Mental Health and Wellbeing in Post Conflict Setting: A Study from Highly Conflict Affected Area in Nepal
Mental Health and Wellbeing in Post Conflict Setting: A Study from Highly Conflict Affected Area in Nepal

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### Abbreviation

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<th>Full Form</th>
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<tr>
<td>DSM IV R</td>
<td>Diagnostic and Statistical Manual of Mental Disorders IV Revised</td>
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<tr>
<td>NGO</td>
<td>Non Government Organization</td>
</tr>
<tr>
<td>CPN-M</td>
<td>Communist Party of Nepal- Maoist</td>
</tr>
<tr>
<td>CPA</td>
<td>Comprehensive Peace Agreement</td>
</tr>
<tr>
<td>QOL</td>
<td>Quality of Life</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>MOPR</td>
<td>Ministry of Peace and Reconstruction</td>
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<tr>
<td>IDP</td>
<td>Internally Displaced Person</td>
</tr>
<tr>
<td>BAI</td>
<td>Beck Anxiety Inventory</td>
</tr>
<tr>
<td>BDI</td>
<td>Beck Depression Inventory</td>
</tr>
<tr>
<td>GHQ</td>
<td>General Health Question</td>
</tr>
<tr>
<td>IFSW</td>
<td>International Federation of Social Work</td>
</tr>
<tr>
<td>VDC</td>
<td>Village Development Committee</td>
</tr>
<tr>
<td>IED</td>
<td>Improvised Explosive Devices</td>
</tr>
<tr>
<td>CPA</td>
<td>Conflicting Party After</td>
</tr>
<tr>
<td>ERW</td>
<td>Explosive Remnant of War</td>
</tr>
<tr>
<td>UN</td>
<td>United Nation</td>
</tr>
<tr>
<td>CBS</td>
<td>Central Bureau of Statistics</td>
</tr>
<tr>
<td>DAO</td>
<td>District Administration Office</td>
</tr>
<tr>
<td>LHMC</td>
<td>Local Health Management Committee</td>
</tr>
<tr>
<td>SHG</td>
<td>Self Help Groups</td>
</tr>
<tr>
<td>PSC</td>
<td>Protracted Social Conflict</td>
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<tr>
<td>FGD</td>
<td>Focal Group Discussion</td>
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<tr>
<td>PPW</td>
<td>Protracted People's War</td>
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<td>SUBI</td>
<td>Subjective Wellbeing Inventory Scale</td>
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Abstract

[Introduction and Objectives]. The basic aim of this study was to establish the prevalence of post mental health among victims of conflict in Nepal, as a measure of the mental health consequences of armed conflict, as well as to inform a quality of life and subjective wellbeing. It investigated thoroughly the mental health issues suffered by the conflict affected and non-affected people and differences between these two groups along with their current standard of living and happiness and satisfaction with their own lives through the systematic use of BDI-II, QOL scale and SUBI measurement. [Methods] An exploratory, descriptive study was conducted to explore mental health problems and their effects on the quality of life (QOL), as well as on the wellbeing of people affected by the conflict in Nepal. The research comprised three aspects. In research 1, the Beck Depression Inventory (BDI) was used to assess and compare categories of depression in participants from a conflict-affected area (n = 75) and a non-conflict-affected control group (n = 25). In research 2, the WHO-Quality of life Brief Scale (WHO QOL) was used to assess and compare social, physical, psychological, and environmental component of the quality of life in participants from a conflict-affected area (n = 50) and a non-conflict-affected control group (n = 25). In research 3, the Subjective Wellbeing Inventory (SUBI) was used to collect data from participants that only included people from a conflict-affected area (n = 50). [Results] The BDI categories interpretation revealed that in exposure group 29% (n=22) out of total participants had severe depression level, 38 % (n=28) had moderate level, 21 % (n=16) had mild and 12 % (n=9) had minimal level of depression. In control groups 8 % (n=2) had severe depression level, 28 % (n=7) had moderate 24 % (n=6) had mild and 40 % (n=10) had minimal level of depression. It showed that 67% participants (n=50) had clear indication of depression symptoms in exposure groups. It was 31% higher than control group. The WHO QOL brief total and sub domain scores among the conflict exposure group B was significantly lower in comparison to the control group B (p< .01) in all scores except social relationship Domain). More over the satisfaction with life (Q1) domain score also showed the relatively lower in conflict exposure group B. Satisfaction with health (Q2) was also lower (p<. 01) among the conflict-affected group compared to control group. In Subjective Well Being the mean value of most of the dimensions score were below than middle value. It indicated that those people who were affected by conflict were experiencing difficulties in terms of happy livings. But four dimensions such as, General Well-being, Positive Affect, Expectation-achievement Congruence; Confidence in Coping, Primary Group Concern carried high mean value. [Conclusion] The evidence provided in this research demonstrates the importance of considering mental health and wellbeing as significant aspects of human life. In particular, it is suggested that mental health services of conflict-affected nations should be integrated into the general health service system of the country, such that these services can benefit conflict-affected groups in the population. It is also suggested that the capacity of national health services in conflict affected nations should be increased to serve the basic needs of people that have are victims of conflicts, and to improve their quality of life and wellbeing.
Acknowledgement

At the age of 14 while internal conflict between Maoist and Government of Nepal initiated I was a witness of being faced the some kind of psychological and social problems. That heart touching and a kind of pitiable moment always hit me to explore the psychological problems faced by the people. So, I decided to conduct research about the mental health situation of post conflict period as part of my doctoral degree. The root of my keen interest to conduct this research is to deliver the psychological impacts faced by the people during and after the conflict in Suryapatuwa V.D.C. of Bardiya. As far this research is based on my own hometown I am very much pleased to be a part to express the effects of the conflict from which most of the people were suffered.

With the continuous attempt, the thesis has been completed. The work has been accomplished because of the inspiration and admiration of many people who involved during the research time. Beneath the completion of the research the concern support and supervision from handful people, I hereby grab the opportunity to express my gratitude to all of them.

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1. **Introduction**

1.1 **Introduction of the study**

A conflict is actual or perceived opposition of interests, needs, ideas, beliefs, values, or goals. Conflict is a fact of life. Therefore some of our views and opinions will differ from those of others. Psychologists define conflict to be a state of opposition and disagreement between two or more people or groups of people, which is sometimes characterized by physical violence. Conflict mostly refers to the existence of the clash, which can be interests, values, actions or directions (Tearfund, 2007). Psychologically, a conflict appears when one motivating stimulus reduces and another increases, so that a new adjustment is demanded. There are many types of conflict. The most common conflicts are emotional, interpersonal, group, organizational, military, workplace and so forth. It can also be summarized in two types, internal conflict (conflict with self) and external conflict (between two and more groups). Conflict often occurs because of a lack of respect for one another’s needs and views. However, in most cases we resolve the conflict. From a personal level to international level, conflict solution skills is usually used to overcome differences and to reach an agreement before violence breaks out. At a personal level, we often do not realize we are overcoming our differences (Tearfund, 2007).

It is the expression of disagreement over something important to both (or all) sides of a dispute. The important thing is to grasp that it is entirely dependent on the people involved. It depends on their having a particular point of view, which may or may not have independent facts and evidence to support it, and on how they behave when they encounter an opposing point of view. Violence is only one kind of conflict-behavior, of course (Peace Pledge Union 2011).

Conflict is a characteristic of human existence. It is part of the dynamic of life that drives us into the future. But it needs to be managed constructively. When associated with violence, destruction and killing, it is no longer a healthy part of living. Violent conflict solves few problems, creates many, and breeds more unhealthy conflict to come. Conflict has characteristics of its own, and it is possible to analyze its structure and behavior. When conflict is understood, it's easier to find ways to predict it, prevent it, transform it, and resolve it.

The way a society is organized can create both the root causes of conflict and the conditions in which it's likely to occur. Any society, which is organized so that some people are treated unequally and unjustly, is likely to erupt into conflict, especially if its leaders don't represent all the members of that society. If an unequal and unjust society is reformed, then conflicts will be
Conflict has been defined by Uppsala University/PRIO (and subsequently the World Bank) as contested incompatibility, which concerns government and/or territory, where the use of armed force between two parties, of which at least one is the government of a state, results in at least 25 battle-related deaths. Events resulting in more than 1,000 battle-deaths are defined as major conflicts (Wallensteen and Sollenberg 2001).

Mental health is more than the absence of disease or disorder. It is defined as a state of complete mental wellbeing including social, spiritual, cognitive and emotional aspects. Mental illness is a disorder of the cognition (thinking) and/or the emotions (mood) as defined by standard diagnostic systems such as the International Classification of Disorders, 10th Edition (ICD 10) or the American Psychiatric Association’s Diagnostic and Statistical Manual, Revised 4th Edition (DSM IV-R). Psychosocial disorders relate to the interrelationship of psychological and social problems, which together constitute the disorder. The term psychosocial is used to underscore the close and dynamic connection between the psychological and the social realms of human experience. Psychological aspects are those that affect thoughts, emotions, behavior, memory, learning ability, perceptions and understanding. Social aspects refer to the effects on relationships, traditions, culture and values, family and community, also extending to the economic realm and its effects on status and social networks. The term is also intended to warn against focusing narrowly on mental health concepts (e.g., psychological trauma) at the risk of ignoring aspects of the social context that are vital to wellbeing. The emphasis on psychosocial also aims to ensure that family and community are fully integrated in assessing needs and interventions (Florence Baigenan, 2005).

1.2 Background of the study
NEPAL, officially the Federal Democratic Republic of Nepal is a landlocked country in Asia and birthplace of Buddha. Nepal is world famous for Mount Everest and Himalayas. The Nepali conflict (labeled people war by the Maoists) was a conflict between government forces and Maoist fighters in Nepal, which lasted from 1996 until 2006. The communist party of Nepal started the war on 13 February 1996, with the aim of overthrowing the Nepalese monarchy and establishing the "Federal Republic of Nepal." It ended with a comprehensive peace accord signed on 21 November 2006. The decade long conflict causing more than 13,000 deaths, thousands
mutilated, displaced, orphaned, widowed and billions of Rupees worth of destruction of the infrastructure, and obstruction to socio-economic development, has been most affected the poor and vulnerable groups including women, children and elderly people. Those youth who have been left out and/or pushed out of school system have been in the center of the vicious cycle of the cause and effect relationship of the armed conflict (Care nepal, 2008).

No individual Nepalese is free from the effect. From very young children to the old age, rural people to the urban, government officials to the laymen all have suffered in one or the other way. Destruction of infrastructures, people being kidnapped from their home, killing of innocent people, people being homeless, people being internally displaced, children being orphan and homeless were the regular phenomena in that period. The economy of the country was in crisis. The economic growth of that period was very low, almost the minimum in the history of Nepal. There has been adverse effect upon all sectors including development, security and even survival. The high numbers of children are victimized. Their sufferings of present will affect their future and even the future of the state. The effect on the Sectors like, health, education, livelihood of children cannot be easily compensated. The impacts remain for a long period of time. So the government, political parties, civil societies and NGOs working in this sector should collaborate to overcome the negative impacts of armed conflict in people. They should bear the responsibility to provide every child with secured and progressive means of sustainable living (shakya,A., 2006).

