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UNDERSTANDING HEALTH ISSUES AMONG ADOLESCENT FEMALES IN A NORTHEAST PROVINCE OF AFGHANISTAN

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UNDERSTANDING HEALTH ISSUES AMONG ADOLESCENT FEMALES IN A
NORTHEAST PROVINCE OF AFGHANISTAN

A Dissertation Presented

by

AMINA DAVLATSHOEVA

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

DOCTOR OF EDUCATION

May 2014

Education

Educational Policy and Leadership

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A Dissertation Presented

by

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DEDICATION

To my parents Saifullakhan Davlatshoev and Muminamoh Lalbekova
for envisioning my pursuit of the highest mountains of wisdom
and
for encouraging me to climb distant mountain peaks
to reach the summit of my education.

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ABSTRACT

UNDERSTANDING HEALTH ISSUES AMONG ADOLESCENT FEMALES IN A NORTHEAST PROVINCE OF AFGHANISTAN

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The purpose of this study is to develop a deeper understanding of the health issues facing adolescent females (ages 18-21) in rural, northeastern Afghanistan. Incorporating participant observations, in-depth interviews, and narrative inquiries, this study seeks to illustrate adolescent females' perspectives on health issues.

To achieve this goal, ten adolescent females were interviewed in rural, northeastern Afghanistan during 2010. The participants were between 18- and 21-years old. The one-on-one interviews were conducted in a multiple-response format and were structured around three research questions:

- How does a young female's understanding of health issues shape her identity in northeastern Afghanistan?
- In what ways do the narrative stories of Afghan females link to issues such as education, health, and family dynamics?

- In what ways are the narrative stories of Afghan females linked to their cultural beliefs about health?

The participants were asked to discuss their perceptions of life, health, body image, illness, and related topics. The participants struggled to articulate answers to these questions, but their personal narratives and body language vividly illustrated the issues they struggled to express. Their narrative responses are reduced in this study to produce a dynamic perspective on adolescent females' perceptions of health issues in northeastern Afghanistan.

During the course of this study, it became apparent that:

1. Family influences shaped the participants' social world. They relied upon their families for daily communication, information, and moral and emotional support.
2. Despite this social dependence, the participants demonstrated a marked reluctance to discuss health issues with their mothers or with other older females in their households.
3. The participants rarely connected health with its traditional meaning (i.e. physical or mental well-being). For them, health was related to a good life—free from stress and care—and education.

There is still much more to learn about adolescent health in rural Afghanistan; yet an understanding of these cultural constructs of family, health, and education is necessary to pursue further inquiries. This study's findings provide the groundwork for future research and discussion—and, ultimately, a deeper understanding of adolescent females' perceptions of health in rural Afghanistan.

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ACRONYMS AND DEFINITIONS OF LOCAL LANGUAGE USED

- Chodari – A head-to-toe veil. Some females use the term *Chodari*, some, *Burqa*.
- Concur exams – a national examination for entrance into higher education and universities in Afghanistan.
- Dari – a dialect of the modern Persian language used in Afghanistan.
- Dukhtar – “girl” in Dari. It is a form of address to young, unmarried females.
- DRA – Democratic Republic of Afghanistan.
- Islamic Hadith – Islamic Traditions.
- I-NGO – International Non-Governmental Organization.
- Mehmon – guest, visitor.
- Mullahs – Islamic religious preachers.
- Nowruz – a festive celebration of a New Year.
- Pashtun language – known as an ethnic “Afghan” language that is mainly derived from eastern Iranian language roots (Pashtoon alt. spelling).
- Shuras – village counsels.
- Tajiks – ethnic groups, mainly Persian-speaking, located in western and northern Afghanistan
- Uzbeks – ethnic groups, mainly Turkic-speaking, located in the southeast and the north of Afghanistan.
- Zan – “women” in Dari. It is a form of address to married females.

CHAPTER 1

INTRODUCTION

Purpose

The purpose of this study is to explore and understand the experiences of Afghan females, ages 18-21, in Afghanistan's Takhar Province, through narrative stories about their health issues. It will link their stories to their cultural beliefs and social context in order to shed light on appropriate strategies for health and education intervention.

Problem Statement

Young women's health is critical for societal development, particularly in developing countries. While this need is commonly acknowledged, personal narratives are rarely considered when determining adolescent females' most pressing health issues. Yet, without their input, well-intentioned health and education programs designed to improve their health and well-being have often proved ineffective.

Recent research has identified several health concerns for adolescent Afghan females, including a high level of depression and anxiety (Rabab, 2005) due to conflict (Miller, 2006; Cardozo, et al., 2005), poor or non-existent medical services in remote areas (CEDAW, 2011), and restricted mobility and limited educational opportunities under Islamic traditions (Grima, 2002). Research has additionally shown that females who are developmentally unprepared for their social roles (e.g. wife and mother by the age of 16) face internal conflicts in personal-identity formation (CEDAW, 2011).

The complexity of the health-care issues that adolescent females (ages 18-21) face is well established. According to Slater et al. (2001), young females often possess low self-esteem and feel depressed, sad, and isolated. Sabiston et al., (2007) state that adolescent perceptions of health and well-being become stronger as females become concerned about their appearance and develop a negative self-image. Young females are subjected to pressures about their physique and body weight (the shape of their bodies and how they and others perceive this), and, as a result, schoolgirls regularly diet in unhealthy ways. In this environment, families, particularly older siblings, can provide support or prove to be a source of additional stress and anxiety (Schart, et al., 2005). Family members, mothers, and peers influence adolescent perceptions and can increase social anxiety and the need for external confirmation. Negative responses from these individuals strongly influence the development of self-esteem in adolescents (Sabiston et al., 2007).

We do not understand, however, the subjective complexities (Gubrium, 2011) of adolescent females' perceptions and experiences of health issues, especially in Afghanistan. Little research linking adolescent females' stories to other social factors impacting their psychosocial health—such as peer pressure, relationships, family, and traditions—has been conducted. We also do not know their awareness of the consequences of risky behaviors (e.g. anxiety) for self-esteem, depression, and/or cultural perceptions of health and well-being.

Typical frameworks for explaining the developmental stages of adolescence fail to adequately consider the important role social context plays, especially in Muslim countries, in influencing young females' understanding of health issues. This

knowledge gap leads to the question: How can health care promoters and educators construct a viable framework? One of the most effective means for gaining this critical understanding is by conducting in-depth interviews and observation in order to gain insight into the stories and experiences of young Afghan girls.

Research questions

- How does a young female's understanding of health issues shape her identity in northeastern Afghanistan?
- In what ways do the narrative stories of Afghan females link to issues such as education, health, and family dynamics?
- In what ways are the narrative stories of Afghan females linked to their cultural beliefs about health?

Significance

This study will help determine appropriate strategies for health and education interventions (Hubley, 1986; Loevinsohn, 1990) for young Afghan females. Knowing more about Afghan girls' perceptions of their health care issues will make it possible to develop strategies to increase their school attendance and raise their participation in community education about health and well-being. Additionally, international health-intervention programs can use the knowledge to create more holistic health-and-education projects for adolescent girls in Afghanistan. Education practitioners will be able to use the information to provide additional health literacy and supplementary health-and-well-being intervention programs to adolescent females.

For health educators, this study can provide a more holistic understanding of adolescent-health issues within adolescent contextual realities. Using adolescent Afghan girls' conceptualization of their own health issues, health educators can make relational linkages through the "voice of the 'other', spoken in the context of their own situation" (Fox, 2009, p.51). Health educators will be able to utilize this new knowledge of adolescent health and the social and environmental factors impacting it in designing intervention programs. Thus this study can contribute to determining appropriate need-based interventions to provide physical and psychosocial health support to young women in rural Afghanistan. The findings will also contribute to wider dialogue, opening the issue to additional and deeper questions to explore and follow up.

CHAPTER 2

REVIEW OF LITERATURE ON ADOLESCENT GIRLS AND THEIR HEALTH

This chapter reviews the related literature in order to contextualize the present study. First, I look at the concept of adolescence through literature, describing the evolution of the concept and looking at individual factors, such as identity and social limitations that influence adolescent growth. In order to understand adolescent development and the influences on adolescents' social worlds (Abel, et al., 2002), I detail external factors such as social norms, economic conditions, and culture expectations. I show how female adolescents around the world face difficulties inherent to their transition from childhood to adulthood.

Next I present a theoretical framework, drawing on critical points of identity formation, women's development, and 'female voice' theories to emphasize the connection between the narration (or expression) of women's voices and a holistic adolescence development. Within this outline, I incorporate health concepts drawn from Islamic literature.

Finally, I narrow my review by looking at the concept of female adolescents and their health issues within the context of Afghanistan, integrating historical background information about the position of females within specific time periods (pre-Taliban period of 1973-1979, Taliban period of 1996-2001, and post-Taliban period from 2004 until present).

Definition and concept of adolescence

Adolescence is a transitional period of physical and mental growth that develops between childhood and adulthood. The transition involves biological, social and

psychological changes (Berk, 2003). Historically, the definition of adolescence was solely based on age categorization; however, Tyyska (2005) suggests that defining adolescence is a fluid process in terms of categorization. Demonstrating this fluidity, the United Nations (UNICEF, 2001) defines youth as young people between 15- and 24-years old, teens as those between 15- and 19-years old, and young adults as those between 20- and 24-years old.

American scientists have researched the concept of adolescence for several centuries. DeLuzio (2007) provides an in-depth history of the development of the concept of adolescence, how it emerged, and how it has been shaped over time. The author divides the development of the concept into several historical periods interrelated with social circumstances that impacted the conceptual understanding of the term.

In the late 19th century, scientists characterized adolescence in terms of anatomy and puberty, describing it as a period of rebellion and irrationality. Moreover, adolescence was perceived as the period when young adults sought to define self-identity and demonstrate more independence. For girls, puberty was considered a negative physical state. Girls, from the age of 12 onwards, were described as being volatile, weak, passive, and unhealthy; therefore, puberty was perceived as a weak point—a regression—in female development. The late 19th century, however, brought a wave of modernity. The concept of adolescent development and female sexual identity began to develop. The sexual identification of females included the recognition of their role as adults, their position in society, and their acquirement of jobs and salaries.

DeLuzio (2007) states: “Teenage years are not determined by the age and physique, but also by dichotomies of gender identities, roles, responsibilities, and relationships that govern man and women” (p. 117).

Internationally, the definition of youth and adolescent growth is embedded in cultural expressions, historical interpretations, and religious and economic factors. In Europe, by the beginning of 21st century, the Nordic Model (a formal structure of youth research) structured youth issues, combining research on youth with small, local, nationalistic groups. The Nordic Model identifies similar patterns of development and growth in youth classified as new-identity Europeans (e.g. youth in Denmark and Sweden facing huge unemployment rates). This model was formed after researchers discovered unifying patterns of adolescent and youth behavior in Nordic countries.

Studies on youth require the unpacking of the various factors beyond physical development that influence identity development (Helve, Leccardi and Kovacheva, 2005). For example, while youth in Italy feel uncertain and distant from their country’s national ideologies, youth in Central Europe (Bratislava, Slovakia) are more engaged in political life. To study youth in these countries, it is helpful to understand the social constructions of: unemployment, homelessness, and addiction.

In non-western countries in the Southern hemisphere, adolescence is defined by specific cultural traditions that force adolescents to take on leadership or adulthood roles at a very young age. Tyyska (2005) asserts:

Children in many parts of the south are compelled through the legacy of colonization, war, increasing economic globalization, towards an “early

maturity” through child labor, shorter education, increased poverty, with the associated ills of poor health, hunger and starvation (p. 4).

According to DeLuzio (2007), America, during the late 18th century, was organized by an authority-hierarchical social order that was implicitly controlled by age division and explicitly maintained by gender roles. Parents maintained and controlled youth and children. Fathers, who had to prepare their sons for the responsibilities of manhood, categorized the roles and duties of boys. Societal norms prescribed that at the age of 25, young men were ready to establish a family and create a separate household. On the other hand, girls reached maturity at age 18 when they were perceived as ready for marriage and domestic responsibility as well as for bearing and raising children. The ultimate goal was to prepare girls for the role of Victorian motherhood¹. The social-class division was clear, and the roles were distributed differently among classes. Girls from middle-class families would learn life and homemaker skills from their mothers. They would often be isolated from their friends. Lower-class families would send their daughters to factories; their role was to support their family by earning money. Education was not a priority for children from lower-class families. These social structures, with their class divisions, were mainly determined by industrial needs and social demands.

On the socio-economic level, the 20th century brought many changes to factories and factory workforces. Many factories endorsed and recognized the importance of a female workforce. Many young girls gained skills and knowledge by working in

¹Victorian motherhood was a conceptual model for young females that represented role division and a woman's position in society. Mothers and adolescent girls would aim to improve the girls' intellectual, social etiquette, and spiritual levels. Daughters had to learn needlepoint, sewing, and domestic chores, such as cooking and cleaning.

factories and began to understand and address more health issues (e.g. hygiene). This move towards a more civilized society involved a re-shaping of gender roles and identities away from Victorian motherhood. Earning their own salaries, young girls began to develop their personal versions of the female self, their roles, and their desired level of emancipation from their parents. Boys' identity formation was still dominant, however, as boys were assigned the role of securing their place, position, and status within society.

The coming-of-age² stage of development brought enormous cultural and anthropological implications to the notion of adolescent growth. Adolescent growth was not only concerned with biological factors, but was also linked to culture and cultural interpretations of adolescent growth. By understanding particular cultural settings, researchers were able to seek a diverse concept of culture, cultural variables, and interpretations specific to youth while drawing on social and historical interpretations of youth.

Over time the concept of culture has been enhanced while still remaining a contested term. From an ethnographic perspective, culture is defined as shared meanings, knowledge, beliefs, morals, and customs (Edles, 2002). According to a symbolic definition, it is a system of shared meanings that are "historically linked to specific social groups at specific moments, intertwined in complex ways with other societal dimensions" (Chouinard and Cousins, 2009, p.21). A more comprehensive concept of culture is shared by Bank (1991):

²"Coming of Age in Samoa" by Margaret Mead (1928) was a cross-cultural study of South Sea Island culture and served as a critique and reaffirmation of Western cultural norms (Conger, 1973, De Luzio, 2007).

Culture consists of patterns, explicit and implicit, of and for behavior acquired and transmitted by symbols, constituting the distinctive achievements of human groups, including their embodiments in artifacts; the essential core of culture consist of traditional (i.e. historically derived and selected) ideas and especially attached values (p.83).

The definition of adolescence has also varied with the passage of time.

Adolescence not only refers to the transition age for youth, as demonstrated by physical and anatomical measurements, but also includes the creation of new roles, identities, and psychosocial values in a particular culture or region. In many cultures, adolescents, either individually or in groups, seek their own paths to define their own process of transformation into adulthood. For instance, in Rom (Gypsy) culture, as shown by Reagan (2005), young children are considered miniature versions of adults; therefore, the rights and roles they perform are similar to adults. Children are active social participants, often substituting for their parents and handling and earning money. Clark (1975), therefore, challenges simplistic definitions of adolescent growth, stating that:

Often a technical term is invented in order to create a social condition and a social fact; such has been true with respect to the term “adolescence”. The idea of adolescence as an intermediary period in life starting at puberty and extended to some period in the life cycle unmarked by any conspicuous physical change but socially defined as “manhood” or “womanhood” is the product of modern times (p.4).

The author further argues that adolescence is controlled by legally defined

mechanisms, such as age categorization. In terms of age categorization, adolescents, he argues, are described as having poor impulse control, weak ego structure, identity crises, instability, incomplete personality development, and immaturity. The author further suggests that school and family can cement the incorporation of cultural factors in an adolescent environment.

Culture also represents how adolescents interpret and perceive the environment around them. Youth develop values and belief systems based on life styles that are pertinent to their specific culture or location in order to foster protection and safety. For example, young girls in Kenya feel that they “have been made to believe the primary role in their life is to be a producer of children” (Hartmann, 1995 p. 84). In this case, the girls tend to develop a set of values around the female role in that specific community and enhance that role in their own lives. A second example comes from post-conflict countries. Youth in these communities are often linked to psychological stress and deep trauma (Goldstein et al, 1997). Adolescents are sensitive and will develop individual worldviews and values specifically shaped by their environment.

Theoretical Construct

The theoretical framework of this study is interdisciplinary. This study explores concepts, ideas, and research methods in the field of adolescent and female development. It draws implications from traditional Islamic views of health that are based on prophetic and naturalistic medicine. It also derives ideas from Carol Gilligan’s theory of feminism and moral obligations and Erik Erikson’s theory of identity formation. The concepts and theories utilized in this study are primarily

from human-development theories and, as such, build on sociological and developmental models of human development and integration within the framework of traditional Islamic beliefs.

Theory of Identity Formation

Erik Erikson's interdisciplinary work on human development focused on the formation and maintenance of identity among people of diverse backgrounds: African American, Caucasian, Native American, wealthy, poor, male, or female (Hoover and Erickson, 2004). Erikson argued that the theory of identity has *constructionists, essentialists, and individualists'* stands. These stands are identified as a self in power, a self in a social and genetic sense, and a self in "I" formation. Erikson argued that all three stands or ways of thinking have problems. Adolescent development and growth, in Erikson's identity theory, are categorized into four identity statuses: *identity achievements, moratorium, foreclosure, and identity diffusion* (Marcia, 2004). Among the four statuses, moratorium or psychosocial moratorium is critical. During the moratorium stage, "the young adult through free role experimentation may find a niche in some section in his society, a niche which is firmly defined and yet seems to be uniquely made for him" (Erikson, 1968 p.156). It is in this stage of moratorium, Erikson argues, that a young person's identity of the "self" or "I" is formed and then interacts with the community, society, and/or family. During the moratorium stage, concepts, such as meanings and perceptions, can be elaborated. Kreidie (2004) notes that in Islamic countries, basic identities (shared daily actions) influence identity formation among young males and females. This reality makes it important to capture the details of how young males and females

live and how “these changing processes of shifting and multiple identities are characterized by complex negotiations between past lives and present realities” (Trahar, 2009 p. 15). Thus, when studying the perceptions and identity formation of young people, it is critical to recognize the stages of identity formation.

Feminist and Human Development Theories

Carol Gilligan, while approaching her work from the viewpoint of human development, focuses a critical lens on female perspectives. Her work emphasizes how different theories of human development marginalize the position of women, their voices, and their individuality. Gilligan (1982) argues that “the psychology of women that has consistently been described as distinctive in its greater orientation towards relationships and interdependence implies a more contextual mode of judgment” (p.22).

The author challenges the ordinary notion that women, by focusing mainly on relationships, are different than men:

Woman’s place in man's life cycle is to protect this recognition while the developmental litany intones the celebration of separation, autonomy, individuation, and natural rights (p.23).

Gilligan’s work focuses on psychological descriptions, female identity, and moral development. Femininity, asserts Gilligan, is a moral equation (Kohlberg, 1971) of goodness and self- sacrifice. Therefore, a conflict arises between how much of self and how much of others determine female development.

Women’s differences are rooted not only in their social subordination but also in the substance of their moral concern. Sensitivity to the needs of others and the

assumption of caregiver roles lead women to incorporate into their perspective other voices and viewpoints (Gilligan, 1982, p 16). Gilligan's work highlights the voices of women and how women position themselves in relation to family, society, and the overall environment.

The Erikson and Gilligan theories of identity formation and female voices/perceptions and their impact on female development support the logic of a smooth transition from childhood-adolescence to adulthood. They are pertinent because they stress the developmental stages of adolescent and young females. Erikson, however, limits the theories into stages of identity formation. To take the concept further, Gilligan's work facilitates complex discussions about female voices brought forth from their context. To rigorously discuss feminism, self-perceptions, identity formation, and human development within the realm of international development, it is important that the voices of Afghan females are heard and their perceptions of their health issues considered.

Islamic Theories of Women and Health

Defining the status of Islamic women involves heated discussions in Western academic and social worlds. These discussions on women are closely related to interpretations of Islam and women's positions within Islamic traditions (Majid, 2000, Ansari, 2001). Not only is the status of women and girls in the Islamic tradition debated, but conflicting studies contest the position of women in the Islamic world. For example, Sharia-minded traditionalists treat women as if they were worth "half of men." Sharia laws are practiced by *hudud* (Sardar and Davies, 2007) and incorporate extreme punishment, such as cutting off the hands of thieves, stoning adulterers and

women who have been raped, and veiling and denying education to women. Clerical Islam (Majid, 2000) defines a woman's position through the interpretation of the Prophet Muhammad's (PBUH) views on women and the tales of the Islamic *Hadith* (Islamic traditions). In contrast, secular Islam argues for the separation of religion from state affairs and urges all genders to participate in social affairs. It also argues that males and females should have equal opportunities.

