 not included
† $p < .05$, ‡ $p < .001$
§ May list more than one

[141] See Grossman, "The Correlation between Health and Schooling," in Terleckyj, N.E., (editor) *Household Production and Consumption*, NBER Studies in Income and Wealth, no. 40, National Bureau of Economic Research and Columbia University, 1975; and Auster, Levenson, & Sarachek, "The Production of Health: An Explanatory Study," *Journal of Human Resources,* 1969; 4(Fall):412-436; and Reldman, J., Makuc, D., Kleinman, J. & Cornoni-Huntly, J., "National Trends in Educational Differentials in Mortality," *American Journal of Epidemiology*, 1989; 129:919-933.

Education has been demonstrated to be one of the strongest predictors of physical health status.[141] If restrictions on education persist, however, it is a virtual certainty that policies of enforced ignorance will affect a woman's ability to make informed choices regarding health practices, accessing health care services, interacting with health personnel and participating in treatment regimens.[142] One of the most immediate and devastating physical health effects of the lack of education for women and girls is that they are more vulnerable to landmine injuries. With an estimated 10 million landmines, Afghanistan is the most heavily mined nation in the world.[143] Most mine awareness training has been in schools. In Taliban-controlled areas where education restrictions are more likely to be enforced, girls may be more vulnerable to landmine injuries. Many of the participants in this study indicated that Taliban policies interfered with landmine awareness and education, and that this effect was worse for women and girls.

Although opportunities for education and work declined markedly in the Taliban-controlled area, over 50% of all women in this study reported "no opportunities" for education and over 1/3 of all women (Taliban and non-Taliban-controlled areas) reported no opportunities for work. In

TABLE 6.
Majority Opinions on Women's Human Rights

Shared by more than 90% of women and men

- Women should have equal access to education
- Women should have equal work opportunities
- Women should be able to express themselves freely
- There should be legal protection for the rights of women
- Women should be able to participate in government
- Women's human rights concerns should be included in any peace talks

Shared by more than 80% of women and men

- Women should be able to move about in public freely
- The teachings of Islam do not restrict women's human rights

Shared by more than 75% of women and men

- Women should be able to associate with people of their choosing

Shared by more than 50% of women and men

- Strict dress codes for women are not appropriate

[142] Iacopino, V. & Rasekh, Z., "Education, a Human Rights Imperative: The Case of Afghanistan," *Health and Human Rights*, 1998; 3(2):98-108.

[143] E/CN.4/1996/64

addition to demonstrating the adverse effects of Taliban policies towards women, these findings illustrate the extent to which all women suffer the continued effects of more than 20 years of war, extreme poverty, and the lack of infrastructure and economic development in Afghanistan.

In PHR's study, the majority of female respondents reported poor physical and mental health. The highest proportion of these were in women from Taliban-controlled areas. Although the participants in this study have experienced years of armed conflict and the devastating effects of poverty and underdevelopment, the majority attributed their overall health perceptions directly to official Taliban policies. This may, in fact, be explained by the Taliban's role in the ongoing conflict and/or Taliban policies that adversely affect the rights of Afghan women (i.e., isolation, loss of employment and education opportunities, and financial hardship).

Perhaps the most telling sign of Afghan women's health in this study is women's perception of their mental health, and high prevalence of suicidal ideation, suicide attempts, and an increase in the prevalence of major depression over the last two years, particularly in women living under Taliban control. The majority of women exposed to Taliban rule attributed their symptoms of depression to official Taliban policy. The frequency of major depression among the study participants exceeded that found in many refugee populations in the United States.[144] Although the prevalence of major depression among the study participants was high, other studies have demonstrated similar findings.[145] That Afghan women continue to experience considerable hardships may account for the high percentages of depression observed in this study.

In addition suicidal ideation and suicide attempts among the Afghan women sampled were alarmingly high, in contrast to prevalence rates of attempted suicide reported by the World Health Organization in other

[144] See Kinzie, J.D., Boehnlein, J.K., Leung, P.K., Moore, L.J., Riley, C. & Smith, D., "The Prevalence of Posttraumatic Stress Disorder and Its Clinical Significance among Southeast Asian Refugees," *American Journal of Psychiatry*, 1990; 147:913-7; and Mollica, R.F., Wyshak, G. & Lavelle, J., "The Psychological Impact of War Trauma and Torture on Southeast Asian Refugees," *American Journal of Psychiatry*, 1987;144:1567-1572; and Westermeyer, J., Vang, T.F. & Neider, J., "A Comparison of Refugees Using and Not Using Psychiatric Service: An Analysis of DSM-III Criteria and Self-rated Scales in Cross-cultural Context," *Journal of Operational Psychiatry*, 1983; 14:36-41; and Mghir, R., Freed, W., Raskin, A. & Katon, W., "Depression and Posttraumatic Stress Disorder among a Community Sample of Adolescent and Young Adult Afghan Refugees," *Journal of Nervous Mental Disorders*, 1995; 183:24-30.