Globally, mental health problems considered as a serious public health problem, contributing 14% to the global burden of disease. In recent years, a huge numbers of studies have been conducted on mental health of the people affected by conflict, presenting the large variation on the rates of depression (3-85%), PTSD (0-99%) and anxiety (6-72.2%)(Murthy RS, Lakshminarayana R.2006). Maoist insurgency in Nepal directly and indirectly affected the mental and physical health of the people in one hand and it gives social, economic and emotional torture on the other hand.

1.3 Statement of the problem
In 1996, the United Communist Party of Nepal (Maoist) (hereafter Maoist) announced a 'people's War' against the government of Nepal, out of dissatisfaction with gender and caste inequality and low quality government in rural areas. Though, they started the conflict against monarchical
system of the country the common people especially in rural and remote areas of the country became victims. People gradually suffered from the several mental problems like stress, anxiety, depression, as well as other physical problems. Common to international trends in armed conflicts, the Maoist insurgency in Nepal was an intrastate conflict, mainly affected civilian-populated areas based by chronic poverty. It formally ended in November 2006 with a comprehensive peace agreement between an alliance political parties and Maoist, which stipulated the participation of the CPN-Maoist in government and the monitoring of weapons by a United Nation Mission in Nepal (World bank 2007). However, Maoist conflict transferred into a political party with peace agreement the people from conflict affected areas still suffered from traumatic stress disorder (PTSD). During the 10 years of conflict, especially people in the countryside lived in fear of reprisals from both sides on suspicion of having aided the other side that caused the various mental disorders. From the start of Maoist insurgency in 1996 through the signing of the Comprehensive Peace Agreement (CPA) in 2006, it has claimed over 16000 lives and there were serious human rights violations committed by both security forces and members of Maoist, including extra-judicial executions, disappearances, torture, arbitrary arrests and detention on the part of the police. Nepal had the height number of 'disappearances' in the world in 2003 (Singh S., Dahal K., Mills E., 2005)

![Figure 1. Death during the conflict (Source: UN 2012 report).](image-url)
The effective attempt was not implemented from the side of government to address the mental disorders of the victims. Due to lack of appropriate consideration towards mental health issues, the victims during conflict remained dangerous situation.

1.4 Objectives of the study
The goal of the research was to ascertain the mental health and social impact of conflict on the victims, from one of the most conflict effected area in Bardiya, Nepal

Specific Objectives
1) To identify depression level of the respondents on post conflict setting through the use of BDI-II.
2) To examine the real situation of post conflict QOL and human wellbeing issues.
3) To understand the social, psychological, environmental, impact of the conflict.
4) To recommend the concerned sector on varied aspects of future programming needs, and establish overall priorities to maximize the impact of interventions.

Furthermore, in the present context, where most advocacy and developmental activities have been undertaken without assessing the real impact and needs of the victims of conflict, particularly excluded and disadvantaged groups, this research has attempted to create a platform where representative voices are heard, so that their concerns can be integrated into programs relating to social inclusion and nation building actions. Further, it will serve the purpose of program guidance and advocacy on the conflicts issue.

1.5 Conceptual framework
Mental health and wellbeing in post conflict situation is dependent variable whereas others components like social well being of the people, quality of life, structural inequalities, social impacts, post traumatic stress disorders and critical intervention are considered as independent variables. The research will be accomplished on the basis of these variables.

If social well being of the people is satisfactory, they are not in condition of mental health problems. The research will focus on the quality of life of the people who are directly involved in armed conflict as well as those who are not directly involve in the conflict. It analyses the
scenario of the lives of the people before and after the conflict. Likewise, how structural inequalities affected the mental health and quality of life of the respondents in study area and its impacts. Whether, those victims who directly and indirectly involved in armed conflict have suffered from depression. If they suffered what kinds of interventions have been used for the preventions of the mental disorders?

**Conceptual framework**

![Conceptual framework diagram]

*Figure 2.* Dependent and independent variables.

### 1.6 Rationale of the study

Ten years long Maoist insurgency was for the abolishment of the monarchical system and class, caste diversity and discrimination among the people in the society. The goal of the armed group was not inappropriate. Even though, some local leaders in rural areas guided by the wrong strategies to fulfill their demands were started to threaten the people who had strong social and economic background. They were considered as a rebellion group to fight with the government side. Mean time, some innocent people were killed and some were disappeared, and rest became compel to live with fear of abduction, threatens and so on. Consequently, mental disorders have
been emerged among the people.

Mental health problems alone demand attention and intervention, prevention and palliative treatment will differ depending on the nature of war-related factor other risk factors. More detailed knowledge of the impact of political violence other chronic social problems can lead to better-informed interventions in post-conflict settings with scarce resources. The identification of mental health problems in these settings preceding conflict demonstrates the need for investment in mental healthcare infrastructure and other psychosocial services in impoverished communities. The post conflict mental health problem can not be seen in Bardiya district as the research has done in some VDCs of Bardiya, it can also be seen all over the country. However, this research represents the effects of the conflict on psychological aspects of the people who faced that situation. Thus, this study will be useful for the formulation and implementation mental health programs for the intervention. It will also significant to give emphasis on mental problems and its importance for human life span.

1.7 Structure of the study
This study has been organized in five different chapters. The first chapter deals with introduction that includes background, objectives of the study statement of the problem, theoretical framework, rational of the study, limitation of the study, operational definition and structure of the study. The second chapter is the review of literature that discusses on the conceptual and theoretical perception and issues regarding this research. Furthermore, this chapter also deals with the Edward Azar's theory of Protracted Social Conflict (PSC). Chapter three consists research- 1 with its methods participants, materials, data presentation and its results. Similarly, chapter four deals about the research-2 along with methods, participants, results and discussion. Research- 3 is in chapter five in which introduction of subjective wellbeing, methods. Participants, data presentation and discussion have been mentioned. The data have been analyzed through frequencies; crosstabs and so on chapter six comprise the major finding, recommendation and conclusion. The overall finding of three different researches, recommendation on the basis of finding of the research and summary of the research has been presented.
1.8 Introduction of the study area

In this research the study area was selected Bardiya district, which is one of the most affected area during ten-year civil war in Nepal. Bardiya has an area of 2025 sq. km. of which 17.12 % is forest area. Only 32.89 % of the land area of Bardiya is cultivable. About 6.58 % of the area of Bardiya district is covered by the rivers, their tributaries and lakes, while 0.43% of the land area is covered by grass-land and uncultivated land. The population of Bardiya district is 4,75,766. Average family number is six per family. Except Gulariya bazaar of Gulariya Municipality, all areas of Bardiya are rural. Bardiya has 31 Village Development Comities (VDCs). The literacy rate in the district is 39.1%. Male literacy rate is 56 % while female literacy rate is 42 %. There are 400 government schools and 65 private schools. The district has one hospital and 33 health posts. During the conflict 398 people from Bardiya were killed and many causalities happen in Bardiya(CZOPP 2010).

Bardiya witnessed massive human rights violations during the ten years of armed conflict between Nepal Government and CPN-M. The effect of armed conflict was widespread in all aspects. This can be summarized in following points.

**Mental and Psychological Aspect**  People were afraid to come out of home. Insecurity of life, fearful environment due to donation drive, forceful abduction, threat to life and property were extensive.

**Economical Aspect.** Business was badly hit and many factories were closed. Seizure of private property, and food grains were and massive Banking services were halted.

**Social Aspect:** People were forcibly displaced, disappeared and killed. People were afraid to express their opinion. One was suspicious with another. Social and cultural gatherings were banned.

**Political Aspect.** People could not hold political ideology as per their conscience. People could not participate in any political activity as it could invite the act of reprisal.

**Education.** Schools were used as a platform for political trainings. Students were forced to join rallies and political demonstrations. Regular education was obstructed.

**Development Aspect:** VDC buildings, police posts and other government infrastructures were destroyed. No new infrastructural development could happen.
Office of the District Administration (DAO) of Bardiya has confirmed 398 persons killed in Bardiya during the ten years of armed conflict. Similarly, Government of Nepal has confirmed that 285 persons had been forcibly disappeared in Bardiya during the ten years of armed conflict.

Table 1

*Causalities in Bardiya district*

<table>
<thead>
<tr>
<th>Killed</th>
<th>Disappeared</th>
<th>Displaced</th>
<th>Wounded</th>
<th>Disabled</th>
<th>Tortured</th>
</tr>
</thead>
<tbody>
<tr>
<td>398</td>
<td>285</td>
<td>565</td>
<td>544</td>
<td>71</td>
<td>176</td>
</tr>
</tbody>
</table>

*Source: District Administration Office Bardiya.*
2. Literature review

2.1 Theoretical review of Nepal conflict

There is a fairly large amount of publications and documents available about the analysis of the causes of the armed conflict in Nepal. Some books have been written by Nepalese and foreign scholars. Various researchers have prepared many research papers and donor agencies and INGOs/NGOs produce several conflict assessment documents. However, there is a dearth of publications on documentation of peace process and negotiations, local approach of conflict management, civil society initiatives on conflict transformation and peace building, human rights approach of dealing with conflict and impacts of armed conflict (Luni and Keshav Lal, 2009). This chapter attempts to find the theoretical review of Nepal conflicts in perspective of Edward Azar's theory of Protracted Social Conflict (PSC).

Edward Azar's theory of Protracted Social Conflict (PSC), characteristic of wider work being done in conflict resolution in the 1970s and 1980s, offered a genuinely original interpretation of prevailing patterns of conflict that was clearly at odds with mainstream international approaches at the time. When the attention of almost all of the specialists in international relations and conflict studies was focused on inter-state wars, Azar was one of those few who were focusing on intra-state conflict having communal content. Azar's work was rarely appreciated by the contemporary literatures of his time. However, only a few years after his death in 1991, conflict studies were being focused on internal wars - for which he used the term PSC - the concept that Azar had been advocating since 1970s (Azar, E., 1990). Azar's model still retains its relevance today. He identified four clusters responsible for the initiation of PSC, viz, communal identity, needs deprivation, governance and state's role, and international linkages.

This paper attempts to analyze the Protracted People's War (PPW) started by Nepal Communist Party Maoist (hereafter only Maoists) in Nepal that lasted for a decade. Firstly, the failure of government to address the fundamental needs of the people and engaging themselves in power politics resulted into the frustration among the people especially the rural mass that were suffering from acute discrimination and poverty. Secondly, discrimination of the people in terms of caste, ethnicity, and religion and their under-representation in the administrative and political echelon and the national army further added to the dissatisfaction of the people. The Maoists effectively exploited the frustration of the masses with regards to these disparities. Nepal's porous border with India facilitated the movement of Maoists to organize their activities and
trainings in the Indian land and co-ordination with similar groups in India. On the other hand, the provision of anns and ammunition to the ruling government by the international forces especially the US and India aggravated the conflicting situation. These factors explained by Azar's four clusters are significant to explain the violent conflict in Nepal also led to the violent conflict in Nepal.