Beginning in the 1970s and 1980s, Islamic feminism began to take shape (Badran, 2002, Mojab, 2001). The Islamic feminism movement began with Islamic reforms. Islamic feminism (Badran, 2002, Mojab, 2001, Wadud, 1999) views women progressively and demands explicit rights and social justice for women even within the parameters of religious and state operations. The reform movement was pushed by the re-interpretation of the Qur'an, aligning it with modern-day practices in places such as Egypt, Iran, and Syria.

Islamic views also strongly affect the approach to health in Afghanistan where beliefs and practices such as Islamic *Hadith*, amulets, and prayers still exist as methods for dealing with sickness and healing. For example, in Islamic *Hadith* there are guiding traditions for health, sickness, and healing. The most prominent and influential traditions are: a) prophetic medicine and b) naturalistic medicine based on science. Prophetic medicine originates from statements by the Prophet Muhammad (PBUH) on how to treat particular diseases and health problems. The vast collections of Hadith, or prophetic sayings, were and are still used in Islamic culture. A famous scholar and historian, Ibn Khaldun (1332-1406) in Ibn Qayyim Al-Jawziyya (1998), developed concepts related to Hadith in the belief that all sicknesses

and illnesses are treatable.

Magic, short prescriptions and spiritual interpretations motivated the development of these concepts. For instance, it was believed that amulets would treat some illnesses. Belief in the “evil eye”³ is common in Muslim countries. Often referred to as the “jealous eye,” it is widely believed that the evil eye can affect and make other people sick. Ibn Qayyim Al-Jawziyya (1998), in his work on compilation of the Prophetic medicine, refers to magic and its treatment by stating that:

Magic is from the influences of the evil, lower spirits. Their influence will be repealed by that which opposes and resists them: by invocation of the name of God, recitation of Qur’anic verses which cancel the action and effect of the spirits. The stronger and the more sincere these verses are, the more comprehensive and absolute is the protection they render (p. 97).

Prayers are also a strong component of Prophetic medicine. Rahman (1987) analyzes the argument that Prophetic medicine should be used not only for physical cures, but also for the spiritual, psychological, physical, and moral integrity of the human body. The author supports the argument by saying that:

Prayers can cause recovery from the pain of the heart, stomach and intestines. First, it is a divinely commanded form of worship. Second, it has psychological benefit. This is because prayers divert the mind from the pain and reduce its feeling whereby the power to repel (the cause of pain) is strengthened” (p. 44).

³ Belief in the evil eye and the protective powers of amulets is still common in many Islamic societies. These beliefs are often encouraged, especially when there is much despair and hopelessness. These beliefs are associated with health treatments.

Religious motivations are often furthered by a majority belief that correlates sickness and illness with sin and non-obedience to traditions (Rahman 1987). For instance, contemporary statements indicate beliefs, such as: a) the importance of abstaining from alcohol to prevent mental intoxication, and b) the need to eat healthy food (as demonstrated by the careful process of slaughtering meat). Thus, Prophetic sayings concerning health have deep roots in Islamic tradition and possess considerable health implications for practicing Muslims.

The concept of naturalistic medicine was encouraged by one of the greatest and most famous Islamic philosophers and doctors, Ibn Sina (d.1037). Ibn Sina, also called Avicenna (980-1037), worked on the “Canon of Medicine”—Kitab al-Qanun Al Tibb. In addition to introducing the principles of healing, medical sicknesses and diseases, and herbal treatment of diseases, he also translated his work into Latin, influencing the European medicine in the 18th and 19th centuries. During this time, the Andalus (Spain) acknowledged Ibn Sina’s medical genius. Many herbalists and medical doctors continue to work on drugs, drug utilization, and basic health principles developed during his time (Aref Abu Rabia, 2005). Ibn Sina challenged the notion of miracles and encouraged people to look at sickness and diseases naturalistically. Ibn Sina argued that all humans get sick and that mental processes determine how the sickness develops in the body. He suggested that the mind controls matter and rejected the idea that miracles impact the sickness and healing process.

Syed (2002) describes a comprehensive health system and the advancement of medicine and health in the 18th and 19th centuries. Islamic scholars contributed to science in the areas of: a) medical-education training in basic science, clinical

observation and analysis training, and oral and practical medical proficiency exams; b) governmental hospitals (containing large libraries for doctors) to treat infections, fever, wounds, and female disorders; and c) a medical studies focused on the new fields of bacteriology, anesthesia, and surgery. Ibn Sina and Al Razi paid careful attention to observation and research and many clinics and hospitals with observation and medical research components were established in Bagdad, Cairo, and Damascus between 705 and 1258 A.D.

In the mid-18th century the Ottoman Empire introduced a new, secular way, influenced by the French, to approaching health and medicine. Madrassas—religious schools—were abandoned. Their traditional medical teachings were left behind and separated from modern medicine, as ritual and tradition. Muslims did not, however, believe in separating healing and health from faith and the soul, which led to a huge clash between Islamic and secular philosophies in the East.

Adolescent Girls in Afghanistan

Afghanistan's adolescent girls face a great number of challenges in maintaining their physical and psychosocial health. Norms and traditions—whether local or society-wide—heavily influence young girls and dictate their lives. Young women in Afghanistan face enormous identity clashes between youth and womanhood (Rabab, 2005), high levels of depression and anxiety (Cardozo et al., (2005), and, due to conflict, mental-health disorders (Miller, 2006). Girls also face an education enrollment rate of only 5% at the secondary level (Human Right Watch, 2006), poor or non-existent medical services in remote areas, and a high reliance on Islamic traditions (Grima, 2002). In a country wracked by war for 23 years, a wide range of

cultural and environmental factors have strongly influenced adolescent girls' growth and health.

Historical overview

During Afghanistan's pre-Taliban period (1973-1979), the role of young girls and women was re-defined repeatedly. As Rahimi (1991) stated;

The first appearance of women without veil occurred in 1959, where Prime Minister Daoud with the dignitary ministers brought their wives and daughters to the state independence celebration. Women began to work in Radio Afghanistan, Ariana Airlines, participating in women international congress in Moscow and further in Helsinki (p. 5).

In July 1973, the Afghan monarch was overthrown and the Democratic Republic of Afghanistan (DRA) was created. The DRA abolished all types of segregation, inequalities, and injustices towards women. Women were expected to show patriotism for their country and to actively participate in politics and civil society.

Despite the legal efforts to free women and to integrate young girls into a modern Afghanistan, the local customs in semi-urban and rural areas were different. For instance, rural areas followed a more feudal life pattern. This life pattern included early marriages for women (between the ages of 8 and 12), maternal mortality at a very young age, polygamy, treatment of women under "*Sharia*" or Islamic law, limited access to education (Rahimi, 1991), and a general belief in the inferiority of women to men. The tribal communities and villages operated under strict religious beliefs and traditions based on tribal concepts and practices. Men were allowed to offer prayers, fast during the holy month of Ramadan, and attend the special festival on

Nowruz (New Year) while women were restricted to their homes.

The Soviets took over the government in 1979 (Ellis, 2000). Despite claims that the Soviets had created a modern government that emphasized women's freedom, young women and girls formed many opposition groups. Their involvement in these opposition groups showed that they were forming self-protecting identities. They became members of grass-roots opposition organizations against the Soviets. Protests and demonstrations were part of the opposition strategy. Women's underground organizations were set up. In rural villages, women provided food for local Afghan resistance soldiers living in the hills, washed the soldiers' laundry, worked in the field at night, and transported weapons from one place to another under their veils. As a form of punishment, the Soviets tortured women by beating them with sticks, wire cables, or rubber lashes. They had women stand for long hours in the burning sun, kept them in a tank of water in winter, burnt them with cigarettes, sexually assaulted them, and left them alone for days in a room containing dead bodies (Ellis, 2000).

When the Soviet army pulled out of Afghanistan in 1988, the Taliban took over (1996-2001). Advocates of Sharia law and supporters of the Taliban ideology penetrated throughout the country. Smith (2001) states:

With the Qur'an in one hand, Kalashnikov (weapon name) in the other, these students of Islam, who had spent years as refugees in Pakistan, studying in their own madrassas, were storming through Afghanistan. Their declared intent was to install what they describe as a true Islamic Government in Kabul. The ultra conservative Pashtoon majority around Kandahar had shown little

resistance as the militant students began to sweep through the country. [The] Taliban's numbers increased as they rolled on towards their ultimate goal-Kabul (p. 185).

The Taliban policy towards adolescent girls and women became the law of the land. First, all adolescent girls and women were prohibited from attending social activities, including: work and school. Second, all females had to be covered. Covering can represent social status in various contexts. In different cultures, the covering can be a sign of wealth or poverty, education or illiteracy (Brydon and Chant, 1989). It was initially a sign of following the Sharia law.

The Taliban, however, enacted the requirement into law. Taliban rules and policies were set as behavioral procedures and norms for all Afghan females. Eliss (2000) describes a few of the Taliban policies, such as:

- a) Taxi drivers were forbidden to pick up women without a man accompanying them. The driver risked punishment and the woman and her husband could also be punished.
- b) Women could not make noise when they walked and could not laugh or talk loudly in the streets.
- c) Women could not go to male doctors.
- d) Widows could only receive aid-agency assistance through a male relative (p.63).

These social policies were strictly enforced by the Taliban government. On Friday afternoons, the people were encouraged to gather at a central stadium to witness the

punishments for breaking the laws: women were stoned to death⁴, some had walls collapsed on them, and homosexuals were killed and their arms and legs cut off.

The assessment of the health and human rights conditions of adolescent girls under Taliban policies by Heisler et al, (1999) reveal a clear shift in adolescent girls' identity. Many adolescent girls sought to change their identity from female to male in order pursue education or bring home money. Heisler, Razekh & Lacopino (1999) describe one girl's wish to become a boy. The girl states:

Mother, please shave my hair, dress me like my brother, and change my name to a boy's name so I can attend school with my brother (p.156).

The study showed that 77% of adolescent girls have mental problems, such as fear, depression and sleeplessness. Out of 21 adolescent girls interviewed, two suffered from injuries related to landmine explosions and were not permitted surgical treatment; two talked about ending their lives; and the rest felt overwhelmed, extremely anxious, fearful of the future, and hopeless.

Under the Taliban government, health issues declined rapidly and limited assistance was allowed. Ellis (2000) links health issues directly to conflict and social pressures, stating:

- a) Young girls were asked to work in the field and collect water from a long distance away. As a result of landmines and missiles, many girls lost their limbs. These girls were not allowed to go to the hospital for surgery and their injuries remained a huge problem that could not be easily treated at

⁴Stoning women to death is rarely recorded. An elaborate image is portrayed in the film, "The Kite Runner" (Marc Forster, 2007), based on a book by the same name written by Khalid Hussein. As the world had seldom seen such terrifying punishments, the film was temporarily banned in Afghanistan.

home.

- b) Tuberculosis, blindness, deafness, mental retardation, and cerebral palsy were recorded as a result of poor treatment.
- c) There was a lack of clean drinking water. Available water was contaminated. There was an increase in maternal mortality for married girls in the age range of 12- to 17-years old due to a number of factors, including: malnutrition (causing small pelvises), heavy labor during pregnancy, miscarriage, hunger, frequent and closely spaced pregnancies, infections from unsanitary home deliveries, and physical and verbal abuse at home.

Even the policy requiring women and girls to wear *chodari* had serious health implications, causing poor vision and hearing, skin rashes, respiratory difficulties, headaches, asthma, hair loss and depression (Eliss, 2000).

Present situation

The notion of adolescent girls' health and growth is ill defined in Afghanistan. In many countries the phase of adolescent growth is perceived as a natural and transitional progression towards adulthood with few influencing factors; yet in Afghanistan, an adolescent girl's development and growth is far more complex.

Many factors affect adolescent girls' health and physical development in Afghanistan, such as: education, mobility, poverty, domestic-work, literacy, health care, health education, cultural views of dignity and honor, marriage age, social status, and traditional roles.

It is often difficult to even determine a girl's age in Afghanistan. In many

circumstances, there are few age indicators for females. Unrecorded births, ages calculated according to the Islamic calendar, and lost documents, make it difficult to calculate age in many illiterate communities. As millions of children are born at home, limited age registrations exist. Many young women associate their date of birth with a season or a cultural festival rather than to a specific day and year. For example, some women might say: "I was born in the spring" or "I was born before the war." Therefore, determining the age of women and girls in order to categorize them into the internationally accepted adolescent age group is difficult, raising the issue of the cultural definition of age.

Many adolescent Afghan girls have vibrant memories from past wars; in fact, all they remember is war. Besides contributing memories, however, the wars have attached their own timeline to the girls' growth and development. Adolescent girls between the ages of 12- and 17-years old either were born during a war or remember one. These young Afghan girls have a different worldview than the young girls growing up now. They perceive life in terms of home-based schooling, prohibited health facilities, limited opportunities, silence, refugee life, poverty, early marriages, young motherhood (starting between 9 and 12 years of age), and heavily enforced Islamic laws.

In Afghanistan, adolescent is an invisible category, and few understand the developmental stages and specific characteristics associated with adolescence. Girls face anxiety, leading to mental problems. Most are severely depressed by the social injustices and the oppression existing in the fragile post-conflict society. In this situation, it is vitally important to observe adolescent girls' identity formation

(Erikson, 1968) and shifting social roles and responsibilities (Thomson, 2002) to properly gauge their health and development.

The term “adolescent girl” has a complex meaning in Afghanistan. Semantically, the term “*zan*” (“women” in the Dari language) is only used for women who are married. The term “*dukhtar*” (“girl” in the Dari language) is used to describe a young girl and to recognize her virginity (Jones, 2006, Brydon and Chant, 1989). An Afghan female is no longer called a “*girl*” once she is married or reaches a child-bearing age and begins to menstruate (Legal Right and Voice, 2003). At that point, she is addressed as a “*woman*.” At the same time, it is culturally offensive to call a young, unmarried girl a “*woman*.” In the vast majority of cases, since adolescent girls marry at a very young age in Afghanistan, they prefer to be called “*woman*” or “*mother*.”

Afghan girls often face restricted mobility and limited access to basic information. Adolescent girls often face strong barriers that prevent their venturing outside their homes to the outside world. In order for adolescent girls to leave their home for health and education services at hospitals, clinics, or even schools, they first need permission from a male or from an elder in the family. Parents and family members must decide to give permission to girls to go outside their home. Radio and television provide girls with their only access to information.

For poor parents burdened with home chores, sending girls to school becomes a second or third priority (World Bank, 2005). Parents decide to prioritize, sending first boys and then girls to school. Primary education is accessible for young females between the ages of 6- to 8-years old; however, when females reach puberty or a marriage age, somewhere between 10- to 14-years old, participation in the outside

world becomes restricted. In a culture where marriage means that daughters become part of their husband's family, the incentives to educate girls are weak. Girls work at home and are perceived as less likely to bring home money to benefit the family. Impoverished, many families cultivate alternative livelihoods, some of which increase the health risks for adolescent girls. For instance, cultivating opium is a common practice in Afghanistan. Women and girls are directly involved in the harvest. Being in the field for a very long time and not having access to energy or food, many girls eat the opium seeds as a "pain reliever." While some families do well in trading and producing opium, others remain in despair and borrow money from landlords or "money lenders." In exchange for money, some families give away their daughters at the early age of 10- to 14-years old.

Many adolescent girls are illiterate and marry and have children at a young age (UNWFP, 2007). They often lack basic information regarding health. "Things that people usually know from school or from their parents—basic hygiene knowledge—is almost completely lacking here," asserted a hospital doctor at Medair, I-NGO (Brokner, 2006, p. 2).

A survey collected from fifteen schools with a total of 82,646 female students (Mukhatari, 2004) revealed the following:

- a) 3.9% of girls are married or engaged.
- b) 90.3% of the respondents thought that women should marry after the age of 16.
- c) Out of 250 students, 10% are engaged and the remaining students will be married before the age of 18. The Ministry of Education reinforces the

policy of transferring young girls who are married to vocational schools, limiting their opportunities.

- d) Eighteen out of 32 inmates in Kabul's women's prison were married before the age of 16. These women all faced family abuse and violence at home.

Bearak (2006) explains that adolescent girls are valued for their ability to: a) help families recover from debt and b) solve disputes among community members. This is done by marrying the girls off at a very young age. In this context, virginity is a matter of honor (the girl's value is factored according to the situation). As Bearak shares (2006):

A man named Mohammed Fazal, 45, took his second wife; 13-year-old Majabin, in lieu of money owed him by the girl's father. The two men had been gambling at cards while also ingesting opium and hashish. Afghan men want to marry virgins, and parents prefer to yield their daughters before misbehavior or abduction has brought the family shame and made any wedding impossible (p. 2).

Virginity and honor, as expressed by Carpenter (2005), are considered a "gift" of "symbolic import." Carpenter notes that historically fathers transfer their daughters as property to their new husbands. This transfer defines the woman's status as property and sets her valuation. As Deboyee (2003) asserts:

The value of girls lies first in the hymen and then in male children: if only daughters are born, the inheritance of family would be broken up at the death of their father, since girls leave the paternal home to join that of their

husbands. The young bride's virginity on the wedding night is the guarantee of being clean and "good." If the bride should not be a virgin, she will be sent back immediately to her father and the money spent for the wedding will be reclaimed" (p. 39).

In the cultural context, virginity has implications for social status, a girl's value in the patriarchal system, and society's traditional norms. Culturally defined, the term "virginity" relates to the level of "knowing." Reflecting on her quest to learn about the health issues of young Afghan women, Jones (2006) tells of a conversation she had with an Afghan health professional about virginity. They discussed the bleeding-and-few-do-not-bleed concept. The presentation of evidence of a girl's bleeding (on her wedding night) represents a symbolic validation of her status as an honorable girl. This is a socially constructed indicator. As Jones (2006) further quotes:

If people knew that some virgins do not bleed, they could send their girls for testing. In Kabul, many educated fathers bring their girls to us for testing before the wedding (p. 177).

Riphenburg (2004) discusses how traditional roles and responsibilities are divided, depending on what social influences affect adolescent girls. A woman develops from a pre-puberty "girl," to a "wife" after marriage, to a "woman" when she gives birth, and finally to a "respected old woman" at menopause. In a family setting, a woman is never called by her name; instead she is referred to as the "wife of so and so" or the "mother of so and so." Along with her title, a woman's duties evolve according to her status.

A woman who loses her male protector, however, faces an even more considerable

evolution of her status. After the fall of the Taliban, 40,000 widows have been recorded in Afghanistan (CEDAW, 2011). In a male-dominated society, a lack of male support in areas such as daily chores, health and education services, shelter, food, health care, and counseling continue to threaten widowed young women unable to perform these actions for themselves.

An adolescent girl's role also shifts if her mother is sick or dies. In either situation, the girl inevitably takes on more responsibilities, redefining her social role.

The concept of 'adolescence' has been developing over several centuries, with the vast majority of the research literature coming from the American scientific perspective. Adolescents everywhere, despite their cultural background, experience many of the same difficulties during the transition from childhood to adulthood. Yet understanding the particular historical, social, and cultural factors affecting female adolescents is critical to developing and implementing effective health and education strategies for young women in that society.

In this chapter, I examined theories of female-identity formation, paying particular attention to the importance of adolescent girls finding and expressing their 'voice' in regard to the material and social worlds in which they live. This self-expression is especially important in traditional-Islamic society where women rarely have access to the knowledge vital to their physical and emotional health and well-being.

I also reviewed a variety of literature regarding adolescents in Afghanistan, positioning adolescent-female experiences within the historical background of Afghanistan (e.g. pre-Taliban: 1973-1979; Taliban: 1996-2001; post-Taliban: 2004-present). While many women experienced greater political and educational freedom

during the Soviet era, many others (particularly those who lived in rural areas) did not. From the rise of the Taliban until the present, Afghanistan has seen a marked increase in adolescent girls' critical health concerns, particularly in regards to young women's social opportunities.

These increasing challenges, the literature shows, impact young Afghan females through identity issues, depression, anxiety, family conflict, and mental disorders (Rabab, 2005, Cardozo, B et al, 2005, Miller, 2006). These young girls also face a dismal 5% enrollment rate at the higher secondary level (Human Right Watch, 2006), poor or non-existent medical services in remote areas (CEDAW, 2011), and a highly traditional Islamic society (Grima, 2002).

CHAPTER 3

RESEARCH DESIGN AND METHODS

This study explores the following questions: *How does a young female's understanding of health issues shape her identity in northeastern Afghanistan? In what ways do the narrative stories of Afghan females link to issues such as education, health, and family dynamics? In what ways are the narrative stories of Afghan females linked to their cultural beliefs about health?* This section focuses on this study's research design, setting, context, researcher stance, sampling, and data collection—including interviews, participant observation, data analysis, and research limitations. The chapter will conclude with a discussion on research subjectivity.

Research Design

This study uses qualitative data to answer the research questions. To conduct this study, I relied on three overarching approaches: participant observations, in-depth interviews (Seidman, 1991), and narrative inquiry. Using an interpretive paradigm, I connected the research topic, the sample data, and narrative linkage-analysis (Gubrium, 2011) to create an overall holistic picture (Marshall and Rossman, 2006).