[145] See Carlson, E.B. & Rosser-Hogan, R., "Trauma Experiences, Posttraumatic Stress, Dissociation and Depression in Cambodian Refugees," *American Journal of Psychiatry,* 1991; 148(11):1548-51; and D'Avanzo, C.E. & Barab, S.A., "Depression and Anxiety Among Cambodian Refugee Women in France and the United States," *Issues in Mental Health Nursing*, 1998;19(6): 541-56.

countries.[146] Suicidal ideation was higher among women exposed to Taliban policies. There was no data to document suicide attempts that were successful, therefore the rate PHR found may be under-reported compared with the true rate of suicides. The majority of women living in the refugee setting attributed their suicidal ideation and/or attempts to the Taliban. This is not surprising since these women were displaced from Afghanistan by Taliban forces. On the other hand, that the majority of women living both in Taliban-controlled and non-Taliban areas did not attribute their suicide ideation or attempts to the Taliban illustrates that suicidal ideation and attempts are multifactorial and are not solely explained by Taliban policy, but may also be a consequence of 20 years of war, severe poverty, and the recent devastating drought. Also, perhaps predisposing factors for suicidal ideation and attempts may require a life experience, or loss, that is acute and overwhelming, and that may not be characteristic of the effects of Taliban policy on major depression.[147]

Although the number of women reporting "no access" to health care services in Afghanistan increased significantly over the past five years, women in Taliban areas reported improved access to health care services in Afghanistan in the past year. Such improvements are likely due to considerable influx of international aid and support (70% of the current health care system in internationally supported)[148] in cooperation with the Taliban.

The Taliban's role in ongoing war, and their policies restricting women from participating in the work force have likely contributed to the poverty experienced by most Afghan families and contributed to the decline in women's physical and mental health through isolation, increased financial hardship, exposure to ongoing war, and family loss. Indirectly, Taliban policy has affected international policy through sanctions and international humanitarian aid resources and the ability of aid organizations to effectively administer their programs to the most vulnerable in both Taliban-controlled and non-Taliban-controlled areas.[149]

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[146] See Schmidtke, A., Bille-Brahe, U., DeLeo, D., Kerkhof, A., Bjerke, T., Crepet, P., et al., "Attempted Suicide in Europe: Rates, Trends and Sociodemographic Characteristics of Suicide Attempters During the Period 1989-1992," Results of the WHO/EURO Multicentre Study on Parasuicide, *Acta Psychiatrica Scandinavica*, 1996;93(5): 327-38; and Weissman, M.M., Bland, R.C., Canino, G.J., et al., "Cross-national Epidemiology of Major Depression and Bipolar Disease," *JAMA* 276 (4): 293-299, 1996; and Daradkeh, T.K., Al-Zayer, N., "Parasuicide in an Arab Industrial Community: The Arabian-American Oil Company Experience, Saudi Arabia," *Acta Psychiatrica Scandinavica* 77 (6): 707-711, 1988.

[147] See Monroe, S.M., Harkness, K., Simons, A. et al., "Life Stress and the Symptoms of Major Depression," *Journal of Nervous Mental Disorders*, 189 (3) 168-75, 2001.

[148] World Health Organization, *Hope*, WHO, December, 1996.

[149] Report of the Secretary General on the Humanitarian Implications of the Measures Imposed by Security Council Resolution 1267 (1999) and 1333 (2000) on Afghanistan, March 15, 2001.

In the present study, women who fled Taliban-controlled areas in Afghanistan reported the highest number of physical abuses. This is most likely due to exposure of this group to armed conflict involving the Taliban and United Front forces. Thus, there appears to be a relationship between living in a "conflict area" and experiences of physical abuse by Taliban forces. Previous studies have reported higher numbers of abuses among Afghan women living in Kabul.[150] Regardless of the frequency of reported abuses, abuses among all participants were attributed almost entirely to Taliban forces.

Although the Taliban claims that its policy of gender restrictions is rooted in Afghan history and culture, this claim is clearly contradicted by the views of Afghan women themselves. Over 90% of women and men surveyed agreed that women should have equal access to education, equal work opportunities, freedom of expression, freedom of association, legal protection for women's human rights, and participation in government, and that women's human rights issues should be included in peace negotiations. Furthermore, there is strong authority within Islamic law and traditions for affirmatively promoting the education of both girls and boys; for the right of women to work, own property, earn a living, and participate in public life; and for the importance of enabling women to take the steps necessary to protect and promote their own health and that of their families.[151]

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[150] See Rasekh, Z., Bauer, H., Manos, M. & Iacopino, V., "Women's Health and Human Rights in Afghanistan," *JAMA*, 1998; 280(5):449-455; and Physicians for Human Rights, *The Taliban's War on Women: A Health and Human Rights Crisis in Afghanistan*, 1998.

[151] See *The Cairo Declaration; Final Report of the International Conference on Population and Reproductive Health in the Muslim World*, 21-24 February 1998, Al-Azhar University, Cairo; and *Health Promotion through Islamic Lifestyles: The Amman Declaration*, WHO, 1996.