Figure 3. Azar's four clusters and its significant conflict in Nepal.

**Outcomes Analysis.** Azar distinguishes Protracted Social Conflicts as those which result in negative-sum outputs in which there is often no clear end-point and no clear winner, yet alone a solution that comes anywhere near in meeting unmet needs.

The process of protracted social conflict deforms and retards the effective operation of political institutions. It reinforces and strengthens pessimism throughout the society, demoralises leaders and immobilizes the search for peaceful solutions. We have observed that societies undergoing protracted social conflict find it difficult to initiate the search for answers to their problems and grievances. As the protracted social conflict becomes part of the culture of the ravaged nation, it builds a sense of paralysis that afflicts the collective consciousness of the

Azar points us to four possible consequences of PSC:

1) Deterioration of physical security
2) Institutional Deformity
3) Psychological Ossification
4) Increased Dependency & Cliency

2.2 Mental Health Biography of Nepal

An explicit mental health policy is an essential and powerful tool for the mental health section in any ministry of health. When properly formulated and implemented through plans and programs, a policy can have a significant impact on the mental health of the population concerned. The outcomes described in the literature include improvements in the organization and quality of service delivery, accessibility, community care, the engagement of people with mental disorders and their careers, and in several indicators of mental health. Despite wide recognition of the importance of national mental health policies, data collected by WHO reveal that 40.5% of countries have no mental health policy and that 30.3% have no program (WHO, 2010). The issues of mental health and the people who suffer from mental disorder are particularly marginalized in Nepal. About 10% of Nepalese people suffers from one or more mental disorder and an estimated 1-3 % of the population suffers from chronic, severe mental disorder (WHO, 2006). The prevailing view about mental disorder in Nepal is extremely negative. Most people think that mental illnesses are incurable. Families rarely recognize a mental disorder when signs of illness appear, and there is a lack of knowledge about the need to seek treatment. Chronically mentally ill patients are considered a burden to both family and society. There is no mental health act at the national level and community mental health programs are grossly inadequate. Few mentally ill patients reach health facilities for treatment and care. Families of patients often resort to locking them in rooms or chaining them up when they become exited or violent, and many are simply abandoned.

The Nepali Civil Code 1963/64, assumes state responsibility for treatment of mentally disorder people. The legal definition of mental disorder was not clarified, but the language of the legislation refers to someone with a broken mind or Madness. This attitude is reflected by day-
to-day practice where mentally ill people are described merely as Mad. In a poor developing
country like Nepal however, such patients don’t get the needed care and attention. The number
of professionals working with mental health in the country is far too few, and out of this small
number of professionals the majority is practicing in the capital city, Kathmandu. In 1997, the
government of Nepal adopted a national mental health policy and included mental health as an
element in primary health care. But mental health continues to have a low priority on the national
health agenda. Only 0.14 % of the national health budget is spent on mental health (WHO, 2006). And this allocation is only for hospital services. Nepal’s mental health policy was
formulated in 1996. Key components of the policy include:
(1) To ensure the availability and accessibility of minimum mental health services
   For all the population of Nepal;
(2) To prepare human resources in the area of mental health;
(3) To protect the fundamental human rights of the mentally ill; and
(4) To improve awareness about mental health.

The Convention on the Rights of Persons with Disability includes mental illness as a
psychosocial disability. The parliament of Nepal ratified this convention on 27 December 2009.
Now the convention must be included in Nepali laws to ensure the rights of persons with mental
illness / psychosocial disability(WHO,2006).

**Human resource in mental health.** The total number of human resources working in
mental health facilities, including the private sector, per 100,000 populations is 0.59. The
breakdown according to profession is as follows: 32 psychiatrists (0.129 per 100,000
population), 16 other medical doctors (not specialized in psychiatry) (0.0645 per 100,000
population), 68 nurses (0.274 per 100,000 population), 6 psychologists (0.024 per 100,000
population), no social workers, no occupational therapists, and 25 (.101 per 100,000 population)
other health or mental health workers (including auxiliary staff, non-doctor/non-physician
primary health care workers, health assistants, medical assistants, professional and
paraprofessional psychosocial counselors(WHO,2006,Fig.4)
2.3 Welfare in Nepal

Nepal is a small country characterized by both bio-diversity and socio-cultural diversity. Nepal indeed is a multi racial or multi-caste/ethnic, multi lingual, multi-religious and multi-cultural and more recently multi-(political) party country. There are 61 indigenous nationalities (21 in the Mountain, 23 in the Hill, 7 in the Inner Terai and 10 in the Terai regions) and about 125 languages and dialects that are still alive in Nepal. Traditional voluntary local governance has neither attracted the attention of social scientists, including anthropologists, nor of development practitioners. So far, very few articles have trickled on the issue. The history of social welfare service in Nepal is as old as the society itself. The traditional social entities such as Guthi (trust), parma(labour exchange system), dhikur(saving/credit), etc. can be taken as important social institutions created even before the unification of Nepal in 1769( Bhattachan, Krishna B. 2001)

The Social Welfare Council, SWC in short, is responsible for the promotion, facilitation, co-ordination, monitoring and evaluation of the activities of the non-governmental social organizations in Nepal. It is also responsible for the extension of its supports to the government in the matters of developing the NGO sector policies and programs of the nation and implement them in a co-ordinate way.

The Council provides with frequent training needs, small grants and back-up supports to the local (national) NGOs affiliated to this. It also cerate necessary environment to link up the
local NGOs with the international NGOs and assist to develop partnership between them for the implementation of the activities.

The council doesn't encourage the international NGOs, to go directly into implementation without taking the local NGOs as their implementing partners for reasons of sustainability, cost-effectiveness and genuine participation. With respect to the INGOs, the Council acts as a link between them and the government ministries and/or agencies. It provides the INGOs with needful guidance, administrative supports and facility arrangements such as obtaining work permit, visa and duty-free facilities including taxes on commodities, materials and equipment based on the prevailing laws and regulations of the Nepal government.

In Nepal, the number and the size of NGOs, in the last few years, have been on the rise, which necessitated a separate institutional arrangement on the part of government to deal with the entire NGO sector. Social Welfare Council was formed to look after the NGO sector by a separate Act known as Social Welfare Act, 2049 Constituted under this Act, the Social Welfare Council is responsible for the promotion, facilitation, coordination, monitoring and evaluation of the activities of the NGOs in Nepal,

Definition according to the social welfare act 2049(1992), "Social Welfare activity" means the welfare activity oriented towards the economic and social up liftment and self-reliance to the weak, helpless and disables individuals. And Social Service" means the social welfare activity done personally or collectively without the purpose of profit.

2.4 Mental Health in Post Conflict

More then 70 civil wars have occurred around the world since 1945, clamming approximately 20 million deaths and displacing more than 67 millions people (Collier, Paul, and Anke Hoeffler 2004). Mental problem is a common condition worldwide and particularly in post-conflict settings. Untreated Mental illness often results in neglect of personal and professional responsibilities and significantly impacts daily life. It also negatively affects the lives of families. Mental health is recognized as a key public health issue for conflict-affected populations. People experiencing poor mental health suffer substantial distress, and may be more vulnerable to violence, suicidality, and poor physical health and harmful health practices such as substance abuse. High levels of poor mental health can affect the ability of individuals, communities and societies to function both during and after conflict. Studies have also explored how exposure to
traumatic events and high levels of mental distress may influence respondent attitudes to reconciliation in post-conflict societies.

The impacts of conflict are complex and wide ranging. They are not confined to countries at war; they ripple outward from the initial violence, spreading from individuals and communities to countries and regions. Conflicts cause widespread insecurity due to forced displacement, sudden destitution, the breakup of families and communities, collapsed social structures and the breakdown of the rule of law. This insecurity can persist long after the conflicts have ended as internally displaced persons (IDP), refugees, and asylum seekers try to adjust to new circumstances around them, cope with loss, and regain a sense of normalcy. Bank research suggests that because these adverse effects persist for a long time, much of the cost of a war occur after it is over (Florence Baigenan, 2005).

Under normal circumstances, 1-3 percent of the population has some form of psychiatric disorder. The psychiatric literature shows that conflict situations increase disorder prevalence. Violent acts such as targeted killings, amputations, gender-based violence, and physical maiming often have long-term psychological effects on those who have experienced or witnessed them. For example, a survey of 750,000 people in East Timor revealed that 40 percent of respondents had been subjected to psychological torture, 33 percent beaten or mauled, 26 percent hit on the head, and 22 percent had witnessed a family member or friend being killed (Florence Baigenan, 2005). Other forms of conflict-related violence can include forced displacement, restricted movement, forced recruitment, harassment and intimidation, and the dangers posed by landmines and unexploded ordnance. Widespread insecurity and increased poverty, coupled with a lack of basic services such as healthcare, education, housing, water and sanitation, exacerbate mental problems.

Mental disorders and psychosocial consequences associated with conflicts include sleeplessness, fear, nervousness, anger, aggressiveness, depression, flashbacks, alcohol and substance abuse, suicide, and domestic and sexual violence. Following a traumatic event, a large proportion of the population may experience nightmares, anxiety, and other stress-related symptoms, although these effects usually decrease in intensity over time. For some, the hopelessness and helplessness associated with persistent insecurity, statelessness and poverty will trigger ephemeral reactions such as those mentioned above. For others, war experiences may lead to Post-Traumatic Stress Disorder (PTSD) and chronic depression. These conditions, in
turn, can lead to suicide ideation and attempts, chronic alcohol and drug abuse, interpersonal violence, and other signs of social dysfunction. Studies by Mollica et al. indicate that populations affected by conflict are not only affected by mental health problems, but have associated dysfunction, which can last up to five years after the conflict. This persistent dysfunction is linked to decreased productivity, poor nutritional, health and educational outcomes for the children of mothers with these problems, and decreased ability to participate in development efforts. The effects of mental health and psychosocial disorders in conflict-affected populations can be an important constraint in reconstruction and development efforts.

The Global Burden of Disease study estimated that the burden of disease from mental and behavioral disorders such as depression, bipolar disorder, psychosis, schizophrenia, and substance abuse would increase from 12 percent in 1990 (WHO 2010), to close to 15 percent by 2020 (De Jong 2001). This estimate was based in part on the projection that violent conflicts would shift from the 16th to the 8th leading cause of disease by 2020, and violence would move from 28th to 12th. Psychoses and mood disorders are widespread in conflict-affected societies (Florence Baigenan, 2005). Although conflict is associated with an increase in the prevalence of mental disorders, there are few population-based studies of adults in conflict-affected areas and low-income countries. The review presents data concerning some major wars/conflicts as follows:

This cross-sectional study was conducted in Nepal among 720 adults in 2008. A three-stage sampling procedure was used following a proportionate stratified random sampling strategy. The outcome measures used in the study were locally validated with Beck Anxiety Inventory (BAI), Beck Depression Inventory (BDI), Post-Traumatic Stress Disorder (PTSD)-Civilian Version (PCL-C) and locally constructed function impairment scale, resources and coping. Of the sample, 27.5 % met threshold for depression, 22.9 % for anxiety, and 9.6 % for PTSD. Prevalence rates were higher among women. Respondents who perceived more negative impact of the conflict (e.g., hampered the business/industry; hindered in getting medical treatment, etc.) in their communities were more at risk for depression (Luitel. NP, 2013)

2.5 Social and Wellbeing Impact of Conflict
According to International federation of social work (IFSW), the social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well being. Utilizing theories of human behaviour and social
systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work. Social work in its various forms addresses the multiple, complex transactions between people and their environments. Its mission is to enable all people to develop their full potential, enrich their lives, and prevent dysfunction. Professional social work is focused on problem solving and change. As such, social workers are change agents in society and in the lives of the individuals, families and communities they serve. Social work is an interrelated system of values, theory and practice.