Rationale for Use of Qualitative Methods

In order to capture young adolescents' perceptions of themselves and their health, this study takes a qualitative approach, drawing upon personal narratives expressed in one-on-one interviews. To further explore the research questions, I sought to understand individually lived experiences that defined the participants' "frames of reference" (Marshall and Rossman, 2006). Understanding the

participants' lived experiences, perceptions of the world, and modes of expression enables greater comprehension of the complex realities of their lives.

I needed to explore and understand the phenomenon in its natural setting, so I conducted a qualitative study in northeast Afghanistan. As Bogdan and Biklen (2003) note, "human behavior is significantly influenced by the setting in which it occurs" (p.5). The qualitative method enables the researcher to explore complex social processes through detailed descriptions (Rossman and Rallis, 2003. p.18). It is also fundamentally interpretive, allowing non-prefigured findings to emerge during the course of the study (Rossman and Rallis, 2003). In summary, as Denzin and Lincoln (2005) write:

Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to the self (p.3).

My work in Afghanistan relied on non-fixed and non-predictable processes, dealing with uncertain variables and contextual complexities. Afghanistan was, and is, a complex place. In this challenging environment, a qualitative research design was the best fitted to explore and answer my research questions.

Narrative Inquiry

The methods of the qualitative-research paradigm were designed to be flexible. In this study, I listened to the narratives of young females as they shared stories about their life experiences. Using narrative inquiries, I sought to explore the girls'

experiences, so that I could understand and communicate their underlying perceptions of health (Connelly and Clandinin, 1990).

Narrative inquiry is interdisciplinary and includes such areas of study as sociology, history, education, biography, and autobiography. In feminist studies, narrative inquiry brings out the female “voice.” In this study, I capture the voices of young, Afghan females as they “make a point, and transmit the message... about the world the teller shares with other people” (Chase, 2003 p. 274). A narrative inquiry allowed me to engage and learn from young, Afghan females, as they shared their own perceptions of life. As Krause (2009) points out:

To do justice to the richness of the oral materials, the narratives needed the context. They needed life....negotiate the tension between life as it is lived and life as it is typed onto a page (p.12).

The narratives lift the “silent voices” (Fox, 2009) of the adolescent girls, bringing out the participants’ own views and perspectives (Cortazzi and Jin, 2009). Narrative inquiry, according to Connelly and Clandinin (1990), is divided into two sections—the “story” (i.e. the phenomenon) and the “narration” (i.e. the process of inquiry). The authors indicate that “people by nature lead storied lives and tell stories of those lives, whereas narrative researchers describe such lives, collect and tell stories of them, and write narratives of experience” (p.2).

On the epistemological level, narrative inquiry leads to questions about how we know the truth. It suggests that narratives look “around the broader and more inclusive question of the meaning of experiences” (LaBoskey 2002, p.15). It is the study of a phenomenon, a probing for deeper specifics, and the eventual capture of

the phenomenon in the form of a story. This process of capturing and presenting the story gives a “voice” to the person’s experience. Methodologically, narrative inquiry relies on the context, the importance of emphasized meaning, the tone set (LaBoskey, 2002), and the separation of “fact” from “fiction” (Clandinin, Connelly and Chan, 2002). With in-depth interviews and lengthy descriptions, these narratives can present the richness of the phenomenon.

One distinct difference between interviewing to gather data and interviewing to conduct narrative inquiry is the critical need during narrative inquiry to develop conversations requiring openness and emotional engagement, which potentially open the door for a long-term and trusting relationship between the interviewer and the participant (Lincoln and Denzin, 2003). As Fontana and Frey (2005) note:

The interview is a conversation—the art of asking questions and listening. It is not a neutral tool, for at least two people create the reality of the interview situation (p. 643).

Research Setting and Context

Location: This study was conducted in Talokan, Takhar Province, Afghanistan.

Why: This location was chosen because of its accessibility for me as a researcher. In this region, I possessed an invitation and organizational affiliation, granting me a culturally acceptable base of operations for my research. I was hired as a consultant for the Marigold Fund—a US-registered non-profit organization that operates in Talokan—to conduct an evaluation of the Midwifery Education Program operated in partnership with the Afghan Midwife Association in Takhar Province.

Description of Talokan: The city of Talokan is the capital of Takhar Province.

Talokan is located in the northeast of Afghanistan. According to World Gazetteer (2011), its population in 2010 was 46,292 with the following demographics: Tajiks, 60%; Uzbeks, 32%; Pashtuns and Kyrgyz, mixed percentage. Talokan has a long history. Travelers of the old Silk Road mention the city, and the old city to the west of the river was described by Marco Polo in 1275 CE (Afghanistan culture article, 2012). The area around Talokan is mostly agrarian. However, as there are no jobs or resources in the surrounding areas, especially for the younger generation, Talokan is urbanizing uncontrollably as people leave their rural districts and villages to come to Talokan to find jobs. Agricultural lands (green fields) are being rapidly converted into residential areas.

The main sources of income for Talokan residents are small dairy productions (milk and its products), businesses (small shops, markets, street vendors), and social services (public baths, hotels, coffee houses, public transport, and government).

Dr. Karim⁵ (2012), observing the development of the Talokan area, stated:

Each morning, there are hundreds of men looking for daily wage work at the main square of the city. There are some high-ranking government officials, warlords, and businessmen who have obtained high socio-economic status,

⁵ I gathered the information about Talokan from e-mail communications with Dr. Karim (pseudonym) (February, 2012), who is from the Talokan area. He provided information about the culture, socioeconomic situation, and status of education and health. Dr. Karim agreed to share the information for the purpose of my thesis. His e-mail communications were based on his observations, interactions with the locals, and his own historical and cultural observations of what was happening in Talokan.

but they are a small percentage of Talokan population. Majority of people are earning hardly enough money to survive, especially those recently moved to the city from districts. The number of beggars, especially women and children is increasing; more than 200 women and children are spread around the city daily to beg.

In Talokan, the men generally work away from home and are the primary income generators for the family. The females generally stay at home and are responsible for raising children and housekeeping. Dr. Karim notes:

Women and children are eating lunch alone and therefore they eat simple food; sometimes only tea and bread. The best food is prepared for the dinner because men are coming back home in the evening. The decision about what to cook for dinner is made by men and mother-in-laws.

Women, housewives, and girls, however, can come together and see each other on special occasions, such as wedding parties, family events, and other ceremonies. Women wear their best clothes on those days. As golden jewelry is a symbol of being rich, the more gold a women wears, the richer she looks.

Schools were promoted in Talokan from 2004-2011 and now schooling is accessible for both boys and girls. Some of the families, adhering to fundamental Islamic values, still do not allow their girls to go to school; however, there appear to be few of these families in Talokan. Thousands of students are enrolled in the local schools. Almost all of the schools are government-funded. (The international community—primarily Germany and the United States—built many of the school buildings in Talokan.) There are only three private (paid) schools in Talokan. The

private schools provide a higher quality of teaching than the government schools, but not all families can afford the costs of the private schools.

Dr. Karim states:

The quality of teaching is relatively poor in government schools. The main reason is low salary payment to the teachers. Teachers are getting 6000-11000 Afghani (equivalent to \$120-220 US) per month. It is not sufficient for running cost of a small family. Some of the teachers do not own their house and they end up paying a house rent. The minimum rent is 5000 Afghan Rupees (equivalent to \$100 US).

In addition to the regular classes, numerous private courses are offered in subjects such as English, science, math, Dari, etc. Families must pay for these supplementary courses. Students must pass an entrance exam, locally called a *concur exam*, in order to be admitted into a university. Students who do not attend a one-year exam-preparation course are unlikely to pass the exam.

Access to health facilities has also improved considerably, according to Dr. Karim. In 2002, there was only one 50-bed hospital in Talokan, but by 2012 there was a well-equipped and staffed 120-bed hospital. There were also four Out Patient Department (OPD) Clinics in the city. Due to the vulnerability of mothers and children, the hospital and clinics focus on maternal and children's health. These achievements are fragile, however, because the hospital and clinics are funded through international aid. At present, the government lacks the revenues to maintain health services without international support, so any decrease in international funding will likely cause deterioration in health services. This lack of

funds undercuts Afghanistan's constitutional commitment to provide free governmental health care at governmental facilities.

There are around eighty private clinics and drug stores in Talokan; patients must pay for the services they receive at these facilities. If they can afford it, people travel to Kabul, Pakistan, or even India for chronic or complicated cases. Sometimes the cost of health services can be catastrophic for families, and they must sacrifice their basic needs to pay for health care.

Mullahs (Islamic religious preachers) and religious leaders strongly influence culture in Talokan. They dictate, according to Islamic guidance, what people may or may not do. While not necessarily fully compliant with the religious instruction, the people actively listen to these religious leaders.

Almost all of the people in the city have access to TV and radio. Ay Khanum, Hamsada, Kalid, Takharistan, Mehr, and BBC provide radio broadcasting. TV broadcasting channels in Talokan include: Ariana, Tolo, Ayana, ART, and Mehr. Indian, Turkish, and Iranian TV movies directly impact the culture. As with any media, the serials/movies/soaps that people watch convey both positive and negative messages. The mullahs seek to prevent people from watching the movies, and some families are encouraged to destroy their TVs. In some families, parents do not allow their children to watch TV at all. These families worry about the "invasion of western culture." According to Dr. Karim, the locals believe that current technology (TVs, movies, mobile phones, etc.) is being misused by the younger generation, making them deviate toward Western culture.

Most people in Talokan strongly oppose the Taliban regime and support the current government. Uzbeks and Tajiks are the two major ethnicities in Talokan. The Uzbeks support the Junbish Party (JP) and follow its leader, General Abdul Rashid Dustom. Over 95% of Uzbeks support his political viewpoints. Tajiks, on the other hand, support the Jamiat Party (JP). Its former leader, Burhanuddin Rabani, was assassinated in Kabul by the Taliban in 2012. Many Tajiks support Dr. Abdullah Abdullah. Dr. Abdullah wants to achieve the vision and goals of the Afghan hero, Ahmad Shah Masoud, who was assassinated September 10, 2001.

There is ongoing conflict between the Tajiks and Uzbeks in Talokan. During the summer of 2011, Talokan witnessed an armed conflict between these two groups. Uzbeks claim to be the majority in Takhar and want their power to be proportionate to their numbers. Due to this disagreement, political power continues to remain an issue at both official and unofficial levels in Talokan. Pashtuns are a relatively small community in Talokan. They mainly support the current government led by Hamid Karzai. These ethnic divisions continue to be the strongest political divider in northeast Afghanistan.

Description of the setting when I arrived

Upon my arrival in Kabul (June, 2010), I encountered a volatile environment and two major events. The first involved allegations that international organizations and communities were engaging in illegal evangelism; after the allegations were made public, protests broke out (Sandelson, 2010). Following significant media interest, the Ministry of Interior Affairs claimed that local churches had been launched in

some places. After the demonstrations, Afghans were suspicious of employees of any international organization who approached them, let alone asked to interview them.

The second event was Kabul's hosting seventy members of the international community for a Peace and Reconciliation Conference. Due to the Taliban and governmental leaders in the city, security was increased, new checkpoints were added, and an anxious atmosphere pervaded the city. The anxiety was echoed in the conversations of the people on the streets. Yet people also expressed hope. Everyone hoped that this conference would bring future stability to Kabul, its outskirts, and, possibly, even into the provinces and remote villages.

Researcher Stance

My role as qualitative researcher was multifaceted. Denzin and Lincoln (2003) would call me a "jazz improviser." Janesick (2003) would call me a "choreographer." Rossman and Rallis (2003) would call me a "learner" in the journey of inquiry. In many cases, I was a "lone ranger" per Bogdan and Biklen (2003). The more involved I became with my research, the more I saw myself as an improvising jazz performer—adapting my research methods to the environment and context of the field. In this study, I sought to depict the complex phenomena I observed. Like a choreographer, I approached the topic holistically. This complex process forced me to make decisions about: where to pause, where to continue, how to apply research ethics, and where to push for more in-depth inquiry. As a learner, my role was to learn and inquire into remaining uncertainties. My role was not confined to any one definition; it evolved in accordance with the complexity of the contextual realities.

Sampling

This study involved ten Afghan females, ages 18-21, from Talokan, Takhar Province, in northeast Afghanistan. My approach to selecting study participants was to consider “accessible sites (convenience sampling) and build on insights” (Marshall and Rossman, 2006, p.70).

First step: While conducting this study, I traveled twice to Talokan. I traveled there first in June/July 2010. During this trip, I was unable to identify females whom I could interview. Because of security constraints, I could not pursue my investigation outside my office. I had to content myself with the resources available in the office. And, as few Afghan officials came to the office, my search for information was circumscribed.

When I arrived in Talokan, I was known to be working for an American non-governmental organization. I recognized that it would take time for people to understand the difference between my dissertation and my work responsibilities.⁶

I asked an education advisor for the Marigold Fund for recommendations for my field-visit process. In particular, I asked her how to find and approach adolescent females, ages 18-21. My criteria for participants was: a) participants must be females between ages 18-21; b) participants must live locally (for easy access); and, c) must be Dari speakers (segments of the local population spoke Uzbek or Pashto).

Also, because Seidman (1991) says, “do it yourself” when you wish to make contacts in the field, I asked the education advisor for the names of local schools,

⁶ The Marigold Fund had me conduct a field-level evaluation study of the effectiveness of an Afghan Midwives Association continuing education program they were co-implementers of in Talokan. While in Talokan, I was also able to do my doctoral research field data collection, but I had to keep the two sets of data separate.

clinics and *shuras*⁷ that I could approach to identify participants for my study. I also shared my request with the Director of the Afghan Midwife Association (AMA), and she conveyed my message to local midwives. I inquired among the local midwives with whom I was working. As I got to know them, I would ask if they knew or could recommend families with females between the ages of 18- and 21-years old. The midwives spoke to others midwives, their sisters, and their daughters; often they suggested the names of mothers of adolescent girls. Several midwives contacted me to learn more about the purpose of the study and to give me contact information for individuals they thought could help me.

Second step: During my second trip to Talokan in October 2010, I was more successful in data gathering. Some people already knew me and my return demonstrated my commitment to the study and to the people.

Participant Observation

Weiss (1998) describes observation as a tool to understand complex realities:

One of the endearing advantages of observation is that it does not involve asking anybody anything, and therefore it does not usually introduce the biases that obtrusive questioning can bring about.... However, observation as a method of data collection remains vulnerable to bias. The observer is the instrument and brings her own set of blinders to the task. She sees what she is looking at, and maybe what she is looking for (p.153).

Observation is used to understand the actions, the circumstances, the environment, and the context; it provides specifics, details, and examples. Schwandt

⁷ Shuras are local committees. Each community has a local female *shura* which maintains data on females by community, village, and household.

(2001) suggests using observation to develop *thick* descriptions by “recording circumstances, meanings, intentions, strategies, motivations and so on that characterize a particular episode” (p.255).

My observations were mainly conducted during the interviews. I also observed participants during non-formal discussions after the interview sessions were finished. Two participants were interviewed in their homes, so I made observation notes about their home environments. Two other participants invited me to their homes for non-formal visits. I was able to make more detailed observations about the participants who invited me to their homes—observations based on their physical surroundings, family connections, and conversations they held with their siblings, mothers, and family at large.

My notes, which included descriptions and detailed observations, were recorded in journals. I developed an observation guide (see Appendix C) to outline non-formal aspects I wanted to observe and record (e.g. description of the location). On the margins, I noted additional observations about symbols, thoughts, and brief reflections. My field notes were all handwritten.

Occasionally, while writing in my field journal during interviews or non-formal conversations, I felt like an “untrustworthy female spy” (Punch, 1994). I wanted to remove that perception, so that the interview could be more natural and contextually acceptable. I decided it would be better to write the participants’ words and my observations down later, so that people did not see me jotting down on paper everything they said and I saw.

Interviews

As Fontana and Frey (2005) observed:

The interview is a conversation—the art of asking questions and listening. It is not a neutral tool, for at least two people create the reality of the interview situation. In this situation, answers are given. Thus the interview produces situated understandings grounded in specific interactional episodes (p. 643).

I conducted 13 sessions of in-depth interviews. Each interview session continued for 90 minutes—sometimes up to two hours in length. As Seidman (1991), shares:

Given that the purpose of this approach is to have the participants reconstruct their experience, put it in the context of their lives, and reflect on its meaning, anything shorter than 90 minutes for each interview seems too short (p.13).

Even 90 minutes felt short for me. I strongly felt that the female participants needed to get comfortable enough to respond (which takes time). Waiting for their response and then clarifying the responses required time. For example, a few participants required me to clarify the questions repeatedly. Some participants took a longer time to respond.

The individual interviews varied in length. Some participants had to finish the interview and go home early before it became dark outside. 4:30 p.m. is often considered late in Talokan. Some female participants only had parental permission to be in the office for an hour and a half. I often felt I needed more time, however, as

participants would take a long time to answer and, when they did, would respond with long pauses or silence in between their words.

Prior to setting up an interview, I spoke to each participant on the phone. I was aware that participants might need time to understand the concept of the study. I conducted short briefings about the University of Massachusetts' norms and procedures, research in general, and, specifically, my study interest. I spoke with each participant about the interview process, describing it from beginning to end, and ensuring that they understood that they could stop me and ask for clarification if the questions were unclear. I gave the interview guidance in Dari.

I often felt as if I was offering a training session rather than creating a comfortable environment for the participants to discuss their lives. By describing the process, I felt that I talked too much about procedures (i.e. we will do this, you will do this, and this is how long the interview will be). Several participants later shared that they thought the interview was for job selection.

Table 1 lists the study participants by name (pseudonyms), age, student/employment status, and the date and location of the interview. All participants were interviewed in the Talokan area.

Table 1 Participant list. Continued onto next page.

Name	Age	Status	Date of Interview and location
Illaha	18	Full-time second-year student at a university in India. She was visiting her parents during the summer break.	July 19, 2010. The interview was conducted in my guesthouse.
Kimran	18	Full-time second-year student at the Teacher Training Institute.	July 22, 2010. The interview was conducted at Kimran's home.
Suraya	18	Part-time science teacher at a school for children with special needs.	July 23, 2010. The interview was conducted

			at Suraya's home.
Nigina	19	Unemployed.	October 11, 2010. The interview was conducted in my guesthouse.
Orzu	20	High-school student.	October 13, 2010. The interview was conducted in my office
Zuhal	22	A teacher at a school for children with special needs.	The morning of October 14, 2010. The interview was conducted in my office.
Mushtari	20	Unemployed.	Afternoon of October 14, 2010. The interview was conducted in my office.
Sayora	19	Full-time second-year student in the English Department of the Institute for Teacher Training.	Afternoon of October 16, 2010. The interview was conducted in my office.
Dilrabo	18	High-school student.	Afternoon of October 17, 2010. The interview was conducted in my office.
Mizgona	19	Unemployed.	Afternoon of October 18, 2010. The interview was conducted in my office.

Informed Consent

Ethical issues in qualitative research are important. Sikes (2004) states that: "ethics has to do with the application of moral principles to prevent harming or warning others, to promote the goods, to be respectful and to be fair" (p.25). I addressed the participants' confidentiality at each stage, and I presented them an explicit consent form outlining the assurance of confidentiality. It stated that no harm would result to the research participant, that the study findings would only be used for the purposes of my dissertation, and that the use of the data would be contingent upon the consent of the study participants.

I had to share, demonstrate, and explain the informed consent form in the participants' own language. I translated the consent form from English (see

Appendix A: Inform Consent in English) to Dari (see Appendix B: Inform Consent in Dari) so that the participants could easily understand it. I gave it to each participant to read. Realizing that the participants might say “yes”—in respect to the *mehmon* (guest)—without understanding the ethical issues involved, I encouraged them to ask questions.

During the initial reading of the informed consent, I noticed that some of the participants had a difficult time reading the form. I had assumed that the participants could easily read and write. My assumption, however, did not align with reality. The participants spent a long time reading the consent form. In subsequent interview sessions, I read and explained it (in Dari) to the participants. This method worked well.

The participants asked me one question: “Where will you take the information?” This was a very legitimate question, and I was glad that they asked it. I was pleased with the participants’ questioning for two reasons: 1) they were taking a step forward, out of a cultural norm that required them to “never ask [outsiders] questions,” and 2) they were forcing me to explain the research process and the use of the data collected. Some participants expressed a desire to have their stories shared: “Yes, use the information and let the outside [outside Afghanistan] know about our problems.” Other participants said that they understood the research ethics and why they were important. All the participants signed the consent form. The participants were more protective of their phone numbers with some sharing their mother’s phone number.

Interview Setting

The interviews were conducted in my office, in my guesthouse, or in the participants' homes. I often wondered: "If I would go to the participants' houses, would they be more open, more relaxed there?" But I knew that by going into their homes, I could create more challenges—such as tension caused by "an outsider" visiting the home and office security issues (per my guidance: "do not go to Afghan homes"). Several mothers, wanting to know who I was, came with their daughters to the interview sessions. In my reflective memo, I wrote:

Trust is very important. It takes time to gain trust. Now I understand that the researchers need to be in the field longer to assure the participants that they are safe. I need to show my presence here. Participants want to feel safe and they want to trust me, relate to me and they need both protection and my availability shows to them that I can be trusted. It is good that I am back to Talokan (Reflective Journal, October 2010).

Interview Process

Prior to the interview, I explained the interview process and told them that the interview would last 90 minutes or longer and be recorded. I also explained to the participants what would happen to the data and how it would be used. While discussing the consent form, I informed the participants that if they felt uncomfortable with the research or questions that they were free to withdraw at any time from the study or interview. Mothers were also free to object if they became uncomfortable with the interview topic or conversation.

The mothers' main hesitation was caused by the interview setting. Of particular importance, males could not be around while the participants entered the office premises. I had to ensure that no male guards could see the participants coming and, subsequently, were not in front of the office doors.

All ten interviews were tape-recorded. In one instance, the tape recorder did not work, and I had to take notes in my journal. In a second instance, the participant asked me to turn off the tape recorder because she was not comfortable sharing some of her views on tape. After each individual interview, I noted my impressions, the environment in which the interview was conducted, and whether my questions were clear to the participant. My reflective notes/journals proved helpful during the data analysis. I often encouraged the interview participants to ask me questions in order to clear up misunderstandings and clarify my questions. The interviews and conversations were conducted in Dari, because the participants were most comfortable with it (Rossman and Rallis, 2003. p.259). Even the participant who insisted on speaking English would switch to Dari during the conversation.

Interview Content

I categorized the interview questions by the study's theoretical framework, focusing on female identity, voice, health issues, and shared perceptions of medicine.

I opened the interviews by asking them to tell me about themselves. I next questioned them about their understanding of female health, asking questions, such as, "what does it mean to be a healthy girl?" My third set of questions dealt with their perception and understanding of health issues, such as body image and illness.

I concluded with questions about their current lives and future dreams. (See Appendix D for the Interview Guide and Lists of Questions.)

The process of transcribing the interviews was conducted between September 2011 and November 2011. Tape-recorded interviews were first sorted electronically. I typed the transcripts while I listened to the recorded interviews. All the transcriptions were typed in English letters but in Dari words. I then sequenced the transcriptions by interview dates to provide for easy reference (Reissman, 1994).

After completing the transcription, I undertook the second step of the process—translation. Translating the interviews was a process of “the transfer of meaning from a source language...to a target language” (Marshall and Rossman, 2006 p.111). While I am fluent in the local Dari/Farsi language, I employed several strategies during my translations to ensure accuracy. These strategies included: a) verifying the meaning of unknown words with a local person, b) leaving phrases structurally intact and italicizing them to guard against corrupting their cultural meaning (suggested by Marshall and Rossman, 2006, see page 112), and c) literally translating poems, idioms, and metaphors unless I knew their exact and universal meaning from academic literature. I kept my own notes and journals in a mix of languages (i.e. Shugni, Russian, Dari (in Cyrillic), and English) to easily access my original thoughts and impressions.

While transcribing, I often recalled the circumstances of the interviews. For example, I recalled having electricity problems during the interviews and sitting on the floor in a dark room for few more minutes to try to finish the interview before

my battery went out. I remembered my impressions of the interviewees and their facial responses to my questions. I would then write my recollections down.

Data Sorting

In organizing the data, I used Boyatzis' (1998) stages of data sorting. During the first stage, the code development, I gathered all the data together so that I could visualize it—the papers, notes, journals, etc. This process, according to Boyatzis, permitted me to “see” my data (1998, p. 10).

I next read the raw data, looking for code-able moments. During this process, I had to understand the data in order to make decisions. For example, I coded education “concur exam-monster” and then subdivided it into further codes. These further divisions included such codes as “no money for school/college/university,” and “missing grandfather.” Sometimes, for one transcribed line, I would have three codes. I used several colors to differentiate my codes and to assist me in visualizing my raw materials.

It is important during the data-analysis stage to understand the difference between analysis and interpretation. As Wolcott (2001) writes,

Interpretation, by contrast, is not derived from rigorous, agreed-upon, carefully specified procedures, but from our efforts at sense making, a human activity that includes intuition, past experience, emotion—personal attributes of human researchers that can be argued endlessly but neither proved nor disproved to the satisfaction of all (p. 33).

I anticipated that my work with the narrative stories could affect me emotionally. Therefore I strove to maintain neutrality in my understanding and empathy during the data reading and its interpretation (Patton, 1990).

Data Analysis

I conducted data analysis and interpretation in parallel with data collection. At the beginning stages of data collection, after collecting some data, I re-assessed the questions and made required modifications (Bogdan and Biklen, 2003). Initially my questions were too broad to answer easily. In the mid-stage of data collection, I again re-assessed to what extent my data “rang true” (Rossman and Rallis, 2003). I found it helpful to refer to my notes to understand the implications of the participants’ narratives.

During each stage of the data transcription, I wrote analytical memos (Rossman and Rallis, 2003). (See Appendix E for an example of an analytical memo). They focused mainly on concepts discussed in the interviews and my research methodology and data collection. My analytical memos contained two reflection sections. One reflection focused on understanding the interviewee’s worldview. The second reflection analyzed my methods, questions, and interview settings. I was also interested in my responses and what I was learning through the interview process. To record this process, I kept a reflection on myself during the transcriptions.

I embedded my analyses in the framework and concepts of identity, female voice, and cultural background. From these concepts I developed categories to help me take greater meaning from the narratives (Reissman, 2008, Rossman and Rallis 2003, p. 282).

As I categorized these three concepts, I cross-compared factors to determine the relationships between divergent factors, such as age, family, and social determinants (Mckay and Diem, 1995). I sought to link the participants' health experiences with their perceptions of health (Riessman, 2008, Gubrium, 2011).

Limitations of the Study

This study focuses on adolescent females' perceptions of health issues in Talokan, Afghanistan, as depicted in their personal narratives. Such a study is limited by its specific context and temporal boundaries. The data collected is location-specific, and the study's findings only represent the perceptions of adolescent females in the Talokan area. The findings should not be generalized to other provinces or locations in Afghanistan, to other social issues, or even to other females' experiences and perceptions of health. This study is about exploring adolescent females' perceptions of health issues from *their* perspectives. It is *not* about technicalities or explanations of medical diseases and treatments. The study is *not* about access to health care. Nor is it about the quality of health services young females receive in Afghanistan. The methods and general themes highlighted in this study, however, are transferable (Marshall and Rossman, 1999), and the findings, methods, and data collection could prove useful for future studies in rural areas of Afghanistan, Central Asia, or South Asia.

Reflections: My subjectivity

The handling of "self-other relationships" (Heshusius, 1994) proved an important challenge to manage during the data-collection process. In the first phase of interviews, I attempted to be objective by keeping my biases, predispositions,

views, presumptions, and academic knowledge to myself. I believed that the interviewees would respond based on the questions I asked. That did not happen. For example, when the participants talked about not passing the entrance exam to enter a university, I was not satisfied with their responses. This was not what I wanted to hear. I had asked about “health issues” and their “perceptions of health,” but they talked about education instead (Reflective Journal notes, July 2010, Talokan).

To maintain my objectivity, I stayed close to my previously designed questions. Yet the more I focused on health-related questions, the more disappointed I became with the answers. If I received an on-topic answer, it was as if the interviewee was reading it out of a book or answering a question in a formal school exam. I found the “objectivity-subjectivity dichotomy” confusing (Heshusius, 1994).

I had a strong sense of “tacit knowing”—“the knowing that we know, but cannot tell” (Heshusius, 1994). I found myself struggling with research objectivity and the sense of “knowing” that I sought from others.

I was confused as to why the participants would talk about family, grief, exams, or house guests, but not about their views on health issues. Similarly, when I talked about females’ puberty phase, they remained silent. I understood why such silence prevailed, but I did not know how to adapt my research approach to their silence. I would hear how “sad” the participant was about “not passing her exam” (Reflective Journal notes, July 2010, Talokan), but I did not see how such a response answered my research questions.

I had to accept that I was also part of the learning process—the subject and I had joined. Peshkin (1998) suggests that while researching, researchers sometimes capture “feelings and reactions” (p.18). I did that periodically. Some of my subjective “feeling and reaction” was part of my learning process, the integration of the whole process of “knowing.”

As a Muslim, my religious identity is defined by the Islamic religion (Peshkin, 1998). I was surprised that my religious identity was less important during the interviews than my Tajik ethnicity. While aware of my Tajik ethnicity, I have been constantly exploring and re-defining my Muslim identity. I often felt during the interviews that my Tajik ethnicity overshadowed my religious identification. The participants saw me as a Tajik and referenced it in a number of ways. I found that I identified with the participants as a Tajik. For example, participants said, “I am Tajik, you know.” Others said, “I am from Badakhshan, you know” or “this is not like Kabul, you know.” I understood exactly what they were saying. Not because of my Tajik background, but because I had worked in Badakhshan, Kabul, and all over Afghanistan. My spoken Dari mixed Dari and Tajik accents, so the participants would comment, “I understand [your language]. In television, they speak like you [Tajik television broadcasts across Afghanistan] as well.” One participant shared that she does not cover her face and that she wears *patlun* (women’s pants or jeans) (Reflective journal notes, June 2010). I knew the implication of wearing *patluns*. It indicated education and a willingness to disregard the local dress-code. I understood how that felt.

Peshkin's "justice seeking" (p.19) also pulled me toward subjectivity. The participants talked about their education and how difficult it was to pass their exams. It appeared more difficult for females than for males. In my reflective journal, I called it the "monster exam." The pressure and expenses of English courses, private universities, and complicated national exams made the whole system a "monster" and prevented females from obtaining a proper education.

I sensed the participants' shyness. At times they had an "unsure" look when responding to my questions or speaking in front of the tape recorder. I often wondered, "How many times per day have these girls ever been asked their opinions or to share their innermost thoughts?"

The participants' tears during the interview (Mushtari, Sayora, and Orzu) indicated that they were fighting for basic human rights: shelter, education, career, marriage, and family. I would comment to myself, "How painful this has been for these girls, as they seem emotional for two and half hour when sharing their life experiences during the interview: do they lack words or it can be more painful than I will ever imagine or understand?" I found myself acknowledging that I had experienced, more or less, the same emotions as I had pursued my own educational journey and maturation process.

I came to see in their eyes, hear in their voices, and witness in their subtle gestures, the poverty and hopelessness in their lives. The participants were extremely embarrassed to enter my office with their shoes. They felt judged, because their shoes were dusty. Some of the girls even hesitated to drink the tea I offered. Only after encouragement, would they finally drink it and eat something. I

never knew exactly how they felt, of course, but I had experienced the kinds of feelings they were experiencing: the shyness, the desperation, the despair.

When my family and I experienced the civil war in Tajikistan (1992-1993), I became familiar with what it feels like to go without eating for days on end. The participants' subtle messages awoke in me strong emotions and feelings.

Noting their faces, I observed to myself: "very young and yet wrinkles are all over their faces, tears in their eyes, dry lips and deep sadness." As the participants recounted how poverty, religious puritanism, male dominance, harsh living conditions, poor self-worth, and a mixed sense of identity were wrecking their lives, I became terrified. The injustice and irrationality of war and its effects on humans aggravated and terrified me (Reflective journal notes, October, 2010).

I found it most difficult to restrain the *human I*. The *human I* was always in conflict with the *justice-seeking I*. For me, the *human I* made the interviews hard. I always felt sad afterwards. I kept thinking about what would happen to the participants after I left. They often invited me to visit their homes. With my limited mobility, however, I was unable to go. My *human I* was reciprocated. Sometimes the participants would say, "Come to our home. Don't be alone in your room," or "where is your family," and "why are you far away from your family? Don't you miss them?" The participants were curious about my life. During the interviews, I normally restrained my emotions, but afterwards, I was sad.

I understood why they empathized with me. They recognized that I was not allowed to leave the narrow confines of my office and room. The participants invited me to their homes so that I would not have to sit alone in my guest room. The office

guards also recognized my isolation and would ask me in the evening if I needed anything. Sometimes the participants phoned or texted me in the evening. They would write, "How are you?" or "What are you doing?" Some texted me to say, "I was happy to meet you today." One participant (Orzu) left a note written on an office board following her interview that said, "I am very happy today." She had ornamented the note with drawings of a smiley face and a flower. Another participant (Kimran) invited me to go to the market with her on Fridays; however, I was restricted and not allowed to go out on Fridays.

CHAPTER 4

NARRATIVE STORIES

This chapter contains the stories of ten participants. These stories reveal significant experiences in the participants' lives that have impacted their concepts of health. All ten participants responded to similar queries, such as; a) Tell me about yourself; b) What is your understanding of what "health" means and what does it mean to be a "healthy girl"? They were also asked about their sense of body image, their memories of happy and sad moments in their lives, and dreams for the future.

All ten participants responded to the questions, but not always directly. Yet, after listening to their narratives, it is possible to draw links between their concerns, experiences, and understanding of health. These narrative stories display a rich constellation of life experiences (Gubrium, 2011) and lead us to a greater understanding of health, embedded within their identity, hidden female voices, and cultural beliefs.

Illaha

Illaha is 18-years old and is the eldest daughter in her family. She has a mother and a father, one sister and two brothers. Her mother is a gynecologist and her father finished his engineering degree during the Soviet regime (1980-1988), which provided educational opportunities for Afghan youth. Illaha studied in Tajikistan through sixth grade and returned to Afghanistan to complete her high-school education in Takhar Province. At present, Illaha is in her second year of studies for a bachelor's degree in business and commerce in New Delhi, India. A scholarship made her studies in New Delhi possible. Illaha misses her mother and her youngest

brother the most, but she also misses her cousin, who is her “best friend.” Her cousin is in Afghanistan, and Illaha has not yet found friends in India. She says,

Mostly when I am sick, I remember my mother. When I want to share something, I remember my friend. When it is lonely, I remember my youngest brother. At nights [many nights] that I remember them [my mother and my brother], I cry (Interview, July 19, 2010. Talokan).

As Illaha talked, her emotional closeness to her mother was evident. In the past, during times of sadness, family crisis, or Illaha’s personal grief, Illaha’s mother provided comfort. Both Illaha’s mother and father gave her advice when she needed it.

Illaha’s view of health is broad and holistic:

A healthy girl to me is a person who is tension-free. She should not have stress from all the things in life, for example not only sickness, but also some anxiety of life should not be there. She should be tension-free (Interview, July 19, 2010).

Illaha described her monthly period experiences. She had her first menstrual cycle period (menarche) while she was in eighth grade. When asked about her reaction to this discovery, she responded:

When I saw it [bleeding] I got scared. Before that I knew a little bit [about periods] since my friends told me about it... I did not share with my mother; I was feeling embarrassed. I felt that I have to be alone, walk alone, and sit alone. I did not like myself; to be honest [laughter] (Interview, July 19, 2010).

Unlike many of the Afghan females that I interviewed, Illaha talked with a smile while we discussed body image (Observation, July 19, 2010).

I am thinking that I am fat. Sometimes my friends say that ‘you are fat and this outfit (indicating the dress she was wearing or *shalvar kamis*⁸) does not suit you’. I would be upset about it [her friends calling her fat]. Because I have classes, I must eat. Otherwise, I do not want to eat food. I wish I had a slim body (Interview, July 19, 2010).

While talking about body image, Illaha brought up and directly linked, guidance that her mother had given her:

When I was a kid, my mother said ‘do not use this’ [indicating mascara, eye shadow, lipstick, face powder], and said, ‘this is not good for you’. When you grow up, then you can use it’ (Interview, July 19, 2010).

Illaha wears the chodari (Observation, July 19, 2010).

Yes, it is very tiring. I get headache. It is also very hot underneath. But I have to wear it. When a person wears a chodari, you cannot see in front of you [pause]. When the sun reaches your eyes or gets on the way [walking towards the sun], you cannot see it [the road or pathway ahead of you] and cannot walk. You walk blindly. Even if there is no sun, still it is very hot underneath of chodari. [How do you see then at night?] At night, since not many people see, you open your face (Interview, July 19, 2010).

Illaha is mainly stressed by “people’s talking” or “gossiping.” Illaha told a story about something that happened a year and a half ago. Sometimes Illaha talked to a

⁸ Shalvar and Kameez are clothes worn by women in South Asia. Shalvar are wide trousers, and a kameez is a long shirt, often made wide and loose.

male cousin (the son of her aunt). He would sometimes call her and ask about her activities at school. Illaha (switching to English) recalled:

He was my friend. Not more than that [stressing tone], he was not my boyfriend [nodding head]... only my friend. Some of my relatives became aware of it and they started spreading it [talking at the wedding gatherings]. When I heard about it, I was crying. I got sick, and I would get headaches. I would cry a lot (Interview, July, 19, 2010).

Eventually her parents found out about it after asking her why she was sick so often.

It was misunderstanding... misunderstanding, you know. That was not nice. When my father find out, he told me: 'Do not talk to that boy'. After that I told the guy, 'never call me again and I will not call you. Never call me'. My father does not allow me to be in contact with this boy (Interview, July 19, 2010).

She shared a second story about a stressful situation; this one about her experience sharing a dormitory room in India. Illaha stated:

I had two roommates. They were both from India. One girl was nice. The second girl was aggressive and often said, 'you always disturb me'. If I would walk and if there will be noise from my sandals [while walking in the room], she would argue and say 'do not do this, do not do that'. I would cry a lot. [Why? Did you talk to her after?] One time, I had to prepare for my exam. I had to stay late night and work. It was 2:30 a.m. and she got up and said, 'turn the light off'. I said to her 'I have exam' but she was arguing with me'. In

that time, I also started arguing. [What did you say to her?] I said, 'I will complain to the management of the dorm. I have a right to study here'. Since then she is not saying anything. [Why?] Because I said, 'I will complain to the management' (Interview July 19, 2010).

Illaha's role models are her parents. She dreams of completing her master's degree and being able to give something back to her parents. Illaha mused:

Everybody in Afghanistan should study and go to school. Everybody [including women and girls] should get education and be literate... secondly; women should be free [in dress code and movements]. I dream that women should get emancipated [released from domestic chores and burden] (Interview, July 19, 2010).

Nigina

Nigina is 19-years old. Nigina has four sisters, four brothers, a father, and a mother. They live in a rented house. At present, Nigina does not work, but stays at home. Nigina worked for two-and-a-half months in an office that handled the province's election process. Nigina was responsible for explaining identity cards to young, female voters (18-year-old girls) and teaching them about the parliamentary-election voting process. Nigina enjoyed her work at the office. Smiling, Nigina explained during her introduction, however, that: "My work is finished now" (Observation, October 11, 2010).

Nigina has since completed high school and has been applying to universities. Every year Nigina has taken the concur exam⁹ to gain admittance to a university, but she has not been successful. Nigina says:

I did not get [good] results. I showed up for two times entry exam and it did not happen [did not receive a high enough score to pass]. You are allowed to take three times, only... not sure what will happen now. Lazy people [students who did not work hard in my class] get accepted. Those who have money, they pass the exam. Those who get high scores, they purchase the answers [people who have money bribe the professors with money to purchase the correct answer for the examination]. Last year, I passed my exam. I had three exams. We even drove all the way to Shuburgon [another city, which is an eight hour drive away]. From 140 people only 40 students got selected. They [examiners/test takers] give you papers [papers to answer the exam questions], and then I had to answer to the questions. I passed. He [examiner] gave me another test, to talk about Turkey. I did find out [information about Turkey]. You learn, and learn... they ask opposite questions. If you share that you are interested in history, they [examiners] would ask you questions from geography by giving them explanations orally. During the test, I felt they could pick on any topic and ask you to elaborate. I had different questions this year to answer (Interview, October 11, 2010).

While discussing what it means “to be healthy,” Nigina shared:

⁹ Concur exam – national examination for entrance to higher education and universities. It is a standardized test conducted in each province every year. The concur exam is administered by the Department of Higher Education in Kabul, Afghanistan.

People who have peaceful life, his/her health are good. [If] the economy is good and life is good [marriage life is good] person health will be good naturally. If you go to doctors they will give you advice or question you—why this, who is he, why did you do it (Interview, October 11, 2010).

Nigina, although close to her sisters, is reserved with them:

Every evening we dance, we share jokes, until we fall asleep. I do not talk to my sisters about [my own] health issues. They [sisters] would go and tell my mother... I would be embarrassed [if my mother would find out about my health problems] (Interview, October 11, 2010).

Nigina also talked about her relations with her mother.