Armed conflicts have profound effects on social relations between family members, neighbors and friends, on how communities relate internally and with other communities and on the operation of local institutions and their relation with state-level institutions. These changes are caused to a large extent by changes in household composition and the displacement and migration of households to safer area. They are also caused by the dynamics of the conflict itself, such as people telling on each other, different groups turning against each other and loss of trust amongst communities. These effects result often in changes and/or the breakdown of social relations and social cohesion and the loss of risk-sharing arrangements. In other words, the violence generated by armed conflict will result in the breakdown of the main components of social capital in any given society (Woolcock 1998).

Armed conflicts create enormous upheaval at the personal, family, societal, and national level. The conflict in Nepal caused immense pain, both physical and emotional, but also created opportunities, space for leadership and empowerment of women, men, of excluded communities. It created greater space for women in the public sphere, which earlier was controlled by men in traditional societies. People seem to grasp these opportunities for their own growth, as well as for demanding and securing social justice. The notion of home as safe refuge was challenged during this period. People had to face constant humiliations during search operations at homes and in checkpoints. Some groups like dalits, Tharus, and others in various geographical locations were stereotyped as Maoists thus; entire villages/ people were harassed, tortured, imprisoned, disappeared, abducted and killed. Similarly, Maoist viewed some others as exploitative feudalist, spies, political opponents, and State forces etc. as enemies. Armed Conflict has made both physical and social impact on society.
2.5.1 Destruction of Infrastructure and Scarcity of services
During the armed conflict basic services like water, fuel, food, health services and communication, etc were scarce. The Maoists destroyed many drinking water systems, health posts, telecommunication towers, Village Development Committee Offices and health posts adjacent to it and police posts. Similarly, due to bandhs/strikes blocked roads prevented in smooth transportation for food, medicine and other goods, at the same time, the government stopped supply of medicines to health posts as it was believed Maoist used it during the conflict. In this way rural people were deprived from access to basic needs. One of the most visible and direct physical impact of the armed conflict is destruction and vandalization of physical structures especially government's.

2.5.2 Trauma
People have been traumatized by grave human rights violations by both the Maoist and the security forces. Both sides killed, tortured suspected family member in front of their families; abductions and arrests occurred at guns points, in some cases, schoolteachers were mutilated, hanged, and/or shot in the school premises. Family, teachers, and others were seen with chopped off hands or legs or heads. In many cases children themselves had to face these tortures and or got killed. Many people and children are killed in cross-fires too. In some cases, the children are so traumatized that they do not want their father to leave home after dusk, if he needs to go they ask many questions before he could leave, and worryingly awaits for his return. Similarly, parents do not want their children to go too far away from their home.

A psychosocial counselor from Nepal shared people still fear sight of gun or sound of it; they have hard time going to sleep and/or they get nightmares in their dreams, many sleepwalk, and fear new faces. Children who have been part of the Maoists campaigns are getting into substance abuse. They find it hard to cope with the society.

2.5.3 Impact of conflict in women
Conflict affects women in many ways. They are not only directly abused, maimed, tortured, raped and killed but get victimized in many different ways. In cases where husbands are killed or missing women face tremendous difficulties in societies where their status in society is linked with their husbands. First they loose the breadwinner; they could even loose other means of
livelihood, right to land protection and have more chances to be raped or sexually exploited (Shakya.A 2006).

There has been a visible increase in violence against women, though not directly linked with the conflict. According to statistics at the Centre for Women and Children of the Nepal Police, the number of domestic violence cases increased by thrice as much between 1998/99 and 2006/07. In 2007, only 1,100 cases of domestic violence were recorded.

2.5.4 Impact of conflict on Children

In February 1996 to October 2003, a total of 155 children (below 17 years) were killed by the state while the Maoists killed 79. Fifty-three of the children killed by the state were females while of those 22 killed by the Maoists were females. Thousands of orphans (victims from both sides) have seen their parents, siblings, or friends being beaten up or tortured or killed. Over 4,000 children have been internally displaced; some of them even live on the street, exposed to various types of danger. Many displaced children have witnessed violence and destruction and thousands have been traumatized. Children who have been directly affected or who have witnessed atrocities from either side are deeply traumatized or have developed a sense of revenge.

In Nepal, crucial areas to foster psychosocial well-being are addressing trauma squeal at the child, family, and community level, focusing on resilience promotion through community psychosocial programs, education and income generation at the level of child, family, and community, and addressing issues related to gender and caste relations at the community level. Ultimately, attending to these issues in a social ecology framework will improve the child soldiers’ mental health and support psychosocial well-being throughout the community (Kohrt BA, 2010).

2.5.5 Impact of conflict on Youths

Youths were amongst the most vulnerable groups that borne the impacts of the armed conflict. The negative impacts of the armed conflict on the youths were most visible and viewed as 'the lost generation”, in a decade of armed conflict they lost their youth-hood in it too.

During armed conflict, youth faced problems regardless of where they lived, in rural areas or urban centers. According to few students we interviewed, both the state and the Maoists considered students at Bardiya and being spying for the other side. The security force
unnecessarily repeatedly searched their rooms. The Maoist similarly, questioned them when they returned home. Due to this kind of physical and mental torture, they said, youth got frustrated and depressed and to get away from difficult reality of State and Maoist torture and suspicion, they seems to have started taking drugs and alcohol. Furthermore, there is increase of male suicides in this district unlike what is found in rest in the country. The armed conflict, threats and terror from both the sides forced youth to remain within the four walls of their homes. They were deprived from sports, entertainment and other activities that are essential for their development.

2.5.6 Impact Based on Occupation
The cognitive, emotional and behavioral effects of psychosocial impairment can severely undermine social functioning and productivity. Studies of mental health impacts in post-conflict and developing countries are very few, although a body of U.S. research has shown that those with depression and other mental illnesses show significantly higher rates of unemployment absenteeism, poor job performance, and difficulties in performing mental and interpersonal tasks. Furthermore, studies in Europe and Central Asia describe not only individuals’ limited ability to develop self-reliance after displacement due to violence, but also depression, demoralization, and feelings of worthlessness (Holtzman S. B. and T Nezam. 2004)
3. Research 1

Post conflict depression: A comparative study from Nepal

Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration. Moreover, depression often comes with symptoms of anxiety. These problems can become chronic or recurrent and lead to substantial impairments in an individual’s ability to take care of his or her everyday responsibilities. At its worst, depression can lead to suicide (WHO, 2010). Conflict is one of the major leading causes for the depression among the conflict-affected groups during conflict between Maoist and the government of Nepal. The people from all age group like children, adult, and old generation badly affected psychologically as well as physically.

This study aims to find out the post conflict depression among the people divided them into two groups like conflict exposure group and control group by using the BDI-II.

3.1 Methods

The study was (comparative) cross-sectional in its design. The psychological aspects of the people in post conflict era have been covered comprehensively in literature review chapter.

3.1.1 Participants

First group of participants were conflict exposure group (People from one of the highly conflict affected area in Nepal) whereas second groups were controls group (people who had never directly effected by conflict). Each participant was asked to provide demographic information, consisting of age, gender education level, and occupation. The interview was taken by visiting the participant's house. As the research participants were the Tharu (Indigenous caste group of Bardiya district) they used to speak and understand their local language and their mother tongue, thus researcher took interview in participant’s own language (Tharu). Basic criteria for selection of participants were:

1) The age group of participants was 15 years above. Researcher chose that age group because they could express their views and suffering about what they expose during Maoist conflict.

2) In conflict exposure group, Local residence of Bardiya and had experience of conflict in Nepal (1996-2006) and for control group local residence of Bardiya not having direct exposure with
conflict. Both groups were divided into two sub groups, conflict exposure group A and control group A. They were involved in the interview of BDI scale.

**Conflict exposure group A:** Participants of the conflict exposure group A were from one of the most conflict affected area of Bardiya. The group consisted 75 people aged 15 years above who had experienced being involved in conflict. Some of participants were directly involved in conflicts so they exposed with severe impacts of conflict. Out of all participants 28 were female and 47 participants were male. 71% of participants were literate and remaining 29% were Illiterate. The majority of groups, which was 55% were farmers, 28% student, 9% Government Job, 3% Non government job and 4% were from others respectively (table 2).

**Control group A:** Participants of control group A were those who did not direct experience the conflict and they were from good socio-economic status. This group consisted of 25 people aged 15 years above. They were not directly involved in civil war. In control group, out of 25 participants, 14 were female and 11 were male. All the participants from this group were literate. 40% of this group were Government jobholder; 16% student 12% farmer 8% non-government job and remaining were from other fields respectively (table 2).
Table 2

Demographic information of Participants Group A

<table>
<thead>
<tr>
<th>Participants</th>
<th>Conflicted affected Percentage (%)</th>
<th>Control group Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group (N=75)</td>
<td></td>
<td>(N=25)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>47</td>
<td>11</td>
</tr>
<tr>
<td>Female</td>
<td>28</td>
<td>14</td>
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<td></td>
<td></td>
<td>44</td>
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<td>56</td>
</tr>
<tr>
<td>Age groups</td>
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<tr>
<td>10+</td>
<td>14</td>
<td>19</td>
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<tr>
<td>20+</td>
<td>34</td>
<td>34</td>
</tr>
<tr>
<td>30+</td>
<td>17</td>
<td>23</td>
</tr>
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<td>40+</td>
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<td>50+</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Literate</td>
<td>53</td>
<td>71</td>
</tr>
<tr>
<td>Illiterate</td>
<td>22</td>
<td>29</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>21</td>
<td>28</td>
</tr>
<tr>
<td>Farmer</td>
<td>41</td>
<td>55</td>
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<tr>
<td>Job</td>
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<td>9</td>
</tr>
<tr>
<td>NGO Job</td>
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<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>24</td>
</tr>
</tbody>
</table>

3.1.2 Materials

The material used during data collection was Beck Depression Inventory –II. The prevalence of depression symptoms among participants was studied using the Beck Depression Inventory-II (BDI II). This Inventory, created by Dr. Aaron Beck, is a 21-question multiple-choice self-report questionnaire, and is one of the most widely used instruments for measuring the severity of depression. The development of BDI marked a shift among health care professionals, who had until then viewed depression from a psychodynamic perspective, instead of it being rooted in the patient's own thoughts. BDI II has a total score of 63 and scores of 0-9, 10-18, 19-29, and 30-63 have been classified as having minimal, mild, moderate, and severe depression respectively. Analysis of the data was done using excel program.
3.2 Data analysis
The researcher has used the window excel and SPSS programme for interpretation and analysis of data.

3.3 Inclusion and exclusion
During this study about mental health and well-being, the researcher could not include the all type of respondent like children. The researcher tried to include all respondents from different caste groups like Brahmam, Chhetri and Dalit without any discrimination. The respondents were included in conflict exposure group and control group. Nevertheless, the researcher could not include all the people resided in that community.

3.4 Ethical consideration
The information collected from the respondents from some VDCs of Bardiya District will be confidential. The information was also collected from the informed consent of the respondents. They provided information happily for the support of the study. The researcher also fulfilled all the necessary process to use BDI-II scale.

3.5 Results
Most of questions of this research were filled in their own home, as field visit so that all participants were abled for the study. Some participants from conflict exposure group had very tragic flash back of conflict, so they took 30 min to one hour for answering questions while other participate completed it with in 15 minutes.

In Conflict exposure group mean age of all participants was 28.45 with a standard deviation (SD) 9.59. The mean of BDI score was 24.2 with 8.6 (SD). In control group mean age was 28.72 with standard deviation 10.53(SD) .The mean BDI score was 17.8 with 7.5 (SD).
Figure 5. BDI categories of the participants group A.

Figure 5 presents the BDI categories of the study population. The figure showed 4 categories of BDI depression level. In exposure group 29% (n=22) of the total participants had significant severe depression level. Similarly, 38%(n=28) had moderate level, 21%(n=16) had mild and 12%(n=9) had minimal level of depression. In control groups 8% (n=2) of the total participant had significant severe depression level. Similarly, 28%(n=7) had moderate level, 24%(n=6) had mild and 40%(n=10) had minimal level of depression.

It has shown that 67% of participants (n=50) had clear indication of depression symptoms in conflict exposure groups. Whereas Severe (22%) and moderate level (38%) in BDI Category. It was 31% higher than control group.

Table 3

<table>
<thead>
<tr>
<th>BDI categories of the participants group A by sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Minimal</td>
</tr>
<tr>
<td>Mild</td>
</tr>
<tr>
<td>Moderate</td>
</tr>
<tr>
<td>Severe</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>
Table 3 presents BDI categories of participants by sex. In conflict exposure group out of 47 male 25%(n=12) had severe depression and 32%(n=15) had moderate depression level and 36%(n=10) female had severe and 46%(n=15) had moderate depression category. It means that female prevalence of depression was higher than male in conflict exposure group. In control group out of 25 participant only 2 participants had severe BDI category of depression. In this group also female had high prevalence of depression because 25% of male had moderate depression category and 31% female in same category.

Table 4

<table>
<thead>
<tr>
<th>BDI categories of group A each item</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>No.</th>
<th>Variables</th>
<th>Affected (N = 75)</th>
<th>Control (N=25)</th>
<th>t</th>
<th>p</th>
<th>95% CI</th>
<th>Cohen's</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Sadness</td>
<td>1.9</td>
<td>0.9</td>
<td>1.2</td>
<td>1.0</td>
<td>3.05</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>2</td>
<td>pessimism</td>
<td>0.9</td>
<td>0.8</td>
<td>0.6</td>
<td>0.7</td>
<td>1.74</td>
<td>.08</td>
</tr>
<tr>
<td>3</td>
<td>Past failure</td>
<td>1.4</td>
<td>0.8</td>
<td>1.0</td>
<td>0.7</td>
<td>2.15</td>
<td>&lt;.03</td>
</tr>
<tr>
<td>4</td>
<td>Loss of pleasure</td>
<td>1.7</td>
<td>0.9</td>
<td>1.2</td>
<td>0.9</td>
<td>2.71</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>5</td>
<td>Guilty feeling</td>
<td>0.1</td>
<td>0.4</td>
<td>0.2</td>
<td>0.4</td>
<td>0.44</td>
<td>.66</td>
</tr>
<tr>
<td>6</td>
<td>Punishment feeling</td>
<td>0.3</td>
<td>0.5</td>
<td>0.3</td>
<td>0.6</td>
<td>0.21</td>
<td>.83</td>
</tr>
<tr>
<td>7</td>
<td>Self Dislike</td>
<td>1.3</td>
<td>0.7</td>
<td>1.1</td>
<td>0.9</td>
<td>1.05</td>
<td>.29</td>
</tr>
<tr>
<td>8</td>
<td>self criticalness</td>
<td>1.1</td>
<td>0.7</td>
<td>0.9</td>
<td>0.7</td>
<td>1.05</td>
<td>.29</td>
</tr>
<tr>
<td>9</td>
<td>suicidal thoughts</td>
<td>0.7</td>
<td>0.8</td>
<td>0.3</td>
<td>0.7</td>
<td>2.02</td>
<td>&lt;.04</td>
</tr>
<tr>
<td>10</td>
<td>Crying</td>
<td>1.5</td>
<td>0.8</td>
<td>1.4</td>
<td>0.8</td>
<td>0.86</td>
<td>.39</td>
</tr>
<tr>
<td>11</td>
<td>Agitation</td>
<td>1.3</td>
<td>0.7</td>
<td>1.0</td>
<td>0.6</td>
<td>1.86</td>
<td>.06</td>
</tr>
<tr>
<td>12</td>
<td>Loss of interest</td>
<td>1.3</td>
<td>0.9</td>
<td>1.0</td>
<td>0.7</td>
<td>1.98</td>
<td>.05</td>
</tr>
<tr>
<td>13</td>
<td>indecisiveness</td>
<td>0.8</td>
<td>0.8</td>
<td>0.4</td>
<td>0.5</td>
<td>3.66</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>14</td>
<td>Worthlessness</td>
<td>0.8</td>
<td>0.7</td>
<td>0.2</td>
<td>0.4</td>
<td>5.29</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>15</td>
<td>Loss of energy</td>
<td>1.0</td>
<td>0.8</td>
<td>0.8</td>
<td>0.7</td>
<td>1.65</td>
<td>.10</td>
</tr>
<tr>
<td>16</td>
<td>Changes in sleeping pattern</td>
<td>1.4</td>
<td>0.8</td>
<td>0.9</td>
<td>0.8</td>
<td>2.38</td>
<td>&lt;.01</td>
</tr>
<tr>
<td>17</td>
<td>Irritability</td>
<td>1.3</td>
<td>0.8</td>
<td>1.0</td>
<td>0.8</td>
<td>1.20</td>
<td>.23</td>
</tr>
<tr>
<td>18</td>
<td>change in appetite</td>
<td>1.2</td>
<td>0.6</td>
<td>0.8</td>
<td>0.7</td>
<td>2.13</td>
<td>&lt;.03</td>
</tr>
<tr>
<td>19</td>
<td>concentration difficulty</td>
<td>1.4</td>
<td>0.9</td>
<td>1.0</td>
<td>0.8</td>
<td>1.93</td>
<td>.05</td>
</tr>
<tr>
<td>20</td>
<td>Tiredness or Fatigue</td>
<td>1.5</td>
<td>0.7</td>
<td>1.2</td>
<td>0.8</td>
<td>1.75</td>
<td>.08</td>
</tr>
<tr>
<td>21</td>
<td>Loss of interest in sex</td>
<td>1.4</td>
<td>0.9</td>
<td>1.4</td>
<td>1.1</td>
<td>0.32</td>
<td>.75</td>
</tr>
</tbody>
</table>

It was also analyzed in each categories of BDI II that shows some large variation between some items of mean. In exposure groups three high mean recorded items were loss of pleasure, sadness, crying and tiredness or fatigue. These three high rate items in fact were the basic symptoms or DSM-IV criteria for depression. In control group’s three high mean recorded items were loss of interest in sex, crying, sadness, loss of pleasure and tiredness or fatigue. It indicates that conflict-affected group is more suffered and vulnerable by depression than the control group.
As such the BDI category shows that the clear difference between mean of conflict group and control group in sadness, past failure, loss of pleasure, suicidal thought and so on (See Table 4).

3.6 Brief Discussion

The major aim of this study was to investigate the mental health condition of two groups in post conflict situation of Nepal. Specifically, this study sought to test the depression level of the respondents who were directly involved in conflict and not involved in conflict.

Data from conflict exposure participants and control group or not affected by conflict were gathered. The demographic information of the respondents was taken from both groups. There were 75 respondents from conflict-affected area and 25 respondents from control groups. 75 respondents were the age of above 15 years who could respond upon the questions. They included male and female without distinguishing them in any respect of caste, religion, ethnicity etc. 63% respondents were male and rest of 37% were female respondents in conflict exposure group. Similarly, age group of respondents was 10 years above were 19%, 20 years above were 34%, the respondent 30 years above were 23%, 40 years above were 8% and 50 years above were 7% respectively. It suggests that all age group of the people were included in the study. The result of occupation of the respondents seems farmer, students, jobholder, NGOs, job and other respectively. Since Nepal is known as the country of agriculture, most of the people are involved in agriculture as their main occupation. The income source of the people is also depends on the agricultural products. Besides that some elite people having education and access to job can involve in the local government sectors job and other non-governmental organizations job. Rest of the respondents or adolescents go for school for gaining education. Likewise, 71% respondents from conflict exposure group were literate and rests 29% were illiterate. As they were from rural part of the Bardiya district had lower socio-economic condition. The access and convenience of education, health facilities could be found merge level according to their needs. Consequently, awareness level of the respondents from rural area was relatively lower than the respondents from city areas. May be lack of sensitization regarding health education and quality of livelihood was the causes from which they were badly suffered from the consequences of the conflict. The threat from rebellion groups, their shelter in their home and neighbor as well as their violent activities with government sectors, government personals and military force created the situation of harassment and suffocation at their daily livelihood pattern.
The control group of the study consist 25 respondents from the city area. Among them 44% were male and remaining 56% were female. Mostly in city area male were engaged in their job for their livelihood. They have to work for their family survival. So, female were more in number in this study because they were involved in their household chores and rearing their children, as it was easier to find in their home.

According to the objectives of the study the demographic information of the respondents was necessary for its comprehensive analysis. The age group of the respondents in control group was also same as the conflict exposure group. Such as 20% from above the age of 10 years, 48% from above 20 years, 16% were above age of 30 years, 8% were above 40 years and remaining 8% were from the age of 50 years above. Basically, control group focused on the non-exposure group of the Maoist conflict or they were not directly involved in the conflict and its direct effect. But maximum respondents in this group were from the teen-aged groups. As such the research has tried to explore the mental health situation of the people after the 10 years long Maoist conflict existed in Nepal by comparing the two groups from different locations. The result is based on the average suffering and mental problems of the people from all age groups. It is not biased on the particular groups like children, women, elderly people and so on. Thus, it carries the different facts regarding mental health; specifically depression level of all types of people. It seems unique and distinctive than other research studies as its implication of BDI for its analysis and for finding the facts.

The respondents from city area (control group) had access to education facilities so they all were literate. Those who were literate and exposed with facilities were migrated from rural areas to urban areas during conflict period. That is why they were less victimized from the threshold of the conflict.