See... like I did take exams several times and did not pass my exams. I was upset or I was complaining. Sometimes I would get sick, and then my mother will give me encouragement. She would say, 'if this did not happen, the next will happen; other doors will open for you (Interview, October 11, 2010).

Discussing her dreams, Nigina explains:

It is hard to move into the future, as the economy of the family is not good. Dreams? [Laughter] Sure, I do. I want a nice job, so that all difficulties get solved. If my mother and father are happy, if economy of a family is good, even that is also a dream. Our life would be better (Interview, October 11, 2010).

Suraya

Suraya is 18-years old. Suraya was born in Talokan and finished twelve years of school. Suraya's family includes three sisters, two brothers, her mother, and her

father. Suraya, as the youngest of the sisters, always felt privileged, receiving extra attention and fewer household chores. As a growing child, her life was easy. Now, however, as one of her sisters is married, she is responsible for some household chores. Her chores include cleaning the house, doing laundry, and ironing clothes. Suraya does not enjoy doing the house cleaning. In her conversations, Suraya mostly talks about the shows that she watches on television.

At present, Suraya teaches in a private school. The private school is for children with special needs, such as hearing and vision impairments. The school also accommodates children who missed several years of schooling (e.g. a 10-year-old child in first grade). It is the only private school of its kind in Takhar Province. Suraya teaches at the primary level, teaching science, English, and Pashto.

At the same time Suraya is preparing to take the concur exam next year. Her interest is law. Suraya is also interested in religious studies.

While we talked, Suraya repeatedly returned to her concerns about education. Suraya struggles with choosing a major. "I am very confused," Suraya shared. She is interested in religious studies, but all the books and curriculum are written in Arabic, making them difficult to understand. To pursue her interest in law, Suraya must move to a dormitory far from home where she would not feel safe. If she pursues legal studies, her family would have to pay \$3000 (U.S.) for tuition and fees. She also noted, "I have no permission to go to those universities, because people talk." Suraya became sad at this point, mentioning one of her father's sayings: "girls that go to other countries to study, they disappear." This is the reason Suraya's

father did not allow her to receive scholarships to study in India, Turkey, or Uzbekistan. Suraya said:

As a family we do not have good financial means. We are also building a house for us and pay rent for the current house. Those who have financial means can go and study medicine in the private university in Mazar. They take \$1,000 US per one semester. When I see others, they finish school, and not even having passed the exam, they get accepted into medical university. I am confused as what to make out of it (Interview, July 23, 2010).

She further noted that:

It is easier for boys to go to Mazar and study, but not for girls. Boys can go and attend courses, they also do not have house chores and other pressures like girls and therefore they can easily study (Interview, July 23, 2010).

Suraya dislikes the idea of studying science or math, because her elder sisters study those subjects. "When I look at my sisters, they study chemistry, mathematics, and physics; I say 'I will not go for medicine for sure,'" Suraya vows.

Suraya is unhappy and complains to her parents all the time. Because of her complaining, Suraya's mother requested her brother to investigate study options at a university in Mazar (a two-hour drive from Talokan). "My father," Suraya complains, "does not allow me to study in Iran and India." Suraya's brother promised to cover her educational fees if she is admitted to a university in Mazar-e-Sharif. It will cost \$900 (U.S.) per semester (Interview, July 23, 2010).

At the school where she is teaching, Suraya faces different challenges. One of her students, who is ten-years old, is very energetic and does not listen to Suraya's instructions during class. Suraya says:

I tried to tell him and did what I could, it did not work out. Then I thought, maybe I am not a good teacher... maybe I did not discipline him on my first day of teaching. Other students may say, "What kind of a teacher is she?" I plan to borrow books to learn how to teach a class. It is stressful to teach in private school and I plan to leave the school so I can have time to prepare for my entry exam for the university (Interview, July 23, 2010).

Suraya wears a *hijab*. (Observations notes, July 23, 2010). Suraya noted:

Yeah... I do wear hijab. In Islam, you are allowed to open your face and hands. My father does not allow us that way [to wear chodari]. I heard, from television that women who wear chodari carry drugs [heroin, opium]. I open my face and until now my name is clean (Interview, July 23, 2010).

Only after discussing her education and educational options, did Suraya share her views on health. She expressed her views in a broad sense. Suraya stated:

Some people have difficulties mentally and intellectually. But the meaning of healthy female is whatever she can do is to be free. The rights of women and men are to be healthy, and understand the meaning of healthy life. For example, I have many dreams [for future]. [I hope people] will remember me with good name, so I can be respected as a [good] Muslim woman. The value of a woman is priceless and she should follow her dreams (Interview, July 23, 2010).

Sayora

Sayora is 19-years old. Sayora's family is from Badakhshan. Her father died when Sayora was only six-months old and her mother remarried. Sayora and her sister were given to their grandmother, and their grandmother raised them. Sayora still lives with her 70-year-old grandmother and her uncle, who has a family of his own (Observation, October 17, 2010). Sayora's uncle is open-minded and encourages her to pursue an education.

Sayora is studying at a university, majoring in English. She is in her third year. During the interview, she sought to speak English to demonstrate her grasp of the language. She said that her university professor is a native English speaker.

Sayora is separated from her mother. She began to weep when we broached the topic during the interview.

Many times, I have feeling of not having my mother [around]. I do not remember my father, but I love my mother a lot [weeping], [Does it gets difficult? How far is your mother from you?] From here, from the city, she is 20 minutes away. [What does she do], "My mom? [She has] Five children. All are girls. Also my mom has *ambog* [another wife to the husband]. Her husband has another wife [pause]... [apparently, we did not know about it], that man had another wife.... they live [all wives] in one house (Interview, October 16, 2010).

Many of Sayora's classmates at the university talk about their mothers and how their mothers care for them. Sayora, however, does not have the same access to her mother. "When I visit my mother, she does not have that [ability to help]. If I say to

her I am sad, why do I have to upset her?" a tearful Sayora asked (Observation notes during the Interview, October 16, 2010).

Sayora expressed confusion about a dilemma involving her rights and wishes. She is engaged to a man, who lives in another province, Badakhshan. Sayora's aunt arranged the engagement and the official *shirini-khuri*¹⁰ has already occurred. Sayora's fiancée is still in high school and is 20-years old. Sayora has never met him or even seen him.

I am saying [to my uncle], do not give me away...I will not agree to [marry] him. I will drink tablets [medicine] and kill myself. My uncle said, 'I raised you, that is why I agreed to this [marriage] proposal'. But I did not agree. I am not at all agreeing and not interested. Many times I feel sad. This is what is happening with me (Interview, October 16, 2010).

Sayora aspires to complete her university degree and has convinced her uncle that she needs more time to finish it.

I do not know what will happen? I am the unluckiest girl in this planet. Why am I far from my father and my mother? I do not even have brother. One girl has dream and wishes, but why my future is so conflicting [referring to her uncle]. These are the thoughts that come to my mind. My mind is very tired and I do not sleep. I think... I think and when I wake up in the morning my mind is confused (Interview, October 16, 2010).

¹⁰ Shirini-khuri—a formal engagement party where the families agree to the marriage.

Kimran

Kimran is 18-years old. She has four sisters, two brothers, a father, and a mother. Kimran is a second-year student at a government university, majoring in mathematics and physics. At home Kimran has clear responsibilities: "Sometimes I have house chores to do, iron clothes, many other things that take me away from studies. I always dream that my house is clean. I cook good food." Kimran's sister used to do all the cooking and meal preparation, but her sister married, so now Kimran bears the responsibility. Kimran, discussing her response to discomfort, relates:

When my heart is sad, I cry. Early [when I was younger], I would cry. When there is no electricity, I go to where the generator¹¹ is and I cry a lot there.... and after some time, my crying finishes [I calm down] Interview, July 22, 2010).

Kimran talks lovingly about her mother:

When anything is wrong with me, my mom observes it first. One or two times I got angry over the dinner table and I made everybody upset. For that [my attitude] when I cry, I upset everyone. Maybe I should cry when there are no people [around] (Interview, July 22, 2010).

Kimran expresses concern for her family, worrying that her attitude affects them. Once over dinner, her father warned her against crying and moodiness since it upset everyone else.

¹¹Most Afghan homes, whether rural or urban, possess a small generator to supply electricity. The generator is usually located at the back of the house (Observation notes, July-October, 2010).

Kimran is burdened with exam preparation (Observation notes, July 22, 2010). She starts her day at 6:30 a.m. She also tries to stay up late at night, but by 10:00 p.m. she feels worn-out and drowsy.

Kimran does not live close to the university library, and she does not feel safe walking to it. The university professors, however, demand that students read additional materials not included in the assigned textbooks.

Challenges are created, especially for females, many cannot, for example go [search for additional information outside of the textbook curriculum]. For boys it is good, because they can go to the library... if it is group work, then we can help each other; girls help each other, and boys collect the information. If there is individual work it is difficult. In that case boys have better subjects [interesting topics] to bring [to class presentation] Interview, July 22, 2010.

A recent experience made Kimran uncomfortable with group work; she explained her frustration. The students had all studied hard and prepared for the group presentation. The group leader, however, was late on the presentation day, so the professor would not let him enter the class. Since the group leader was not there, the entire group presentation was cancelled. Kimran felt it was an unfair decision: "I stormed outside, I did not get permission. It was the last class and everybody left the class. My professor came after me." She had worked hard to gather the information [data for the presentation]; she stated:

I did not even take the information from Internet, but collected my own information. Many got from Internet and that is Iranian language, which is

hard to read. I also felt I should not say anything to the professor's face, as he may get angry with me. So I made up an excuse to my class professor, by saying, 'I miss my mom'. After that I did not go to my University for two days. I was upset (Interview, July 22, 2010).

Kimran wears a hijab. When Kimran goes outside, she wears denim jeans, a coat, and a hijab (Observation notes, July 22, 2010). Kimran does not like the chodari: she explained, "in my view, women look very down, low, [and] do not have value. In my view, it is very bad." Kimran faces a lot of criticism from her friends at the university for showing her face, eating meals in the same room with male family members, and not covering her head in the house. Kimran often has to explain to her friends why her family is different and how it values women. She told of an experience she had wearing a chodari:

We traveled by bus to Mazar-i-Sharif for my brother's engagement party. I was weeping [underneath chodari], as I mentioned it makes a person feel with no value. I am afraid in a city [since my face is open], because many people talk. Underneath [chodari] you feel suffocated; it blocks the air (Interview, July 22, 2010).

She continued:

In Talokan, girls are scared to go outside without chodari... people take pictures of them on mobile phones. When they release a picture it is very bad for the girls. From Islamic perspective, a little bit of face, little bit of hands and feet are allowed to be open. You know, in man there are seventy-two devils. They have such lust.... if one person wears tight clothes, man look.

That is sin. A woman in the eyes of man does not have value. He [man] wants her to do the house chores, do only cooking, and clean his clothes". Further, she indicates that a man often complains to women as ' why did you wash your clothes first and not mine, why did you go out to the city, why do you have mobile phone, why do you talk to man. All this is bad' (Interview, July 22, 2010).

Kimran feels that there is a vast difference between educated parents and non-educated parents. She observes from her experiences at the university:

Other girls who are "wearing chodari" go to the city and parents do not know about their mobility. Parents are not aware of their daughters' behaviors. Parents of many families sit separately. Father and sons eat food separately (Interview, July 22, 2010).

Kimran's role model is her elder sister. Despite her sister's studies, she always maintained her housework, and, even now, her sister is able to keep her house clean.

I want to be a good teacher and help everybody. My wish, if I get lots of money to help needy people. When I have money, as a teacher, I will help in guiding the person (Interview July 22, 2010).

Zuhal

Zuhal is 22-years old. Zuhal has four brothers and one sister. Zuhal's parents both work. Her mother and father come from different ethnic backgrounds. (Her mother is Tajik and her father is Pashtun.) After high school, Zuhal studied at a teacher college. At present, Zuhal is a teacher and teaches at a special-needs school.

Zuhal's family moved to Talokan from Badakhshan five years ago. The family lives in a rented house, which costs \$100 (U.S.) per month¹². The family's income goes to covering the expenses.

Zuhal possesses a broad concept of a healthy girl. Zuhal links health to family upbringing and education.

It is good if she has health, good health, so she can do her education. Many families do not allow girls to study. Do not allow at all. I went to school. Three of my cousins who were older than me were not allowed to go to school. They stayed not studying.... Now they are happy for my mother that my mother allowed me to go school (Interview, October 14, 2010).

As an example, Zuhal told about her aunt. Her aunt's family married her to a 50-year-old man when she was 20-years old. After their marriage, they moved to Iran. Her husband, however, died, leaving her to raise their two children. This devastated her aunt. Talking to her aunt and receiving her advice provided Zuhal with a broader perspective.

Zuhal's extended family (aunt, cousins, and other relatives) often mention her weight and worry about her not eating well. Zuhal says:

Before I was overweight.... Now relatives that come from Kishm [another village] tell me of 'why you are not gaining weight', as seeing me skinny. Then again everybody say what is happening that 'you are skinny'. I say, 'no I am well this year'. My mother gets upset with me, and says that 'you are not

¹² House rent must be paid three months in advance. Families borrow money from each other in order to come up with the rent. Money earned during the next three months goes to repay the borrowed money. Zuhal's mother is a nurse with a salary equal to \$100 (U.S.) per month. The family is also having a house built (Non-formal conversation with Zuhal's mother, October 14, 2010).

eating enough. Oh Allah, you may have concerns, what is going on that you are so slim'. I say, 'I do not have any concerns' (Interview, October 14, 2010).

Zuhal's refusal to eat was obvious to her mother. A few months ago, it was rumored among her relatives that Zuhal was in "love with one man." The whole family heard it. Zuhal was surprised to hear of the gossip from her aunt. Zuhal was depressed, "I was very disappointed, and I got sick. I am not that kind of girl." Zuhal protested to her aunt that she was not in love. Eventually, her mother noticed how the rumors were affecting her daughter's health, so she clarified the situation to her relatives in order to protect Zuhal's reputation.

Zuhal's happiest memory is of the birth of her youngest brother. She recalls: 14 years after, my mother gave a birth to a baby boy. All family was so happy. I do like children... my mother had difficulties in her pregnancies, but still she made it. (Interview, October 14, 2010).

Her little brother is very attached to Zuhal and considers her as his mother. Zuhal happily recounted that her family laughs and teases her: "Zuhal will be married soon, but the little brother protects Zuhal and does not wish to give Zuhal away."

Zuhal worries about her family. It frustrates her that her brothers are content to learn vocational skills and do not desire to go to school or pursue higher education. One of her brothers is working in Iran, but he is not doing well there. The family worries about him. Talking about him, she said, "I am very sad for him" (Interview, October 14, 2010).

Dilrabo

Dilrabo is 18-years old. She spoke softly or in a whisper. Sometimes it appeared that only her lips moved. Wearing a chodari and with only her face visible, Dilrabo appeared to have come from school. The uniform of the school is a black skirt and a white shirt that is partially visible under the chodari. Dilrabo had probably been walking a lot, as her chodari had gathered a lot of dust and mud, which she tried to cover during the interview. Her face was pale and lips were dry. Her voice was low and she seemed timid and shy when speaking (Observation notes, October 17, 2010).

Her biological parents have seven boys and three daughters. One of her brothers is a schoolteacher; two of her sisters are in 11th grade; and another brother is in 9th grade. The rest of the children are at home. Dilrabo's mother does not work and stays at home to raise the children. Her father has a bakery shop. He does not own the shop, so he has to pay the rent out of his earnings. The family's house is also rented.

Dilrabo lives with her grandmother. Dilrabo's grandfather passed away fourteen days before the interview. Recounting the event, Dilrabo shared:

My grandfather was sick. I was looking after him. Though my grandfather had a son, but I looked after him. My grandfather was paralyzed and could not walk. I would feed him or change his clothes (Interview, October 17, 2010).

Her grandmother's house is near the local market. Her grandmother prepares *mantu* (dumplings with onions and meat), which she sells in the market. From her

earnings, Dilrabo's grandmother gives some of the money to Dilrabo and some of it is kept to cover house expenses.

Dilrabo's understanding of health is linked to mental concerns. According to Dilrabo,

A "healthy girl" is the one that stays in a place where it is quiet and that a girl can study her classes. The house of my grandmother's has lots of children. There are only two rooms and one entry terrace. The place is small and not comfortable. I cannot say anything to family members, since they are elder than me. Our house is near the market and children are not allowed to play outside. I go to school at 6:00 a.m. and come back by 10:30 a.m. The house has many guests and I tell myself not to go to the house (Interview, October, 17, 2010).

Dilrabo's understanding of health is constantly challenged by her family members' comments, such as "Dilrabo eats a lot and therefore she is gaining weight." This upsets her because she feels these comments are not true and are unsubstantiated. Dilrabo softly expresses her sadness (Observation notes, October 17, 2010), sharing:

When I look at my grandmother, I feel sorry that the economic status is poor; when I look at my father, he works alone in his shop... I get sad in my grandmother's house and then I go to my parents' house (Interview, October 17, 2010).

Dilrabo has a hard time sleeping at night. She has to stay awake, because her grandmother has high-blood pressure and does not sleep. Dilrabo stays awake to

watch her grandmother. During the day, Dilrabo wants to rest, even for one hour, because she gets very tired. Dilrabo feels that she has lost weight as a result of the recent death and sadness within her family.

Months ago, her entire family went to Badakhshan Province, because her uncle passed away. Two weeks later, Dilrabo's aunt lost her husband. Dilrabo says: "Again sadness. After grieving for that, my grandfather passed away. Everywhere that I look there is a grief."

When I look at the side, where the grandfather sits... I feel sad. I tell to our guests 'you eat, I have to go out'. [pause] I hardly smile. I do not have a habit of smiling (Interview, October 17, 2010).

Dilrabo has school friends. "They are like my sisters, we go [stay in school] together," Dilrabo confides. She feels happy when she is with her school friends. At home, Dilrabo does not talk much, and, when guests visit, she usually goes to the kitchen to do the chores. One of her dreams is "to stay at home, when everybody has gone shopping" (Interview, October 17, 2010).

Orzu

Orzu is 20-years old and attending high school. She is also attending English courses at Dunya University in Talokan. Orzu has three brothers and three sisters. Her family moved to Talokan from Mazar-i-Sharif. Orzu, her mother, and all her siblings live with her grandparents, who are around 80-years old. Orzu appears several years younger than her actual age (Observation notes, October 13, 2010). Orzu insisted on speaking only in English during the interview. She began the interview speaking in English. I asked if she would be more comfortable talking in

her own language, but she preferred talking in English. Her mother, who attended the interview, remained a calm observer throughout the interview process. Orzu appeared to be ignoring her mother's presence, so that she could focus on conversing with me in English (Observation notes, October 13, 2010).

Orzu's family moved to Talokan because of family challenges. Orzu's father had been sentenced to jail for ten years in Shuburgon Province. Orzu tried to explain in her broken English:

Before, you know... [pause] I am from Mazar-i-Sharif. I have a problem, because of that I came here. [pause] I have come here... my father is in jail. Because of that [using strong tone] we must, we should [pause]... come here. We live with our grandfather and grandmother [in Talokan]. I have three sisters. My mother does not have a job. I study in school (Interview, October 13, 2010).

According to Orzu, her father had fought with a man he had met while he was traveling. The man he had fought was later found dead, presumably killed. Orzu does not know the full story. She only heard some details from her mother. The next thing she heard was her father telling her over the phone that she had to be strong and look after the family because she was the eldest.

You know when our father... Hmm, [taking time to think] did not leave the house and was with us [long pause]. You know [person] have so [many] problems. We have to study in school. We also need a person [in our life]. We have so [many] problem. We must study. No one comes with me to [visit] my house (Interview, October 13, 2010).

She feels that other people consider the family “bad” because her father is in jail. This embarrasses Orzu, and she thinks that is the reason no one visits her home.

If our father was with us in our house, maybe he could help my brothers or me. We need our father (Interview, October 13, 2010).

Orzu enjoyed school before her father went to jail. She had done well in school and was one of the top-three students at her school. After the family tragedy, however, Orzu started to struggle, and now she is the sixteenth on the grade list.

Some laugh at me. [Who? Girls in the school?], Yes, girls. They tell me ‘your father is in jail’. How will I start my life? How we will live our life [pausing].... [They] always laugh at me. When I come from school... I just cry. I am broken... I am really broken down [weeping] (Interview and observation notes, October 13, 2010).

Orzu continued:

Why I have headache? I always think about my father. At night, when I think about him, I cannot study. I want to study and when I take a book in my hand, an English book, or any book I cannot focus. I just sit and study and study. When I think... I am not studying. I think about my father. Every time, I am thinking about him... that is why I have a big headache (Interview, October 13, 2010).

Orzu’s emotional pain spills over into the rest of the family.

When I come home... I just think and I cry.... I want to cry and cry. Sometimes when I cry, I fight with my brother and sister. Sometimes I argue with my

mother. When I argue with her, after one hour I feel happy (October 13, 2010).