As per the objectives of the research is to find the mental health condition of the people from rural and urban areas, researcher attempted to include the respondents from all occupation like students, farmers, jobholders etc. the data shows that maximal numbers i.e. 40% were involved in job, 16% students, 12% farmers, 8% were in NGOs. Job and remaining 24% were in other professions. By analyzing the occupational status of the respondents most of the respondents were employed and literate that indicates the concensitization about their mental health and avoidance from the impacts of conflict by migrating to secure place.
Moreover, all the respondents from both group completed all items on the Beck Depression Inventory (BDI). The BDI-II is a self-administered inventory that consists of 21 items presented in a multiple-choice format. The inventory takes approximately five to ten minutes to complete and respondents require a fifth- to sixth-grade reading level to adequately comprehend the items (Beck et al., 1996). Each of the items is rated on a 4-point scale from 0 - 3 with a total possible score of 63. Higher total scores represent higher levels of depression. Ratings are summed to comprise a total score ranging from 0-63 indicating depression severity. Score ranges for the BDI-II indicating severity of depression are as follows: minimal (0 - 13), mild (14 - 19), moderate (20 - 29), and severe (29 - 63) (Beck, Steer, & Brown, 1996). To address these research aims, the BDI-II was used to examine the relationship between depression of conflict exposure group and control group. In the study it has distinguished as the minimal, mild, moderate and severe level of depression in both groups according to the sex of the respondents. The result shows that 13% male and 11% female from conflict exposure group had minimal depression. Here male have more depressed than female may be due to the direct exposure with the conflict and threat of the rebellion group to join their group. During conflict male and young generation were asked to join in the rebellion group to increase their numbers to get victory. Whereas, 50% male and 31% female from control group had minimal depression. The BDI range score suggests that the people from urban area not directly exposure with the conflict were more in number. It means less numbers were in mild, moderate and severe types of depression. Less threats of conflict, awareness about the health, access to education and other factors responsible for the less chance of being depressed.

The second score of BDI clearly shows that 30% male and 7% female from conflict exposure group had mild depression. Similarly, 17% male and 31% female from control group had mild depression. The depression scoring in rural area has been increased and urban area has been decreased. Though, conflict badly affected the people from rural areas, as the area was the place of shelter and conduction training and other activities of the combatants of Maoist. On the other hand they conducted the lots of violent activities like killing the elite people, threatening the youth to join them, forcing people to provide them money, ransom etc. such circumstances made the rural people afraid to live. Therefore, this is a reason responsible for the emergence of mild depression among the people with conflict expose.
Moderate scoring of depression consists 32% male and 46% female in conflict exposure group and 25% male and 31% female in control group. A Number of male victims in conflict exposure and female in control group seem higher as such male from both conflict exposure and control group were protected than female. Female from conflict exposure were busy in their household chores and rearing the children than outside works like work for their breads. But in control group female can also involve in employment, household chores and so on.

Final score is severe depression that has shown that 25% male and 36% female from conflict affected group and 8% male and 7% female from control group were consisted. Moderate and severe depressions are considered as the presence of depression among the people. Conflict exposure group in the study was placed on the rural and remote area of the Bardiya in which female were more suffered from the conflict and its psychological impacts. Thus, they had depression due to more responsibilities needed to carry out in the house. Male members of their family have to go to city areas for earning money for their survival. The presence of female in home and violent activities by Maoist in remote area or in conflict areas directly affected the condition of the women severe.
4. Research 2

QOL at post conflict area: Study from post conflict area in Nepal

The Constitution of the World Health Organization (WHO) defines health as "A State of complete physical, mental, and social well-being not merely the absence of disease ". It follows that the measurement of health and the effects of health care must include not only an indication of changes in the frequency and severity of diseases but also an estimation of well being and this can be assessed by measuring the improvement in the quality of life related to health care. Although there are generally satisfactory ways of measuring the frequency and severity of diseases this is not the case in so far as the measurement of well being and quality of life are concerned (WHO 1996).

WHO defines Quality of Life as individual’s perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, personal beliefs and their relationship to salient features of their environment(WHO1996).

The purpose of this study was to measure the physical, mental, social, psychological and environmental quality of life among the people by distinguishing them into two groups namely, conflict exposure group and control group.

4.1 Methods

The researcher conducted a cross sectional (comparative) study of two groups of people from Bardiya. The researcher has used the quality of Life brief scale of WHO for the data collection and its interpretation. The sample size was 50 in conflict exposure group and 25 in control group with age above 15 years.

4.1.1 Participants

The following participants were selected for the measurement of quality of life:

Conflict exposure groups B: This group was consisted 50 people with age of 15 years above who had involved directly in conflict. 64% among all participants were male and 36% participants were female. Whereas 58% participants were literate and remaining 48% were
Illiterate. The majority of this group was 56% farmers, 26% student, and 18% were from jobholders respectively (table 5)

**Control group B:** In control group B, there were total 25 participants with age of 15 years above, among them 48% were male and 52% were female. All the participants from this group were literate because they were from city area having access to all the facilities. 32% of these groups were Government jobholders, and 28% had non-government job, 16% student and rest of the participants were from farmer's family (table 5).

Table 5

*Demographic information of Participants Group B*

<table>
<thead>
<tr>
<th>Participants</th>
<th>Exposure group</th>
<th>Percentage (%)</th>
<th>Control group</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>32</td>
<td>64</td>
<td>12</td>
<td>48</td>
</tr>
<tr>
<td>Female</td>
<td>18</td>
<td>36</td>
<td>13</td>
<td>52</td>
</tr>
<tr>
<td>Age groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10+</td>
<td>8</td>
<td>16</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>20+</td>
<td>27</td>
<td>54</td>
<td>12</td>
<td>48</td>
</tr>
<tr>
<td>30+</td>
<td>7</td>
<td>14</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>40+</td>
<td>3</td>
<td>6</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>50+</td>
<td>5</td>
<td>10</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Literate</td>
<td>29</td>
<td>58</td>
<td>25</td>
<td>100</td>
</tr>
<tr>
<td>Illiterate</td>
<td>21</td>
<td>42</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>13</td>
<td>26</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Farmer</td>
<td>28</td>
<td>56</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Job</td>
<td>9</td>
<td>18</td>
<td>8</td>
<td>32</td>
</tr>
<tr>
<td>NGO</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>28</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>8</td>
</tr>
</tbody>
</table>

4.1.2 Materials

The material used during data collection was Quality of Life-Brief Scale. The details of the materials can be mentioned below:

Quality of life -The World Health Organization Quality of Life-Bref Scale (WHOQOL-Bref) is a self-report, abbreviated version of the WHOQOL-100 containing 26 items divided into four domains and 2 general items. The first general items measures overall quality of life, the second
general item measures overall general health, while the first domain measures physical health (7 items), the second domain measures psychological health (6 items), the third domain measures social relationships (3 items), and the fourth domain measures environmental quality of life (8 items). The WHOQOL-Bref was originally developed for use as a cross-cultural instrument and validated across 15 field centers worldwide. The items are rated on a Likert scale from 1 to 5, with domains scores ranging from 4 to 20 where higher scores indicate a better quality of life. The original version of the WHOQOL-Bref produced the following Cronbach’s alpha coefficients: physical health = 0.80, psychological health = 0.76, social relationships = 0.66 and environment = 0.80.

4.2 Data processing
The researcher has used the window excel and SPSS software programme for interpretation and presentation of the data. The data are presented on the table, and bar diagram.

4.3 Inclusion and exclusion
As objectives of the study, the researcher included the respondents above 15 years so children and elderly people could not be included. The researcher tried to include all respondents from different caste groups like Brahmin, Chhetri and Dalit without any caste and racial discrimination. The respondents were divided into two groups named conflict exposure group and control group. Nevertheless, the study only could include the respondents from Bardiya District of Nepal.

4.4 Ethical consideration
The information collected with the respondents from Bardiya District will be confidential and will use only for the research purpose. The information was also collected from the informed consent of the respondents. All the ethical requirements have been fulfilled.

4.5 Results
Quality of life assessment Estimated QOL domains scores were calculated and are summarized in Table 6. The WHO QOL brief total and sub domain scores among the conflict exposure group B were significantly lower in compared to the control group B (p< .01) for all scores, except for
the social relationship Domain). More over the satisfaction with life (Q1) domain score also showed lower (p<.01) in conflict exposure group B. Satisfaction with health (Q2) is also one of the major domain in QOL score lower value (p<.01) among the conflict-affected group compared to control group B. The difference can be found between the QOL of conflict affected group and control group. However social life is seen similar in both groups.

Table 6
Comparisons of QOL between conflict exposures group B and control group B

<table>
<thead>
<tr>
<th>No.</th>
<th>Exposure Variables</th>
<th>Exposure (n=50)</th>
<th>Control (n=25)</th>
<th>95% CI</th>
<th>Cohen's d</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>1</td>
<td>Q1:Satisfaction with life</td>
<td>1.9</td>
<td>0.7</td>
<td>3.3</td>
<td>1.2</td>
</tr>
<tr>
<td>2</td>
<td>Q2:Satisfaction with health</td>
<td>2.5</td>
<td>1.1</td>
<td>3.4</td>
<td>1.3</td>
</tr>
<tr>
<td>3</td>
<td>I:Physical</td>
<td>18.5</td>
<td>3.5</td>
<td>22.1</td>
<td>3.8</td>
</tr>
<tr>
<td>4</td>
<td>II:Psychological</td>
<td>15.2</td>
<td>3.9</td>
<td>18.9</td>
<td>4.4</td>
</tr>
<tr>
<td>5</td>
<td>III:Social</td>
<td>9.7</td>
<td>2.1</td>
<td>10.4</td>
<td>2.5</td>
</tr>
<tr>
<td>6</td>
<td>IV:Environment</td>
<td>20.4</td>
<td>3.4</td>
<td>25.1</td>
<td>5.2</td>
</tr>
<tr>
<td>7</td>
<td>QOLtotal</td>
<td>63.8</td>
<td>9.5</td>
<td>76.5</td>
<td>12.6</td>
</tr>
</tbody>
</table>

Note. CI=confidence interval; LL=lower limit; UL=upper limit.

Table 7
Gender differences of QOL in Exposed group B

<table>
<thead>
<tr>
<th>No.</th>
<th>Exposure Group Variables</th>
<th>Male (n=32)</th>
<th>Female (n=18)</th>
<th>95% CI</th>
<th>Cohen's d</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>1</td>
<td>Q1:Satisfaction with life</td>
<td>1.8</td>
<td>0.6</td>
<td>2.1</td>
<td>1.0</td>
</tr>
<tr>
<td>2</td>
<td>Q2:Satisfaction with health</td>
<td>2.5</td>
<td>1.1</td>
<td>2.6</td>
<td>1.0</td>
</tr>
<tr>
<td>3</td>
<td>I:Physical</td>
<td>18.3</td>
<td>3.4</td>
<td>18.9</td>
<td>1.0</td>
</tr>
<tr>
<td>4</td>
<td>II:Psychological</td>
<td>14.5</td>
<td>3.4</td>
<td>16.6</td>
<td>1.0</td>
</tr>
<tr>
<td>5</td>
<td>III:Social</td>
<td>9.3</td>
<td>2.0</td>
<td>10.4</td>
<td>1.0</td>
</tr>
<tr>
<td>6</td>
<td>IV:Environment</td>
<td>19.8</td>
<td>3.1</td>
<td>21.4</td>
<td>1.0</td>
</tr>
<tr>
<td>7</td>
<td>QOLtotal</td>
<td>61.8</td>
<td>8.1</td>
<td>67.4</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Note. CI=confidence interval; LL=lower limit; UL=upper limit.