Her mother took Orzu to the doctor because of her migraines and headaches.

I go to doctor. But all of them told me do not worry about anything. He [doctor] told to my mother, 'what is her problem ...why is she thinking, she is still young. But it is difficult if I go to doctor, you know. I told him, 'my father is in a jail. Because of that I am thinking about this.' (Interview, October, 13, 2010).

At this point in the interview, Orzu's mother spoke up to say that the doctor had prescribed some medicine to treat Orzu's migraines and headaches. She stated,

The medicine is for *asab* (nerves). She [referring to Orzu] developed short breathing problem. I spent 4000 Afghan rupees for medical procedures and 110 Afghan rupees for medicine. There are 2 types of tablets that she [referring to Orzu] has to take at night. That can help her with her nerves [mental stress]. It is similar to *diazepam*. Something is used for headache. There are two types [tablets], which I do not know. Both [tablets] make her sleepy. The other [medicine] is like glycine, which is like having green color inside. That is for nerves. [Do you know the names]? I forgot the names (Interview, October 13, 2010).

The prescriptions from local doctors make Orzu feel sleepy all the time.

When I add [eat] the tablets I feel like sleeping. When I use those tablets at 6 p.m. or at 7 p.m., I wake up at 10 o'clock or 11 o'clock in the morning. [For

how long have you been taking these medicines]? For one year now
(Interview, October 13, 2010).

Orzu spoke about her body image in a way that was both sad and humorous. She does not want to be slim. Orzu thinks that she looks like her mother. She feels that her mother was beautiful when she was young and wonders why she lacks her mother's beauty. Sometimes Orzu wants to look like women she has seen on television. During the interview, she showed me pictures on her mobile phone of women she thinks are beautiful. She wants to look like the women in these pictures.

But despite her insecurity with her own body, Orzu admitted, "When I see people having some other problems, I show my gratitude to my body that I have." Orzu wishes to become a doctor and go abroad. She shared:

There will be a time, when I will go abroad. So I imagine that there will be six to seven cars under my feet [laughing and talking] and I will not recognize my mother, and I will have very high position [teasingly looking at her mother] (Interview and observation notes, October 13, 2010).

Orzu finds refuge in prayer. "You know I wake up at night and I pray. After praying, I feel very calm" (Interview, October 13, 2010).

The interview was interrupted by a phone call from Iran. Orzu had received a marriage proposal from a family in Iran, but the family had a few details to discuss with her mother. Both Orzu and her mother looked very concerned (Observation notes, October 13, 2010).

Mushtari

Mushtari is 20-years old. Mushtari has two brothers, one sister, and a mother. Mushtari's father went to war (while the Taliban was in power) and never returned. Mushtari was in 2nd grade when her father disappeared. Her family moved from Kunduz to Talokan four years ago. She currently stays at her home in Talokan.

Mushtari talked about her conception of a healthy girl in a general manner: Thoughts are not in one place. If my father was with us, my brothers may listen to him. I cry often because we have this kind of life. If we buy bread, then we cannot purchase our chodari [if we get money for bread, then there is not enough money to purchase chodari]. We do not have money. I wish I would be a teacher and have some connections [means] (Interview, October 14, 2010).

Mushtari openly expresses her anger. Sometimes she confronts her mother, expressing her self-pity and asking why her family is not as fortunate as other families. When her mother gets upset, however, she sympathizes with her mother and wants to assist her. To help her mother is the reason Mushtari wants to go back to work.

I do not go to weddings; so that people don't say that I have lousy dresses [my clothes are not good for wedding parties]. I cry a lot. These things [thoughts] make me uncomfortable. When my father was announced lost, the family had to move to Talokan. We did not have anything here. When we came, it was not nice. It was difficult to move to this house. We had to pay rent, which is 12 Afghan rupees per day. The teacher salary was only 5000

Afghan rupees. We paid 3000 Afghan rupees and 2000 Afghan rupees remained (Interview, October 14, 2010).

In the wishful tone, Mushtari said:

[I wish] if we have home of our own then we will have a peaceful mind. [I wish], if I finish my study that would be healthy future [for me] without any tensions (Interview, October 14, 2010).

Mizgona

Mizgona is 19-years old. She is from Badakhshan. When she was one-year old, her father passed away from a heart attack. Mizgona's mother was only 16-years old. Her maternal grandfather and uncle married her mother off to another man because she was still young, and Mizgona and her brother were given to her paternal aunt. They still live with Mizgona's aunt in Talokan. According to Mizgona, "My auntie did not have many children on her own. She said, 'I will raise Mizgona and her brother'" (Interview, October 18, 2010).

Mizgona's aunt lacks a good income. Mizgona's cousin works as a steel worker, making iron doors and gates. They all stay in one house, which they share with a guest.

Mizgona displayed self-confidence and an ability to share her story. She constantly checked her mobile phone, as if she was expecting a call. Mizgona's determination and energy were evident as she talked about her future goals. Mizgona had a realistic approach to utilizing her time and looking for a job (Observation notes, October 18, 2010), and was considering both her resources and her aspirations in her job search.

After 18 years, Mizgona went to visit her mother in Badakhshan for the first time. After the long separation, Mizgona feels emotionally distant from her mother.

Mizgona struggles as a student and, alluding to her studies, said:

That time, I was very busy. Half of the day I studied and then I would attend English language courses. I took three courses. My brother was selling a juice in a small bottle. He would come in the evening and bring 10 Afghan rupees. The book cost for courses was 300 Afghan rupees per month and the expense would go to 100 Afghan rupees. When I finished my study, by that time I developed depression. [Due to the depression] I was thinking, when I pass my exam, I still would not go for higher education. My auntie healed me, so I am much better now (Interview, October 18, 2010).

Mizgona was unable to attend college: "I was not allowed; no one told me you go and I will support you [financially]." Her uncle did not allow her to study. Mizgona became a school teacher. She then got a job at the Department of Health in Talokan, before switching to a job with a microfinance agency. At the time of the interview, however, she was unemployed and looking for another job.

Mizgona was uninterested in discussing body image, but she shared her thoughts about the chodari:

Wearing chodari... I get headache. I like to be in Kabul. Those who do not wear chodari [in Talokan], people say 'they are bad'. People are narrow-minded. When one wears chodari, they say 'it is good'. Small scarf should be appropriate for Muslim women to wear (Interview October 18, 2010).

Mizgona dreams of studying medicine or law. “I want to study. After that [study] I dream to have my life and also to have a husband who is nice and sensitive” (Interview, October 18, 2010).

Drawing upon these narrative stories of adolescent girls in Afghanistan, it is possible to discern something of their life experiences and conceptions of health. Exploring the complex web of details and linkages contained in these narratives will shed light on these young females’ ‘hidden voices’ and open up new realms of inquiry.

CHAPTER 5

DISCUSSION

This chapter focuses on the shared understanding of health that emerged from the narrative stories of the adolescent Afghan females interviewed during this study. (A detailed account of these narratives was provided in Chapter 4.) I discuss and analyze the individual narratives, paying special attention to a) family relationships, b) education, and c) health.

I close the chapter by raising new questions drawn from my findings—questions designed to encourage a greater understanding of the health issues facing adolescent females in Talokan, Afghanistan.

Family Relationships

These interviews indicate that adolescent females in Afghanistan prefer to draw “informal” support from their family (Boldero and Fallon, 1995) and seek to understand, express, and resolve their concerns in the context of their families.

Importance of Siblings

The adolescent females in this study perceived family relationships in the context of their relational attachment to their family members (e.g. grandmothers, aunts, female cousins, younger siblings, etc.). While the study participants did not clearly distinguish how they help their siblings, nine out of ten study participants stated that they helped their younger siblings. As Scharf points out, siblings can be playmates, caretakers, and sources of support (Scharf et al., 2005). Siblings often perform the role of caregiver—especially to younger siblings—and provide support to each other during family events and crises (Tucker et. al., 2001). For example;

The happiest moment for me was when my youngest brother was born. After 14 years, my mother gave a birth to a baby boy. All our family was happy. I do like children [looking after them]. I am like his mother. In our family they laugh and say 'Zuhal will be married soon'. But my baby brother does not wish me to go (Zuhal Interview, October 14, 2010).

Mostly when I am homesick, I remember my mother. When I want to share something, I remember my friend. When it is lonely, I remember my youngest brother (since I am attached to him) (Illaha interview, October 14, 2010).

Every evening we [my little sister and I] dance, we share jokes, until we fall asleep (Nigina interview, October 11, 2010).

Concerns about the Future

The study participants expressed, in great detail, their concern about their families' economic situations and their inability to assist their parents. Dilrabo felt sorry for her parents because of their poverty and because she was unable to see any solution to their poverty. She sought solace by flitting back and forth between her two homes—her grandmother's house and her biological parents' house:

When I look at my grandmother, I feel sorry that the economic status is poor; when I look at my father, he works alone in his shop... I get sad in my grandmother house, and then go to my parents' house (Dilrabo interview, October 17, 2010).

Mushtari expresses her concerns differently. Mushtari knows that her family's economic resources are inadequate and unstable due to her mother being the only financial provider. (Her mother works as a midwife in the medical clinic.) Mushtari hopes to get a decent job and pities her mother, who bears the financial burden for the family's survival. Future-oriented plans and sorrow over the family's economic plight are interwoven in Mushtari's narratives.

If my father was with us, my brothers may listen to him. I cry often because we have this kind of life... we do not have money. I wish I would be a teacher and have some connections [means], and I could be a supportive hand for my mother (Mushtari interview, October 14, 2010).

Adolescents share strong connections with their families. The participants' willingness to receive help from their families, offer help to their families, and take care of their siblings was directly related to the level of family support they received. The participants also showed their concern for their families by expressing their desire and inability to help or support their parents financially. Their concerns focused on personal themes, both now and in the future (e.g. how can I improve myself? How can I help my parents? What will happen to my family's economic situation in the future?). Research has shown that adolescents feel concern about the future and their future plans (Violato and Holden 1998, Robertson, 1990). This fact demonstrates that young people develop formal operational thoughts—reflecting abstract-reasoning capabilities—at this stage of adolescence. Adolescent girls develop the ability to create future plans, make decisions, and take action. Yet

they do not lose sight of their day-to-day concerns and the future ramifications of their current plans and decisions.

Relationships with Family are Influenced by Culture

Relationships within the family are linked to the social, economic and traditional characteristics of the culture in which they are embedded (Schneider et al., 1997). Afghanistan, specifically the Talokan area, has strong family and cultural values. For example, the culture of mutual commitment, respect for parents, and respect for mothers (by daughters) is strong. The social and cultural determinants of Western families—with their espousal of individualistic values—differ from those of Afghan families (Florian, 1989). In Afghan families, the mother and father are respected, and the family is strongly bonded together as a unit. Internal family rivalry and conflict are not discussed with outsiders. Within the cultural realm, there is a line of respectability—based on established hierarchy—that must prevail: the younger must respect the older; the daughter must respect the mother, etc. This is evident in the case of Dilrabo, who stated;

The house of my grandmother has lots of children. The place is small and not comfortable. I cannot say anything to family members, since they are elder than me. The house has many guests and I tell myself not to go to the house (Dilrabo interview, October 17, 2010).

Relationships with Family are both Helpful and Unhelpful

Family dynamics can create both helpful and unhelpful relationships within the family. Reviewing the participants' narratives, I listed both the helpful and unhelpful aspects of the family relationships in Table 2:

Table2. Helpful and unhelpful aspects of family dynamics.

Study participant	Helpful aspects	Unhelpful aspects
Illaha	Close to her youngest brother; serves as caretaker; and plays with her younger sister.	Does not talk to her mother about health issues.
Nigina	Close to her younger sister; serves as caretaker; and close to her mother.	Does not talk to her mother about health issues.
Mushtari		Argues with brothers; tension between herself and her mother; and does not talk to her mother about health issues.
Zuhal	Close to her younger brother; feels sorry for her mother who is sick and not feeling well; and worries about her brother who is in Iran.	Argues with relatives on her father's side of the family.
Orzu		Tensions with her brother; and argues with her mother.
Kimran	Looks up to her elder sister; and feels sorry for her mother.	
Suraya	Close with elder sister; and close with her mother and father.	
Sayora	Feels sorry for her biological mother who lives in a faraway village.	Does not talk to her grandmother about health issues.
Dilrabo	Feels sorry for her grandmother who is not feeling well and for her biological parents who have financial problems.	Does not communicate with relatives.
Mizgona	Cares for her younger brother.	Does not feel close to her biological mother; stays with her aunt but is not close to her; and does not talk to her aunt about health issues.

Helpful Aspects

The social context in which these adolescents live matters, as health behaviors result from a combination of life choices, social influences, and perceived messages

(Higgins et al., 2006). Adolescent females, in this study, who had younger siblings, were more prone to interact with others and socialize. Study participants did not specify what they discussed with their younger sisters or how they were close to their younger brothers; instead they talked about their caretaker roles. Cultural and ethnical norms influence Afghan females' socialization, as demonstrated by elder siblings developing a nurturing personality characterized by their care for their younger siblings. These family relationships are vital to their socialization, foster healthy behaviors, and steer them toward nurturance and responsibility (Chodorov, 1989).

Unhelpful Aspects

Adolescents rely on social interactions to interpret their observations, especially in regard to their understanding of health. Research has indicated that a low-level of communication about health issues is correlated to poor health and health choices (Institute of Medicine, 2004). Several of the study participants who experience personal, emotional, or health-related issues exhibited a lack of communication with family members, specifically with their mothers.

When I come home [from school], I just think and cry. I want to cry and cry.

Sometimes when I cry, I argue with my mother. I am alone [I go to my room and stay there]. When I argue with her, after one hour I feel happy. (Orzu interview, October 13, 2010).

When I visit my mother, she does not have that [ability to help]. (Sayora interview, October 16, 2010).

A few study participants, reflecting the complex cultural and relationship dynamics in their families, shared that they were embarrassed and ashamed to talk to their mothers about health-related issues. Six study participants live with both parents, two with grandparents, and two with only their mothers. Regardless of the household configuration, all shared a similar reticence to communicate about health issues. They expressed reservation in discussing health issues with their mothers (or other female authority figures).

I do not talk to my sisters about [my own] health issues. They [sisters] go and tell to my mother... I get embarrassed [if my mother will find out about my health problems (Nigina interview, October 11, 2010)].

When I saw it [bleeding] I got scared. Before that I knew a little bit [about monthly bleedings] since my friends told me about it. I did not share with my mother, I was feeling embarrassed. I felt that I have to be alone, walk alone, and sit alone. I did not like myself to be honest [laughter] (Illaha interview, July 19, 2010).

Implications of Family Relationships and Dynamics for Health

Analysis demonstrates that family members are an important source of information for adolescents. During an adolescent's developmental stages, research has shown that the family (even through day-to-day conversations) strongly influences health perceptions, choices, and behaviors (Peattie, 2007; Brewer, 1991, Abel et al., 2002). The participants in this study relied on their family for daily communication, information, and moral and emotional support to shape their social

world (e.g. adolescents performing a caretaker role toward younger siblings).

Adolescents act based upon their interaction with and understanding of the world around them. Their family dynamics play a vital role in creating these basic impressions of life.

While family relationships can exercise both helpful and unhelpful influences on female adolescents, research suggests that adolescents with inadequate social support may be at increased risk for health problems (Sheffield et al., 2004, McKay and Diem, 1995, Boldero and Fallon, 1995). This study shows that adolescent females in Afghanistan rarely communicate about health issues with their mothers or with any other older female in their households. A girl's limited social support from her family may also influence her attitude and perceptions toward health-promoting and health-compromising behaviors. Parents, by modeling and discussing health choices with their daughters, can often either encourage or discourage healthy lifestyles. Their level of health education, however, impacts their ability to encourage their children to make wise decisions.

Education

The literacy rate among women/females was approximately 13% in 2010 (CEDAW, 2011). Most of the participants' female guardians and mothers were unable to complete basic schooling, let alone higher education. Participants in this study were selected during field visits to Talokan; all ten of the study participants have completed high school or are currently studying and pursuing their educational goals. Table 3 indicates the study participants' ages and educational levels.

Table 3. Participants' ages and educational levels.

Name	Age	Education level
Zuhal	22	Studied at a teacher college after completing high school.
Orzu	20	High-school student.
Mushtari	20	Completed high school. Attempting to enter a midwifery program.
Nigina	19	Completed high school. Attempting for the third time to pass the national examination test so that she can attend a university.
Mizgona	19	Completed high school. Attended certificate courses for computers and English.
Sayora	19	Second-year student in the English department at the Institute for Teacher Training.
Illaha	18	Completed high school. Attending college in India.
Dilrabo	18	High-school student.
Kimran	18	Second-year student at the Teacher Training Institute
Suraya	18	Completed high school. Preparing (for the second year) to take the national examination test so that she can attend a university.

Participants—and Sometimes Mothers—Strongly Value Education

All the study participants, despite living in a semi-rural area and coming from complex family and economic backgrounds, had achieved a basic level of education (i.e. high school), and they continuously expressed strong interest in pursuing further education. This strong interest in pursuing education and wisdom is linked to cultural values within Islamic teachings (Reagan, 2005, Wadud, 1999).

Everybody in Afghanistan should study and go to school. Everybody [including women and girls] should get education and be literate (Illaha interview, July 19, 2010).

I want my daughter to get acceptance into midwifery school. I want her to study. I want her to get a job as a midwife (Mushtari's mother's comments during house visit on October 17, 2010).

All ten study participants vividly illustrate the immense difficulties that cultural and traditional obstacles pose to their educational goals. Even with those obstacles, however, all ten study participants actively pursued their education and sought to complete their studies. Suraya, for example, expressed many times that her father will not allow her to travel to Mazar to study (Interview, July 23, 2010). Yet she continues to search for ways to achieve her end (e.g. she asked her brother to pay for her educational costs, hoping to convince her father to change his mind and let her travel to another place to study) (Interview, July 23, 2010). Nigina, despite the expenses incurred by her family, is making a third attempt to pass her concur exam (Interview, October 11, 2010). Mizgona, after finding a job to cover her brother's educational expenses, hopes to study either law or medicine (Interview, October 18, 2010).

Some of the girls recognized that family support for their educational efforts was crucial. One of the study participants completed her education with her mother's encouragement. She connects her values and her perception of health with her upbringing, her mother's support, and her decision to pursue education.

Many families do not allow girls to study. [Families] do not allow it at all. I went to school. Three of my cousins who were older than me were not allowed to go to school. They stayed [at home] not studying. Now they

[relatives] are happy for my mother [for her decision] to allow me to go to school (Zuhal interview, October 14, 2010).

The mothers of Kimran, Zuhal, Mushtari, and Orzu expressed (in informal conversations after each interview) a desire to advocate for their daughters and other female family members to pursue higher educational degrees. This advocacy is a critical encouragement to females to climb the social ladder, gain self-respect and self-autonomy, make their own decisions, and help their families.

I want to have a nice job [after completion of my education], so that all difficulties get solved. If my mother and father are happy, if economy of a family is good, even that is also a dream. Our life would be better (Nigina, Interview October 11, 2010).

If I finish my study [to finish the midwifery classes] that would be a healthy future [for me] without tensions (Mushtari interview, October 14, 2010).

I want to be a good teacher and help everybody (Zuhal October 14, 2010).

The meaning of healthy female is whatever she can do is to be free. For example, I have many dreams [for future]. [I hope people] will remember me with good name, so I can be respected as a [good] Muslim woman (Suraya Interview, July 23, 2010).

All ten participants compared and connected the lives of their mothers or other women (i.e. elder sisters, aunts, neighbors, relatives) with their own, contrasting the personal outcomes for educated vs. uneducated. As a result, they all valued education. Sayora's narrative, in particular, stands out. Her struggle against

marriage and her desire to complete her university education demonstrate how highly she values education. Sayora drew general conclusions about females' lives from her mother's own story and so-call "loss." She is fighting for her future, for her education, and for her "inner small voice." Yet she is still trying to understand what happened to her mother—why she was forced to get married and leave her children behind. Fearfully, she wonders: "what if that can happen to me?" (Interview, October 16, 2010 and Observation Notes from a visit to Sayora's house, October 2010).

Participants See a Connection between Health and Education

Social pressure to pursue education and demonstrate achievement motivates females to be healthy (Ruglis and Freudenberg, 2010). All ten participants are students or want to become one—hoping, if possible, to complete a college or university degree.

It is good that a girl has health—good health so she can do [be able to perform] her education. (Zuhal interview, October 14, 2010).

It is good that she [any female] have health, good health, so she can do [study] her education. I want to study (Mizgona interview, October 18, 2010).

Participants Face Cultural and Personal Barriers to Completing their Education

A common theme stood out in the girls' interviews—the difficulties of pursuing, persisting in, and completing their education.

We have to study in school... we have so many problems. [But] we must study (Orzu interview, October 13, 2010).