Differences in QOL brief total and sub domains scores in male and female participants scores of conflict-exposed group B has shown in table 7. Overall scores of this group were very low but there was no significant different in sub domains in comparison to male and female
participants. The QOL Brief total of the female has been shown comparatively good than of male. The reason behind this may be the increasing empowerment of the women.

Table 8

*Gender differences of QOL in control group B*

<table>
<thead>
<tr>
<th>No.</th>
<th>Control Group Variables</th>
<th>Male (n=12) M</th>
<th>SD</th>
<th>Female (n=13) M</th>
<th>SD</th>
<th>t</th>
<th>p</th>
<th>95% CI LL</th>
<th>95% CI UL</th>
<th>Cohen’s d</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Q1:Satisfaction with life</td>
<td>3.3</td>
<td>1.2</td>
<td>3.2</td>
<td>1.2</td>
<td>0.21</td>
<td>.832</td>
<td>-2.59</td>
<td>3.02</td>
<td>0.09</td>
</tr>
<tr>
<td>2</td>
<td>Q2:Satisfaction with health</td>
<td>3.6</td>
<td>1.3</td>
<td>3.2</td>
<td>1.3</td>
<td>0.67</td>
<td>.507</td>
<td>-2.13</td>
<td>3.48</td>
<td>0.27</td>
</tr>
<tr>
<td>3</td>
<td>I:Physical</td>
<td>21.6</td>
<td>4.0</td>
<td>22.5</td>
<td>3.6</td>
<td>0.62</td>
<td>.539</td>
<td>-2.18</td>
<td>3.43</td>
<td>-0.25</td>
</tr>
<tr>
<td>4</td>
<td>II:Psychological</td>
<td>19.6</td>
<td>5.1</td>
<td>18.2</td>
<td>3.7</td>
<td>0.76</td>
<td>.454</td>
<td>-2.05</td>
<td>3.57</td>
<td>0.30</td>
</tr>
<tr>
<td>5</td>
<td>III:Social</td>
<td>10.2</td>
<td>2.4</td>
<td>10.7</td>
<td>2.6</td>
<td>0.52</td>
<td>.610</td>
<td>-2.29</td>
<td>3.32</td>
<td>-0.21</td>
</tr>
<tr>
<td>6</td>
<td>IV:Environment</td>
<td>25.6</td>
<td>5.8</td>
<td>24.7</td>
<td>4.8</td>
<td>0.42</td>
<td>.680</td>
<td>-2.39</td>
<td>3.22</td>
<td>0.17</td>
</tr>
<tr>
<td>7</td>
<td>QOL Total</td>
<td>76.9</td>
<td>14.3</td>
<td>76.2</td>
<td>11.5</td>
<td>0.15</td>
<td>.884</td>
<td>-2.66</td>
<td>2.96</td>
<td>0.06</td>
</tr>
</tbody>
</table>

*Note.* CI=confidence interval; LL=lower limit; UL=upper limit.

Table 8 shows comparisons of male and female participant of control group with no significant differences.

### 4.6 Brief Discussion

As study objectives concerned regarding quality of life of the respondents, the difference was found between two groups of respondents. The respondents from control group were satisfied with the life than the participants of conflict exposure group. The respondents who did not feel the effect of the conflict due to being in secure place like in city area were happy with their life. Armed conflicts created enormous upheaval at the personal, family, societal, and national level. Conflict caused immense pain, both physical and emotional but at the same time it created opportunities, space for leadership and empowerment of women, men, and marginalized communities, which never existed before. So that QOL of women was good than men because women got chance for their empowerment (Anjana S., 2006). Along with that the violent activities from both side was responsible for the pitiable psychological, environmental, physical life of the conflict exposure group. The result shows that QOL of the conflict exposure was low. On the other hand control group seems less victimized in all the cases.

The result shows with conflict exposure group that of 10-year long conflict affected the overall quality of life as low level. A basic need of the people was not available at that time and still it was not easy to get basic needs of life in post conflict period too. According to the result
the causes behind uncertainty was from lack of awareness, which prevented them from seeking help for their physical, environmental psychological and social problem sooner.

Concerning the physical domains, the exposure group reported the result that due to a lack of proper medical infrastructure services they were deprived from medical care for their physical problems and also unable to actively involve in daily activities of their livelihood. So, they suffered from the body pain, fatigue, body discomfort etc.

In addition, their psychological states were also highly affected since most of them had some sort of psychological problem. It has been shown that participants from exposure group had low level of awareness regarding post conflict mental health and there was no any facility in mental health sector.

During the conflict period most of the industries were completely destroyed, so there was problems in new income generation because of that QOL was affected in particular area. Although there was no difference in QOL of social domain of both groups, there was low social domain score in both groups. Their social life was highly affected since they were not allowed to participant in community activities and festivals, leading to insecurity, consequent economic loss in conflict period. But after finishing the conflict the people could pass their lives as their interest by following cultural and social activities. The hindrances prevalence before for such activities was already resolved with peace agreement with the government. Thus, social life in post conflict period seems relatively better than other domains.

The quality of life of the female has been shown as comparatively good than of male. The reason behind this may be the increasing empowerment of the women. Different government and non-government organization are implementing several programs and project for the upliftment of the status of women in rural areas. Now a days women have been involved in different income generating activities like sewing and knotting, modern commercial agricultural activities, live stock and so on. Furthermore, some literate women had involved in job like in teaching, local co-operatives, etc. such kinds of income generating activities have developed the capacities of the women in some of the rural part of the Nepal. As this study is based on the Terai region and respondents were from the marginalized group i.e. Tharu community. Marginalized groups were taken as the priority for the mainstream of the development of Nepal especially after the restoration of democracy. On the other hand the conflict of Maoist also targeted to the marginalized group with raising voice for their rights, though their goal was different. They had
taken those strategies that if they fight on behalf of the vulnerable group they would go for
victory. From that time marginalized groups like women, children, ethnic group, dalits had
involved in the mainstream of the development and different programs had been formulated with
goal to uplift the living standard of those marginalized people. As consequences the quality of
life of the women has seemed to be better than the men among the respondents.
Subjective Wellbeing (SWB), historically conceptualized as happiness, has been a goal of humankind throughout the ages. (Darwin, 1871). The composition of happiness, and the most expeditious manner in which it may be attained and maintained over time, has been a topic of philosophical debate and investigation since pre-Socratic times (Tatarkiewicz, 1976). Subjective well being (SWB) refers to how people experience the quality of their lives and includes both emotional reactions and cognitive judgments. Psychologists have defined happiness as a combination of life satisfaction and the relative frequency of positive and negative affect. SWB therefore encompasses moods and emotions as well as evaluations of one's satisfaction with general and specific areas of one's life. Concepts encompassed by SWB include positive and negative affect, happiness, and life satisfaction. Positive psychology is particularly concerned with the study of SWB. SWB tends to be stable over time and is strongly related to personality traits. There is evidence that health and SWB may mutually influence each other, as good health tends to be associated with greater happiness, and a number of studies have found that positive emotions and optimism can have a beneficial influence on health (Nagpal, R. and H. Sell: 1985).

Peoples were badly affected during a war. The happiness of people was therefore strongly decreased. It may recover after some time but on average will not reach the same level of wellbeing previously enjoyed. Even if the recovery was full, there is still a shorter or longer period in which the person experienced a drastic loss of happiness. The happiness indicator for the particular country is therefore lower than it would be without this war incident (Bruno S. Frey. 2011).

The objective is to examine the well-being or the happiness of the respondents especially the conflict exposure groups.

5.1 Methods
The researcher collected the data by using direct interview methods. The researcher used in-depth interview from which the required information were got. During the in-depth interview the
researcher filled the questions. The opinion of the people and the answer for the questions were obtained from the interview with the respondents.

5.1.1 Participants
This group consisted 50 people with age of 15 years above who had involved directly in conflict. 64% among all participants were male and 36% participants were female. Whereas 58% participants were literate and remaining 42% were Illiterate. The majority of this group was farmers, they were 56%, 26% student, and 18% were from jobholders respectively (table 9).

Table 9
Demographic information of Participants for SUBI Scale

<table>
<thead>
<tr>
<th>Participants</th>
<th>Exposure group</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td>N=50</td>
</tr>
<tr>
<td>Male</td>
<td>32</td>
<td>64</td>
</tr>
<tr>
<td>Female</td>
<td>18</td>
<td>36</td>
</tr>
<tr>
<td>Age groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10+</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>20+</td>
<td>27</td>
<td>54</td>
</tr>
<tr>
<td>30+</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>40+</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>50+</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Literate</td>
<td>29</td>
<td>58</td>
</tr>
<tr>
<td>Illiterate</td>
<td>21</td>
<td>42</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>13</td>
<td>26</td>
</tr>
<tr>
<td>Farmer</td>
<td>28</td>
<td>56</td>
</tr>
<tr>
<td>Job</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>NGO</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

5.1.2 Materials
The 40-item subjective well-being inventory (Sell.H and Nagpal.R.1992), is an inventory that has eleven dimensions. The scoring is done according to the scoring key provided in the manual. The items are grouped under the dimensions to which they belong and total score of each
dimension is calculated. Nineteen of the items elicit positive affect (i.e., whether one feels happy, good, or satisfied about particular life concerns). 21 items elicit negative affect (i.e., unhappiness, worry, or regret about particular life concerns. The inventory had been standardized with an adult population. The total sum of the 40 items gives the overall subjective well-being score. Attributing the values 3, 2 and 1 to response categories of positive items and 1, 2 and 3 to the negative items scores the SUBI. Thus range of scores is 40 (minimum) to 120 (maximum). The factor analyses over the different samples in different languages, and from different parts of India showed not only an extraordinary degree of stability in content of factors, but also stability over time of 18 months when re-tested (Sell.H and Nagpal.R.1992). This scale has high inter-rater reliability, inter-scores reliability, and test-retest reliability. The scale has been found to be highly significant and satisfactory in validity.

5.2 Data processing
The data collected from the respondents have been processed through the use of Microsoft window Excel and SPSS programme. Similarly, the researcher has used the table and bar diagram for the presentation of the data.

5.3 Inclusion and exclusion
This study about mental health and welfare has included the respondents from conflict exposure group only. But researcher could not include the all type of respondent like children. The respondents were from different caste groups like Brahmin, Chhetri and Dalit without any discrimination. However, the researcher could not include all the people resided in that community.