While all the study participants faced similar educational issues, the younger participants expressed more concerns and worries. Eighteen-year-old Dirlabo, for example, worried that her domestic conditions and chores kept her from completing her homework. She stated:

A 'healthy girl' is the one that stays in a place where it is quiet and that a girl can study her classes [do her homework]. The house of my grandmother has lots of children. There are only two rooms and one entry terrace. I go to school at 6:00 a.m. and come back by 10:30 a.m. The house has many guests... I go to kitchen and do the house chores and can't [do my homework] (Dirlabo interview, October 17, 2010).

Illaha, age 18, also has educational concerns at her college in India. She experiences difficulties preparing for exams due to conflicts with her roommate.

A "healthy girl" to me is a person who is tension-free. She should not have stress, from all the things in life for example, not only sickness, but also some anxieties of life [conflict with roommate in the dorms and inability to concentrate on exams] should not be there, she should be tension-free [when studying] (Illaha interview, July 19, 2010).

Age, however, was not the main factor affecting girls' access to education; limited opportunities—due to cultural and family issues, particularly economic problems—had a greater impact on their educational pursuits. Eighteen-year-old Suraya's inability to choose a university is linked to her economic concerns. Her educational decisions are linked to socioeconomic determinants, financial burdens,

and poverty. As she told her story, she acknowledged the link between decision-making, financial pressure, and her own stress.

As a family we do not have good financial means. We are also building a house for us and pay rent for the current house. Those who have financial means can go and study medicine in the private universities in Mazar. They cost \$1000 US per one semester. I see others who finish school, and do not even pass the exam, and get accepted into medical university. [For me] I am confused as what to do and what to make of it (Suraya interview, July 23, 2010).

Nigina, talking about her educational concerns, stated:

[If] the economy is good in my family and we have money to pay for my education and then life will be good [personal health will be good naturally] (Nigina Interview, July 2010).

Nigina linked her educational experiences to socioeconomic determinants (i.e. her family being able to financially assist Nigina with her education costs). While telling her story, Nigina talked extensively about her lack of educational access and the complicated process of gaining admission to higher education. Her parents must pay the heavy costs of travel, security, and examination expenses for her to retake the concur exam (Nigina interview, July 2010). This accords with the findings of Graham-Brown (1991), who stated: “in countries with deficiency and poverty in the education infrastructure, increasing financial burden falls on family” (p.43).

Participants whose families were run by a single-woman (e.g. mothers, grandmothers, or aunts) had additional economic burdens and poverty to overcome

(Graham-Brown, 1991). The participants' economic status impacted their emotional and psychosocial state. For example, Mushtari, who comes from a single-mother household, shared:

Thoughts are not in one place. If my father was with us, my brothers may listen to him. I cry until we will have this kind of life. [I wish] if we have had a home of our own then we would have peaceful mind. [I wish], if I get my study done that would be healthy future [for me] without tension (Mushtari interview, October 14, 2010).

Orzu, who also comes from a single-mother household, is repeating a year in a school because she was unable to pass the national exams while in high school.

Why I have headache? I always think about my father. At night I think about him, I can't study. When I want to study, when I take a book... English book, [any] book—I just study and study [but I cannot concentrate or memorize]. When I think, I am not studying. I think about my father (Orzu interview, October 13, 2010).

Mizgona, who was raised by her aunt, said:

[When I was in high school]... that time I was very busy. Half of the day I studied and then would attend English language courses. I took three courses. My brother was selling juice in small bottles. He would come in the evening and bring 10 Afghan rupees. The books cost was 300 Afghan rupees per month and the expenses would add 100 Afghan rupees. By the time I finished my study, I had developed depression. I was thinking, if I pass my

exam, I should not go for higher education (Mizgona interview, October 18, 2010).

Families with female heads of household (e.g. as is the case with Mushtari and Orzu's families) face increased pressure for the mothers or girls to work and contribute to the families' finances.

Implications of Education for Health

None of the ten participants directly pinpointed what health meant to them; instead they gave rudimentary answers. They all expressed, however, a connection between health and educational attainment. It is important to note that the participants were not asked why education was important to them. Their views on health and education were extracted from their narratives.

The study participants shared slightly different stressors such as: the concur exam (Nigina interview, October, 2010), the midwifery exam, (Mushtari interview, October 14, 2010), paternal approval to attend college (Suraya interview July 2010), and group work and study experiences as a woman at a co-ed college (Kimran interview, October 16, 2010).

For the participants, education was not only a strategy to escape domestic chores but also a vehicle for social mobility—one that added value to their lives. Going to school/college gave value to the lives of these adolescent females, and it gave them a place to go. An education also signaled to society that they had social worth (Kimran interview, October, 2010), that they were smart (Sayora interview, October 16, 2010), and that they could be accepted as a member of society (Kimran and Zuhail Interviews, 2010).

Educational pursuits were also perceived as a healthy, valuable behavior—one respected by cultural norms. According to the National Poverty Center, educated people have increased access to health information, greater cognitive skills, higher social rank, and larger social networks (National Poverty Center’s Policy Brief, 2007). The study participants, seeking similar ends, want to pursue their educations. For example—Mushtari wants to get her midwifery education so that she can help her mother; Mizgona wants a balanced life and marriage; and Kimran wants to be a teacher and help others. As Graham-Brown (1991) says: “School or higher education can be an opportunity for autonomy” (p.59) and independence. Suraya—sharing similar ideas—believes that education will prove her worth and intellectual ability just as it did for her sister.

In summary, the study participants consider education as a tool for upward mobility. It is a vehicle to be used to pursue further ends (e.g. jobs, social acceptance, self-worth). For the study participants, education is not intrinsically valuable; it is valued for the goals it enables.

Health

The study participants’ perceptions of health and healthy women were often postulated and embedded upon social realities and subjectivities. Their concepts of health did not always address a traditional concept of “health”—as in physical or mental well-being. Instead, they spoke of it in relation to its *embodiments* (Ruglis, 2009) and *appearance* (Walker et al., 1982, Holden, 1988) within unspoken cultural practices. The big picture of “understanding health” and adolescent well-being in semi-rural of Talokan emerges only after studying these cultural constructs.

Participants' Embodiment of Health Demonstrates the Stresses They Face

The concept of embodiment is understood as:

How we literally incorporate, biologically, the material and social world in which we live, from utero to death; a corollary is that no aspect of our biology can be understood in the absence of knowledge of history and individual and societal ways of living" (Krieger, 2005, p.352. see also at Ruglis, 2009).

Embodiment also provides a construct to recognize, understand, and comprehend the human body, the specifications of human psyche, the human position within specific contexts, and the variations in a population's health across time, place, and social groups (Ruglis, 2009).

In this study, ten study participants vividly expressed the process of embodiment and the contextual realities they face in day-to-day life, conveying it through body language, tone of voice, color of skin, language, and topics discussed during the interviews (Ruglis, 2009). The harsh realities of Afghanistan and the semi-rural setting of Talokan visibly emerge from the narratives, expressed through tired faces, tears, fear for safety, worry about survival, self-hatred, signs and symptoms of depression, deprivations (from eating disorders), and fatigue (from not sleeping). Some of the participants hardly uncovered their faces during the interview; the veil offered self-protection and self-preservation. There was an observable shyness in sharing their thoughts.

A wide array of literature (McKay and Diem, 1995, Sheffield, 2004) use the term *psychological functioning* as a category for evaluating health (i.e. nervousness, feeling 'down' or 'blue', headaches, anger, miscommunications with peers). For the

purpose of this chapter, the concept, term, and process of *embodiments* is used instead to explain a more holistic view—the view of the adolescent world in Afghanistan within the cultural, historical, and contextual realities of Afghanistan.

Table 4 maps out the embodiment elements (Ruglis, 2009) demonstrated by the study participants.

Table 4: Embodiment elements and stressors. Continued onto next page.

Study participants	Demonstrated Embodiments
Illaha	Homesick, headaches, tensions from being far from home, gossip, dorm life in India, roommate pressure, favoritism, unfairness, hunger, tensions about exams, nationality marginalization, fatigue, and refusal to eat food.
Nigina	High-stake exam, travel security, school expenses, test failure, lack of money, ethnicity privileges, favoritism, female vs. male privileges, no autonomy of choice, headaches, worry about safety, confidentiality issues with doctors.
Suraya	House chores (laundry, ironing, cleaning), headaches from thinking, traveling safely to/from school, gossip, peer pressure at workplace, no autonomy (e.g. unable to choose between studying law or medicine), high cost of entrance exams, high-stake exam/test failure, ethnicity privileges—Tajik vs. Pashtun, no books or materials to prepare for exams.
Sayora	Gossip, abandonment (biological mother is not present), no autonomy (e.g. cannot choose her own life course due to an arranged marriage), differences between the resources available to males and females, school expenses, hunger, poverty.
Kimran	House chores, lots of homework, no books for girls, high stake exams, peer pressure, courses of no interest, worry about safe travel to/from college, confidentiality issues of girls' pictures taken by mobile phone, favoritism/teacher unfairness to girls vs. boys.
Zuhal	Ethnicity marginalization—Pashtun vs. Tajik, gossip, peer pressure, abandonment, worry about safe travel to/from school, headaches, expense for schooling, failing the national test.
Dilrabo	Gossip, pressure from relatives, refusal to eat, abandonment, headaches, sleep deprivation, too much work at home, school expenses, security for travel.
Orzu	Abandonment, worry about safety, headaches, courses of no interest, no autonomy for class selections, unfairness, having to repeat grade for second year, expense for schooling, expense for

	medicine, sleep deprivation, mood swings.
Mushtari	Abandonment, worry about safety, headaches, failing the exam for midwifery college, unfairness, ethnicity privileges of Tajiks vs. Pashtuns, money, sleep deprivations.
Mizgona	Abandonment, worry about security, favoritism, unfairness, ethnicity privileges, expense for schooling, hunger, poverty

The data presented in Table 4 subjectively measures health through the study of participants' emotional experiences. It suggests that contextual embodiments are closely related to stress, anxiety and fear. It is well documented that stressors, particularly those embedded within specific population or contextual realities, can cause health issues and health-compromising behaviors. In this study, three study participants clearly agreed:

A healthy girl to me is a person who is tension-free. She should not have stress, from all the things in life, for example, not only sickness, but also some anxiety of life should not be there (Illaha interview, July 19, 2010).

Some people have difficulties mentally and intellectually. But the meaning of healthy female is whatever she can do is to be free (Suraya interview, July 23, 2010).

[I wish] if we have home of our own then we will have a peaceful mind. If I finish my study that would be healthy future [for me] without tensions (Mushtari interview, October 14, 2010).

Included within the process of embodiments is the concept of performative expressions. Performative expressions include silence, crying, weeping, sobbing,

and expressions of sadness, nervousness, or happiness (Ruglis, 2009). Nine study participants wept during the interview (Analytical memo notes, October 20, 2010). Their tears represented their despair (“What is the solution if my father is in a jail?” Orzu’s narrative), their cries for help (“How can I get help when I have bad headache?” Mushtari’s narrative), their grief (“My uncle died and then my auntie’s husband died and then my grandfather died,” Dilrabo’s narrative), or their abandonment and self-pity.

Many times, I have feeling of not having my mother [around]. I do not remember my father, but I love my mother a lot [weeping during interview] and [long pause] (Sayora interview and my observation notes, October 16, 2010).

The participants also talked about what caused them to cry:

When my heart is sad, I cry. Early [when I was younger], I would cry. Where there is no electricity, I go to where the generator is and I cry a lot there... and after some time, my cry finish [I calm down] (Kimran interview, July 22, 2010).

Everywhere that I look there is a grief (Dilrabo interview, October 17, 2010).

I cry a lot (Mushtari interview, October 14, 2010).

Girls Raised in Single-Parent Households Express More Stress

Two participants demonstrated notably higher levels of performative expressions throughout their interviews. They were Mushtari and Orzu. Both came from single-mother households. While sharing her story, Mushtari wept, expressing

her anxiety about whether she passed the entrance exam for the midwifery program.

We do not have money. We will continue such life [until I can begin working].

They [friends and relatives] study to be teachers. But I do not want to be a teacher. I want to be a midwife. I want to get accepted to midwifery program.

And I do not have means and connections [we have to know influential people in Talokan, so they can help] (Mushtari interview, October 14, 2010).

Mushtari feels sorry for her mother, which makes her sad (Observation notes, Mushtari house, Talokan. October 17, 2010).

For Orzu, anxiety and fear for the future are interwoven. Because her father is in jail, Orzu experiences these emotions. She feels ashamed. School pressures make her anxious and stressed:

Some laugh at me. [Who? Girls in the school?] Yes, girls. They tell me 'your father is in jail'. How will I start my life? How we will live our life [pausing]... [They] always laugh at me. When I come from school... I just cry. I am broken... I am really broken down [weeping] (Orzu interview, October 13, 2010).

Orzu recognizes the limitations of her family's financial situation; the family must survive without the support of her father. Orzu feels threatened by future uncertainties, negatively affecting her academic performance at school. She wonders, "What the future holds for me."

Participants' Stress is Related to Family Dynamics

The participants' narratives indicated that health and anger issues are interconnected with domestic concerns. The participants demonstrated their anger through raised voices and rebellious attitudes toward family members. Sometimes the participants expressed their anger during meal times:

One or two times I got angry over the dinner table and I made everybody upset. For that [my attitude] when I cry, I upset everybody (Kimran interview July 22, 2010).

At other times, the participants ceased communicating with family members (Comments by Mushtari's mother during the interview, October 14, 2010) or argued with their mothers (Comments by Orzu's mother during the observation October 13, 2010).

Mushtari and Orzu both expressed mood swings (e.g. happy in the morning, but crying by evening). Both were angry with their mothers and siblings, especially their younger brothers. Mushtari and Orzu both fight with their brothers (beat them, verbally abuse them, chase them from the room, patronize them, etc.). Mushtari confronts her mother, expressing self-pity over their poverty and complaining about not being as fortunate as other families.

The participants' emotional vulnerability also extended to neighbors and community members. Nigina, Mushtari, and Orzu wept during their interviews for the relatives and neighbors who lost family members in a suicide-bomb explosion and the devastations within Talokan during the autumn of 2010.

Participants' Awareness of Self-image Indicates Developing Identity

Adolescents develop self-image once they begin to conceptualize the thinking of others or are influenced by the outside world. Consideration of the thoughts of others is a vital step in maturation, creating a pervasive self-consciousness (Elkind, 1984). Girls become more concerned about their appearance and often develop negative self-images if criticized (Slater et.al., 2001, p. 445). Illaha shared:

Sometimes, my friends say that ‘you are fat; this outfit (indicating the dress she was wearing) does not suit you’. I would be upset about it [friends calling me fat]. Because I have classes, I must eat. Otherwise, I do not want to eat food. I wish I had slim body (Illaha interview, July 19, 2010).

Appearance is intertwined with beauty in Illaha’s narrative. Perceptions of *fatness*¹³ or *thinness* are directly related to the third-party validation. The comments of Illaha’s friends pain her, but she feels that she has to eat in order to maintain energy for her studies. When wearing mascara or face powder, Illaha looks to her mother for validation.

Zuhal also is concerned about her relatives’ (i.e. aunts, female cousins) comments about her appearance:

Before I was overweight. Now relatives that come from Kishm [village name] ask me ‘why you are not gaining weight?’, and seeing me as skinny. Then everybody says ‘what is happening that you are skinny?’ I say, ‘no I am well this year’. My mother gets upset with me, and says that ‘you are not eating enough’ (Zuhal, Interview, October 14, 2010).

Dilrabo noted:

¹³ Expressions such as “fat” or “thin” have different connotations in Afghanistan than in the U.S. “Fat” can mean that a girl has wealth, access to a good life, and social position. “Thin” is often a reference non-traditional influences and media.

I hear often comments from my relatives ‘Dilrabo eats a lot and therefore she is gaining weight’ (Interview, October 17, 2010).

Cultural factors and accepted standards of approval and validation shape individuals’ concept of body image (Slater et al., 2001). Adolescent self-image is correlated with their developing abstract-thinking skills (Piaget, 1977). Adolescents often create imaginary audiences and believe that everyone is noticing and thinking about them, causing them to become highly preoccupied with their actions and appearance (Elkind, 1984, Grower et al., 1992, Slater et.al., 2001).

Many social factors influence adolescents’ understanding of health and healthy behaviors. The study participants mentioned many external sources affecting their understanding of body image (particularly in regard to body size), such as popular media, television, and other media. These sources influenced their understanding of the ideal body. For the study participants, preferred body types are still understood through the perceptions of others, not through their own perceptions. The study participants are still developing, in the context of Talokan cultural influences, their own perspectives on body types.

Participants’ Health and Health Behaviors are Influenced by Islamic Culture

The participants’ narratives indicate that specific cultural and religious customs impact their physical and mental health. Two particular customs do this directly: wearing *chodari* (a garment that covers most of a woman’s head and body) and polygamy.

A *chodari* is made from non-breathable polyester material and is cut long to envelop the whole body from head to toe. A *chodari* is traditionally either blue or

white. Recently, however, I observed (during my travel observation in June-October 2010) orange chodari. The small facial grille is small and does not allow the wearer to see or breathe well; wearing a chodari also makes it difficult to walk or cross a road in heavy car traffic. In the summer, Talokan is often hot and dry; under these conditions, the non-breathable chodari traps dust and hot air inside its folds, resulting in “enveloped bodies.” During the winter, a chodari makes it extremely difficult to walk.

The chodari is widely worn in rural areas. These areas are more traditional and still encourage obedience to traditions or the “Taliban legacy on wearing chodari.” Although Afghanistan’s constitution and laws grant women the right to choose their head garments (CEDAW, 2011), for many women, social pressure limits their freedom. Wearing chodari is a sign of “respectability.” Carol Gilligan observed that cultural and socioeconomic influences can silence the voices of adolescent girls (Tylor, 1995). Girls are “silenced” by conforming to dominant cultural pressures. In Talokan, the dominant cultural pressure is to wear chodari.

I was weeping [underneath chodari] as I mentioned it makes a person to feel with no value. I am afraid in a city [if my face will be open], because many people will talk (Kimran interview, July 22, 2010).

For some girls, however, the chodari becomes a symbolic demonstration of protection. Many of the study participants felt that the chodari protected them when they were in the public. Talokan is dominated by Uzbek and Tajik ethnic groups. In these groups, community elders still exercise considerable influence on how women dress. Nigina and Illaha come from a Tajik background (Interview conversations on

July, 2010), so they feel it is important to wear chodari to express their social status within the community:

Those who do not wear chodari, people say ‘they are bad behaved’. People are narrow-minded [in remote areas]. When one wears chodari, they say ‘it is good’ (Mizgona interview, October 18, 2010).

Other participants wore the hijab with the face and hands visible:

I wear Hijab. In Islam, you are allowed to open your face and hands. My father does not allow us that way [to wear chodari]. I watched television and heard that women who wear chodari carry drugs [heroin, opium] (Suraya interview, October 2010).

Participants reported that wearing chodari raises health issues, such as low visibility, skin deterioration, headaches, and limited mobility and movement.

Yes, it [wearing chodari] is very tiring. I get headache. It is also very hot underneath. But I have to wear it. When a person wears chodari, you cannot see in front of you [pause]. When the sun reaches your eyes or gets on the way [walking towards the sun], you cannot see it [the road or pathway ahead of you] and cannot walk. You walk “blindly”. [How do you see then at night?]. ‘At night, since not many people see, you open your face [from chodari] (Illaha, Interview, July 19, 2010).

Socioeconomics, social class, and ethnic background influence (Tylor, 1995) young females’ behavior and the stories they share. In Talokan, social and ethnic tensions often dominate the community and, perhaps, the social code in family settings. Mushtari related how chodari impact the family economy:

If we buy bread, then we cannot purchase our *burqa*. We do not have money [for both] (Mushtari interview, October 14, 2010).

The practice of polygamy created stress for some of the participants. According to Wadud (1999), polygamy is practiced in many Islamic countries. Some cultures, however, maintain critical misconceptions about the practice. In the context of the seventh-century Arabian world, Qur'anic polygamy provided a means to look after the widows and orphans of the men who died in war. Remarriage, for a widow, meant protection and provision for herself and her children.

Participants' stories demonstrated the impact of polygamous traditions upon the mother-daughter relationship. Sayora's story provides an example. After her father died, Sayora's mother was married (as a second wife) to a man in Badakhshan. Sayora and her sister were handed off to their grandparents. Sayora, now grown up, feels betrayed and abandoned by her mother. She is still struggling to understand the Islamic perspective on marriage and polygamy.

I am an unluckiest girl in this planet. Why am I separated from my mother? I do not have even brothers. One girl has dreams and wishes, but my future is conflicting.... Many times I have a feeling of missing [having] my mother [around]. I do not remember my father, but I love my mother a lot [weeping]. My mother is *amboq* [second wife to the husband]. Her husband has another wife [pause]. We did not know about this, that the man had another wife. They live [all wives] in one house (Interview, October 16, 2010).

Participants Seldom Share Stories of Actual Health Care or Coping Strategies

Out of ten participants, only Orzu discussed going to a doctor or taking actions to improve her health. Orzu uses medications to address the pain in her life. She suffers from mood swings, worrying, crying, and anxiety, so she went to a doctor for medical assistance. For Orzu, grappling with stress and anxiety, going to the doctor for medication was an act of survival to help alleviate her pain. The medicine she takes is an antidepressant made in Iran. Orzu's mother talked about the experiences of taking Orzu to a doctor. She shared:

The medicine is for *asab* (nerves). She [referring to Orzu] developed breathing problem, where she was short of breath. I spent 4000 Afghan rupees for medical procedures and 110 Afghan rupees for medicine. There are 2 types of tablets that she [referring to Orzu] has to take at night that help her with her nerves [mental stress]. It is similar to *diazepam*; something used for headaches. There are two types [tablets], which I do not know. Both [tablets] make her sleepy. The other [medicine] is like glycine, which is like having green color inside. That is for nerves. [Do you know the names]? I forgot the names (Comments by Orzu's mother during the interview, October 13, 2010).

The prescriptions from local doctors make Orzu feel sleepy all the time:

When I add [eat] the tablets I feel like sleeping. When I use those tablets at 6 p.m. or at 7 p.m., I wake up at 10 o'clock or 11 o'clock in the morning. [For how long have you been taking these medicines]? For one year now (Orzu interview, October 13, 2010).

Complex emotional processes—including positive and negative mental-, psychological-, and health-behaviors—cause anxiety. Orzu’s anxiety demonstrates how location, social pressures, and cultural structure can create vulnerability. Her story also exhibits the contrasting ways people cope with anxiety (Wilkinson, 1969).

Only a few study participants discussed their coping strategies for daily life issues. Illaha understood health through behavioral and cultural experiences. Illaha’s studies took her far from her home and native country—to India. Her coping strategies must be understood within this context (Bartley, 2004). She sees health in terms of “tension-free” behavior. When she experiences tension, she uses her internal coping strategies to deal with it. One example of her coping strategy is how she dealt with tension and verbal abuse in her dorm. Besides confronting her roommate, she also sought medical attention for the headaches and migraines that she believed were related to the stress. Illaha demonstrates psychologically healthy behavior to deal with tension; her response shows internal strength and internal coping skills. Illaha, as Bartley (2004) says, “learns how to learn behaviors that are shaped by exposure to a certain social environment” (p.69). Illaha believed that her experiences with her roommates in India were unhealthy and created health concerns and tension. In response, however, she has resiliently developed a collection of learned behaviors to handle outside pressures and stay healthy.

One coping strategy mentioned by several participants related to their Islamic faith—prayer. Secular Islamic medical beliefs and Islamic Hadith both inform attitudes and beliefs about the nature and cause of illness. These cultural beliefs link individuals’ illnesses to their sin and non-compliance with traditions and Prophetic

statements. The Qur'an¹⁴ provides Muslims with many examples of prayer and faith in overcoming adversities and bringing internal harmony. Prayer is an essential element in prophetic medicine and healing in Islamic culture (Rahman, 1987). Higgins (1994) notes, "faith is an activity of meaning making in its most ultimate and intimate dimensions—findings patterns, order, and significance to our lives" (p.172).

The participants did not express their prayers and faith in terms of meaning-making activities; however, their non-formal conversations demonstrated that they viewed prayer as a calming activity that helped them to see life more clearly. Two study participants shared that they turned to prayer in times of anxiety and stress. They refer to prayer as an activity.

You know I wake up at night and I pray. After praying, I feel very calm (Orzu interview, October 13, 2010).

I pray at night in my living room. I like to pray and then I feel better (Suraya interview, July 23, 2010).

Orzu combined self-help solutions and traditional and cultural beliefs to navigate her health challenges. Suraya shared that she often studies books on Islam and prays when she is confused about her educational choices.

This study did not examine in great depth how (and to what extent) faith and prayer shape female identities. The participants' references and linkages to faith and

¹⁴ The study participants made several comments such as: "Yes, I pray and it does say in Qur'an..." (Illaha, Sayora, Suraya, Mizgona, Kimran), so I examined Qur'anic suras to understand the relationship between faith, life, and prayer for adolescent Afghan females.

prayer, however, invite us to recognize that they could serve as tools for “organizing a person’s deepest convictions about herself and others” and understanding the world and themselves (Higgins, 1994). Understanding faith and prayer in the context of tools, it would be possible to explore whether they decrease adolescent Afghan girls’ tensions during times of difficulty.

Summary of Participants' Perceptions of Health

Three main research questions drove this study:

1. How does a young female’s understanding of health issues shape her identity in northeastern Afghanistan?

This study demonstrates that young, Afghan females view health not only in terms of medical treatment, but also in connection to their wider experiences. The study participants did not make the links and connections themselves. While categorizing and analyzing the study participants’ narratives, it became apparent that their perceptions of health were framed, not only in terms of anatomy and biology, but also in terms of emotion. Perceptions of health also seem strongly correlated to elements of embodiments (e.g. anxiety, tension, lack of autonomy) and cultural norms (e.g. chodari, body image, prayer, polygamy) in Talokan, Afghanistan.¹⁵

The study participants continuously connected their perceptions of health to their own context (e.g. embodiments and stressors related to their conditions,

¹⁵ This study was conducted in Talokan, Afghanistan. The findings are only pertinent for understanding conditions and perceptions in Talokan. They do not, necessarily, reflect other areas in Afghanistan, such as Kabul Badakshan, etc.

chodari, body image, relationships with their mothers, social criticism, etc.) and the norms of their culture.

2. In what ways do the narrative stories of Afghan females link to issues such as education, health, and family dynamics?

In this study, the participants strongly connected health and education, directly correlating stress with educational concerns. Participants saw good health as an enabling factor for their education, and they saw education as an enabling factor for their life goals. As Illaha stated, “I want to eat well, so I can study” (Illaha’s narrative).

In addition to education, the participants directly connected health to a low-tension life. This study suggests that poor, adolescent females, struggling to survive within their limited means, face considerable challenges in making healthy choices and resisting health-compromising behaviors.

Most importantly, however, family relationships shaped the participants’ identities, providing the participants with their primary socialization. The participants linked education, socioeconomics, and family dynamics to their understanding of health issues and socialization. In this way, the participants overall well-being was directly related to their family dynamics.

3. In what ways are the narrative stories of Afghan females linked to their cultural beliefs about health?

The study participants did not directly link their Islamic faith, social customs, and cultural belief with their perception of health and a healthy lifestyle. As was

demonstrated in the responses to Question 2, cultural norms shaped the participants' shared perceptions of health.

Questions for Future Research

In this section, I outline questions that surfaced during the course of my study regarding: a) family relationships, b) education, c) and health. These questions can be used for future research aimed towards a deeper understanding of adolescent females' perceptions of health in Talokan, Afghanistan. And, finally, I conclude with a discussion of effective research methods and strategies for these future studies.

Family Relationships

Discussing health concerns with family members can encourage healthy behaviors (Sheffield, et. al., 2004). Adolescent females unable to discuss their feelings can develop negative perceptions that lead to depression; these negative perceptions can be expressed through sadness, isolation, anger, negative self-image, etc. If adolescent females in Talokan do not have adequate family support, who will they talk to about their health issues? Questions for further research could include:

- As adolescent girls in Talokan are uncomfortable talking about health issues with the women in their family, do they talk to anyone about their health issues? If so, to whom? If not, what are the consequences of their inability to discuss their health issues?
- In cases where family members are a source of support, how effective is their support in regard to health issues?
- How can understanding, knowledge, and information relating to health be developed in isolation and without discussion about health matters?

- How is information about health disseminated to women and adolescent girls and women in semi-rural Talokan or similar areas?

Education

The participants in this study viewed education as vital tool for healthy behavior and choices. As schools and universities can effectively communicate and disseminate health information (McKay and Diem, 1995), the following questions arise:

- Do schools in semi-rural Afghanistan convey health information to adolescent girls? If so, at what grade/level? If not, what barriers exist to teaching about health in semi-rural settings of Afghanistan?
- What resources, curriculum, and other support would be required for Afghan schools to run a health-awareness initiative?
- How can health information reach adolescent girls in Talokan who do not attend school? How can communities and social services help disadvantaged adolescent girls develop an understanding of health and health behaviors?

Health

During the study, questions arose about whether socioeconomic level impacted adolescent females' support systems and their advocacy of healthy behaviors in Talokan, Afghanistan. The participants coming from higher socioeconomic backgrounds were pressured to conform to the dominant culture and ethnic traditions while the participants coming from lower socioeconomic backgrounds were more isolated and lacked support. Illaha and Nigina came from the dominant Tajik background. Orzu, Mushtari, and Sayora came from the minority Pashtun

background and seemed to “stand alone” in regard to health matters and information.

- In what ways and under what conditions do adolescent girls in semi-rural Afghanistan identify themselves as “silenced” or “isolated”?
- Under what circumstances do adolescent girls feel comfortable or capable of sharing their voices?
- What are the psychological, social, and logistical barriers facing adolescent females in semi-rural Afghanistan who are seeking medical assistance?

Research Methods

It will require careful attention to culture, local perceptions, and tradition to resolve these questions about adolescent females in semi-rural Afghanistan. In this context, a researcher must capture and describe the subjective details of interactions with study participants. A researcher accustomed to oral cultures will be the most qualified to explore these issues. Afghans, especially in semi-rural areas, want to ensure the confidentiality and integrity of the researcher.

Future researchers must carefully consider the conversion of abstract elements of a highly oral culture into text, focusing particularly on narrative linkages and analysis. Riessman (2008) is a helpful resource for researchers examining the impact of language and culture upon social behavior through the lens of oral testimony. Riessman’s work also includes useful insight on how a researcher analyzes a participant’s silence, tears, or internal resilience and how a researcher maintains balance between subjectivity and objectivity while analyzing the complexities of war-torn countries.

APPENDICES

APPENDIX A

PROJECT PARTICIPATION: INFORMED CONSENT FOR DISSERTATION RESEARCH (ENGLISH)

Dear Participant:

I am a graduate student in the CIE, School of Education at the University of Massachusetts, Amherst, USA. I would like to invite you to participate in a research project about young females' perceptions of their health issues in the Takhar area of Afghanistan. I am interested in exploring the views of young Afghan females and hearing their stories about their health issues. This study is expected to increase understanding of the health issues that Afghan adolescents face in rural areas. It will also help researchers to hear and understand the voices of adolescent Afghan females.

In this study, I will have group conversations (group semi-structured interviews). I will also have individual conversations (individual in-depth interviews) with each participant. All the interviews and conversations will be in Dari. I will also take notes and observations of the whole process. I will use a tape recorder in the interviews. The tape recording will help me to transcribe (to convert to the text) the data later.

The data collected and information obtained in this study will be used for my dissertation only. If, in the future, I wish to publish it, I will contact you all again to have your permission. Your real name will not be disclosed in the dissertation. I will use pseudonyms instead. Any locations or reference to another person in the interview will also be changed (e.g. if your real name is Aziza, I will call you Fatima in my study).

Your participation in this study is voluntary; it is based on your choice. If during the study you become uncomfortable with further participation or if circumstances change, you can withdraw at any time. Upon your request to withdraw, all information pertaining to you will be destroyed and will not be used for this study.

If you choose to participate, all the information will be strictly confidential. The study will only be shared with my dissertation committee at the University of Massachusetts, U.S.A. A hard copy of the dissertation that results from this study will be published and kept in W. E. B. Du Bois Library on campus.

If you are willing to take part in this study, I will provide you this form to sign. Your signature will signify your written agreement. A copy of this form will be shared with you.

I appreciate you sharing your time to participate in this study. It will help me to learn more about adolescent-health issues in northeastern Afghanistan.

Thank you very much.

Contact Information

Amina Davlatshoeva

E-mail address: adavlats@educ.umass.edu

My primary adviser, Prof. Cristine Smith at (e-mail address)

cristine@educ.umass.edu

I have read and understood the information on the form, and I agree to volunteer to be part of this study. I understand that my responses are completely confidential and that I have the right to withdraw at any time.

Researcher's Signature

Date

Participant's Signature

Contact information:_____

Phone number or location where I can be reached_____

Date_____

APPENDIX B

PROJECT PARTICIPATION: INFORMED CONSENT FOR DISSERTATION RESEARCH (DARI)

موافقت نامه اشتراک در پروژه تحقیقی

اشتراک کنندگان عزیز!

من محصل دانشکده مرکز تعلیمات بین المللی در دانشگاه مسیچوسس که در ایالات متحده امریکا موقعیت دارد هستم. من از شما دعوت میکنم تا در پروژه تحقیقی صحت خاتمه‌های جوان ولایت تخار که در شمال شرق افغانستان موقعیت دارد اشتراک نمائید و نظر تان را در مورد وضعیت صحتی تان ارائه بدارید. من علاقمند جمع آوری نظر و قصه های خاتمه‌های جوان در مورد مسایل صحتی تان هستم. این تحقیق صحتی فهم خاتمه‌های جوان را که در دهات زندگی میکنند تقویت بخشیده و همچنان ریسرچرها ویا محققان را کمک میکند تا صدای خاتمه‌های جوان افغانستان را بشنوند و وضعیت صحتی شان را درک کنند. ما در این تحقیق گفتگوهای گروهی و مصاحبه های چند نفری خواهیم داشت. مصاحبه های دونفری با اشتراک کنندگان نیز صورت خواهد گرفت. تمام مصاحبه ها و گفتگوها به لسان دری خواهد بود. من مشاهده تمام پروسه را یادداشت و ثبت نوار مینمایم. معلومات ثبت شده نوار را بعداً رونویس نموده و در رساله خود از آن استفاده خواهم نمود. اگر در آینده خواستم این معلومات ها طبع و نشر کنم ابتدا با شما تماس گرفته و طلب اجازه خواهم کرد. نام و آدرس اصلی شما در این رساله نوشته نمیشود بلکه نامهای مستعار را در عوض نوشته خواهم کرد. (مثلاً اگر نام اصلی شما عزیزه است من در رساله خود نام فائمه را به عوض نام اصلی شما نوشته میکنم). اشتراک شما در این مصاحبه ها دواطلبانه است و در جریان مصاحبه هر زمان که احساس ناراحتی کردید مصاحبه را توقف داده و باطل میسازیم. در صورت شما حاضر به ادامه مصاحبه نباشید تمام معلومات مربوط به شما را از بین برده و در رساله خود نوشته نخواهم کرد. در صورت شما موافق به اشتراک و تکمیل مصاحبه باشید تمام معلومات شخصی شما محرمانه حفظ خواهد شد و کمینه مربوطه دانشگاه مسیچوسس تنها نتایج تحقیقات من را خواهد دید. نتایج تحقیقات در کاغذ چاپ شده و در کتابخانه این دانشگاه نگهداری خواهد شد.

در صورت رضایت شما در اشتراک به این تحقیق ، من این فورمه را که رضایت شما را تصدیق میکند بریتان میدهم تا امضا نماید. یک نقل این فورمه را برای شما میدهم که نگاه کنید.

ابراز تشکر میکنم از شما که در این تحقیق اشتراک نمودید و مرا کمک کردید تا در مورد وضعیت صحتی خاتمه‌های جوان در نواحی شمال شرق افغانستان آگاه شوم و بیاموزم.

جهان سیاس !

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من این فورمه را خواندم و محتوی این را درک کردم. من حاضر هستم که در این تحقیق داوطلبانه اشتراک
نمایم. من میفهمم که جوابات من کاملاً محرمانه حفظ میگردد و من این حق را دارم که هر زمانی خواسته
باشم مصاحبه را توقف و باطل نمایم.

امضا ریسرچر یا محقق

تاریخ

امضای اشتراک کننده

نمبر تماس:

نمبر تلفون و آدرس:

تاریخ :

OBSERVATION GUIDE

Duration of Observation/Time: _____

<p>Descriptions: What did I see:</p> <p>What did I hear:</p> <p>How did I hear:</p> <p>Description of location:</p> <p>Who/what/how/where/when/—narrative points to signal from</p> <p>Observing oneself (thoughts, feelings, how did the story affect me, what are the sources of my own perspectives):</p>	<p>My comments and notes:</p>
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APPENDIX D

INTERVIEW GUIDE

The following sets of questions explore the perceptions of adolescent girls in northeastern Afghanistan. Besides these questions, a variety of other questions will be generated during the conversations with the participants.

- **Tell me about yourself**
- **Perceptions and understandings**
 - What is health? What does it mean to be healthy?
 - How do you view your health?
 - How often do you talk about health?
- **Health issues**
 - How do you describe your body?
 - How do you react when somebody talks to you about their health?
 - What do you do when you get sick?
 - Do you have a close friend that you talk to very often? Do you share your health issues with her?
 - Describe your day?
 - Do you want to talk about chodari, purdah (veil)?
- **Family**
 - Do you share your health issues with your parents?
- **Environment**
 - Describe of your living environment.
- **Additional question**
 - Who is your role model?
 - What are your dreams?

APPENDIX E

ANALYTICAL MEMO - SURAYA

**(After transcribing)
Oct 5, 2010. 18.00 p.m.**

Family. Role of a Father.

I think Suraya is close to her father. She refers to him, rather than her mother, in our conversations. Suraya apparently does not do much. I recall now that her mother mentioned that Suraya does not do much work at home (i.e. domestic chores). I think Suraya watches many television programs. She often refers to TV programs while she talks. She also learns from TV programs.

Strange. We wanted to talk about religion, and she asked me to turn off the tape recorder. I liked it in fact—she is aware of what she is saying and what she wishes to be recorded. Interesting? It was also very bold of her to ask, because not many Afghan girls would do that. (Maybe it is because she is youngest in the family and she can ask for what she wishes. Hah! Not sure?). I felt she was aware of the recording issues.

At the second interview, she told me in the beginning that I have to slow down in my talk. (NICE!) She felt that she was talking a lot. I did not feel that way. She was thinking of her talking. (NICE! She reflected about what she said to me earlier. She is reflective.)

Culture/Tradition/Tape Recording

As I was listening to transcripts of Suraya, I noticed that when she is uncertain what to say—or is shy about sharing—she laughs and lowers her voice. She was shy about:

- Religion and prayers – she did not want to talk about them and asked me to turn off the voice recorder.

As we talked about her studies and study plans, she was better—more reciprocal, more open to talk.

Suraya was very formal at first. “Did I answer you correctly? Did I?” (I am not sure why she asks. I am not looking for correct answers.) I noticed that Suraya is more interested in talking about religion and religious education. Is it her interest? Or does she want to show her religious behavior? What does religion have to do with health? I have to reconsider my questions.

“Monster” Exam: Concur Exam

I think Suraya is trying to figure out of where to go for her future education. She is thinking of means and places for her studies. She does not want to study for *concur*. (Concur is like a university entry exam.) But at the same time, she thinks practically about what her family (probably her father) want her to be and how she can get into a university. There are money issues, location issues, and place issues. Her father will not allow her to study in other provinces; it could be a safety concern. Her study interest—she does not want to pursue teacher education. Her sisters did and they are all teachers. She does not want to do that. Her interest is in religion and she wants to study it. All these issues factor into her transition into the future. I also realized that no matter what topic I broach, she comes back to the

discussion about her studies, her study selection, and what will happen to her educational aspirations. Hmm, she seems reflective and wants to engage in dialogue. Or maybe she wishes to hear advice from me? *Question to follow up in order to explore the linkages: falling into pitfalls after finishing school? I wonder how many other study participants feel the same way. Need to ask this.*

Culture/Contextual Realities/Images, TV, Media

Suraya likes Turkey. She has watched some Turkish movies on TV. I thought that Suraya was struggling between her own “wants” and the limitations and restrictions of an Afghan girl. She cannot go to other countries because her father said they are not good countries—Iran, Pakistan and India. Dad said, “You can go to Tajikistan, Russia, and USA, but not to Iran, Pakistan and India. “What does all this mean? So much of: “My father said.... My father said.” Her father is a big influence on Suraya. Could the media images be affecting her parent’s perceptions and where they will permit her to go to pursue her education? It seems that she is restricted and that her father will decide the location of her education.

Reflections on Self

An interview with Sayora feels relational. She is more engaged in discussions. All she wishes to discuss is her educational choices. We sat long hours—the room was getting dark since there was no electricity (I did not noticed)—and continued our discussion. Suraya’s mom came in and said: “why are you sitting in a dark room?” When I was about to go, she asked me about my education choices. I think Suraya is looking for advice. Suraya’s questions for me were: How did you do it? Where did you stay? Who did you stay with during your schooling? I was a bit

worried that she would talk to her father and reference my educational experiences.

I was worried that her father would say: “what did you talk to my daughter about that she now wants to go to other countries for the study.” I hope that will not happen.

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