5.4 Ethical consideration
The information collected from the respondents who were from some VDCs of Bardiya District will be confidential. The information was also collected from the informed consent of the respondents. The requirement for the ethical consideration has been obtained.
5.5 Result

The minimum and maximum score of subjective well-being is given in table 11. It is possible to interpret the profile by comparing it with the middle values of score in each factor. If most of the score fall above middle value, the probability is that the person enjoys a good sense of wellbeing. While, most of score below have the middle values, it may be inferred that the individual is experiencing difficulties in terms of happy living. Table 11 shows that most of the dimensions in mean value score are below the middle value. It indicates that those people who were affected by conflict were experiencing difficulties in terms of happy livings. But four dimensions such as, General Well-being, Positive Affect, Expectation-achievement Congruence; Confidence in Coping, Primary Group Concern had more mean value.

Table 10

Subjective wellbeing (SUBI) categories with conflict exposure group B

<table>
<thead>
<tr>
<th>Factors</th>
<th>No. of Items</th>
<th>Conflicted exposure (Mean)</th>
<th>Minimum score</th>
<th>Maximum Score</th>
<th>Middle Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3</td>
<td>7.2</td>
<td>3</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>6.9</td>
<td>3</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>7.0</td>
<td>3</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>5.6</td>
<td>3</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>5</td>
<td>3</td>
<td>4.2</td>
<td>3</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>6</td>
<td>3</td>
<td>4.4</td>
<td>3</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>3</td>
<td>6.2</td>
<td>3</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>8</td>
<td>7</td>
<td>12.7</td>
<td>7</td>
<td>21</td>
<td>14</td>
</tr>
<tr>
<td>9</td>
<td>6</td>
<td>10.8</td>
<td>6</td>
<td>18</td>
<td>12</td>
</tr>
<tr>
<td>10</td>
<td>3</td>
<td>4.4</td>
<td>3</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>11</td>
<td>3</td>
<td>5.0</td>
<td>3</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
<td>74.5</td>
<td>40</td>
<td>120</td>
<td>80</td>
</tr>
</tbody>
</table>
Table 11

**SUBI category of conflict exposure group B each item**

<table>
<thead>
<tr>
<th>No.</th>
<th>Variables</th>
<th>Male (N=41)</th>
<th>Female (N=9)</th>
<th>t</th>
<th>p</th>
<th>95% CI LL</th>
<th>95% CI UL</th>
<th>Cohen’s d</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SUBI-Sum1</td>
<td>7.2</td>
<td>7.0</td>
<td>0.54</td>
<td>.59</td>
<td>-2.15</td>
<td>3.22</td>
<td>0.21</td>
</tr>
<tr>
<td>2</td>
<td>SUBI-Sum2</td>
<td>7.0</td>
<td>6.8</td>
<td>0.42</td>
<td>.69</td>
<td>-2.80</td>
<td>3.63</td>
<td>0.17</td>
</tr>
<tr>
<td>3</td>
<td>SUBI-Sum3</td>
<td>7.0</td>
<td>6.7</td>
<td>1.55</td>
<td>.13</td>
<td>-1.20</td>
<td>4.30</td>
<td>0.43</td>
</tr>
<tr>
<td>4</td>
<td>SUBI-Sum4</td>
<td>5.8</td>
<td>5.1</td>
<td>2.79</td>
<td>&lt;.05</td>
<td>0.10</td>
<td>5.47</td>
<td>0.68</td>
</tr>
<tr>
<td>5</td>
<td>SUBI-Sum5</td>
<td>4.1</td>
<td>4.8</td>
<td>1.50</td>
<td>.14</td>
<td>-1.18</td>
<td>4.18</td>
<td>-0.49</td>
</tr>
<tr>
<td>6</td>
<td>SUBI-Sum6</td>
<td>4.4</td>
<td>4.7</td>
<td>0.70</td>
<td>.49</td>
<td>-1.98</td>
<td>3.38</td>
<td>-0.24</td>
</tr>
<tr>
<td>7</td>
<td>SUBI-Sum7_1</td>
<td>2.1</td>
<td>2.3</td>
<td>0.42</td>
<td>.68</td>
<td>-2.26</td>
<td>3.10</td>
<td>-0.14</td>
</tr>
<tr>
<td>8</td>
<td>SUBI-Sum7_2</td>
<td>3.8</td>
<td>4.9</td>
<td>1.24</td>
<td>.22</td>
<td>-1.44</td>
<td>3.93</td>
<td>-0.41</td>
</tr>
<tr>
<td>9</td>
<td>SUBI-Sum8</td>
<td>12.8</td>
<td>12.3</td>
<td>0.53</td>
<td>.60</td>
<td>-2.15</td>
<td>3.22</td>
<td>0.22</td>
</tr>
<tr>
<td>10</td>
<td>SUBI-Sum9</td>
<td>11.0</td>
<td>10.0</td>
<td>1.39</td>
<td>.17</td>
<td>-1.29</td>
<td>4.07</td>
<td>0.48</td>
</tr>
<tr>
<td>11</td>
<td>SUBI-Sum10</td>
<td>4.3</td>
<td>4.8</td>
<td>1.11</td>
<td>.27</td>
<td>-1.57</td>
<td>3.79</td>
<td>-0.36</td>
</tr>
<tr>
<td>12</td>
<td>SUBI-Sum11</td>
<td>4.9</td>
<td>5.3</td>
<td>0.77</td>
<td>.45</td>
<td>-1.91</td>
<td>3.45</td>
<td>-0.26</td>
</tr>
<tr>
<td>13</td>
<td>Mental Health</td>
<td>37.6</td>
<td>37.3</td>
<td>0.13</td>
<td>.90</td>
<td>-2.55</td>
<td>2.81</td>
<td>0.05</td>
</tr>
<tr>
<td>14</td>
<td>Mental Fatigue</td>
<td>36.9</td>
<td>37.3</td>
<td>0.22</td>
<td>.83</td>
<td>-2.46</td>
<td>2.90</td>
<td>-0.09</td>
</tr>
</tbody>
</table>

Table 12 shows mean value of differences between male and female participants, but no significant different was found except Transcendence dimensions. The 40-items of SUBI are an inventory that has eleven dimensions. In table 11 the scoring was done according to the scoring key provided in the manual.

The items content of all the 11 dimensions are described below:

1. General Well-being Positive Affect
   The referents of this dimension reflect feelings of well being arising from an overall perception of life as functioning smoothly and joyfully as at present as compared with the past. Examples are a happy feeling about one’s accomplishments, finding life enjoyable and interesting. The mean of this dimension is 7.2, which was not less than minimum value of this dimension.

2. Expectation-achievement Congruence
   Most of the items on this dimension refer to feelings of well-being generated by achieving the standard of living, social status, success and freedom as per one's expectations or what may be called satisfaction. This dimension score mean 6.9, which was not less than minimum value of this dimension.

3. Confidence in Coping
   Items on this dimension relates to positive personality strengths-one’s ability to manage
situations when they do not turn out as expected, ability to remain calm in critical situations, confidence in coping with crisis, ability to concentrate well on things one is doing. The confidence in coping dimension score mean is 7, which was not less than minimum value of this dimension.

4. Transcendence

All items with high loading on this dimension relate to life experiences that are beyond the ordinary day-to-day material and rational existence. They relate the feeling of subjective well-being derived from values of a spiritual quality such as being part of mankind or belonging to a common force, having moments of intense happiness such as ecstasy or bliss and having a deep religious fulfillment in life. The theoretical constructs of rootedness and belongingness are included in this dimension. The mean value of this transcendence dimension (mean-5.6) is lower than the minimum score.

5. Family Group Support

Items on this dimension reflect positive feelings derived from the perception of the wider family as supportive, cohesive and emotionally attached. This dimension reflects cohesive aspects of family life. The family group dimension score mean is 4.2 that were less than middle value.

6. Social Support

This dimension contains items relating to the perception of social environment beyond the realm of the family as supportive in general and also in times of crisis, e.g., the feeling of being part of a friendly and mutually supportive group or finding company of a friend if desired. This dimension also less value than the middle value of dimension. The mean value of social support score is 4.4.

7. Primary Group Concern

The mean scores of primary group concern is 6.2. The items on this dimension relate to feelings of happiness or worry about one’s relationship with the primary family, viz., parents and siblings.

8. Inadequate Mental Mastery

Inadequate Mental mastery dimension mean value is 12.7, which is less than middle value of dimension. Items with significant loading on this dimension imply a sense of insufficient control over or inability to deal efficiently with certain aspects of everyday life that are
9. Perceived ill health

The items on this dimension are complaints of getting tired too easily, concern over palpitation, giddiness, pain in various parts of the body and worries over health and physical fitness in general. This dimension of perceived ill health scores 10.8 mean value, it means conflict exposure group had significant low dimension.

10. Deficiency in Social Contacts

The items have common feature of missing friends or worrying about being disliked. The deficiency of social contact dimension is scored mean 4.4, which was less value than middle score of this dimension.

11. General well being Negative Affect

These dimensions score 5 mean values that is less than middle value of this dimension. Items with high loading on this dimension are disruption of life in a broad and general perspective-whether one considers life as useless or miserable, boring or uninteresting, lack of confidence in what one is doing, worry about mental well-being and being disturbed by anxiety and tension. This dimension would, therefore, appear to denote a generally depressed outlook on life.

5.6 Brief Discussion

Subjective wellbeing of the people suggested in the study that conflict affected group who had fear of threat, abduction resulted unhappiness and unpleasant situation among the people. The people basically cannot satisfy with their lives and living condition if there is uncertainty in surrounding. Suffocation, killing of family members, abduction really creates them feeling of trauma, violent situation and so on.

The research studies conducted before have not intensively covered the psychological and mental condition of the people. The emphasis is found on the physical, economic and infrastructural impacts of the conflict. That is why this study carries the different perspectives that are hidden but very important part of human live span and well-being.

The result of SUBI intensively clarifies that due to threats and chaos during conflict the respondents were lost their coping capacities for everything. They had to bear economic crisis, health crisis, and other necessary things. The obstruction and hindrances created by the rebellion
groups directly affected the lives of the people connected with conflict. Most of the family lost their family members either in fight between two parties or abduction of the fighters. Not only these conditions if there was two or more than two people talking with each other would be punished in reason of being spy and making conspiracy. The contemporary circumstances made the people neither live freely nor died aimlessly. Several kinds of tortures, violence and threats snatched the happiness of the people. The family and group cohesiveness, entertainments of their cultural values, rituals were in danger that deprived them from their holistic development. Likewise, destruction of infrastructure, killing of government personals curtailed the health facilities in their hometown.
6. Major Finding, Recommendation and Conclusion

6.1 Discussion

6.1.1 Main finding and its significance

The main objective of this research was to find out the real situation of mental health in conflict-affected area by using the BDI-II, QOL scale and SUBI. As researcher used interview, field visit, key informants interview, non-participants observation as the data collection methods, the data and its interpretation reached in finding that the conflict exposure groups found to be very depressed and mentally suffered than the control group. The respondents of BDI were from different professional background like; farmers, jobholder, students, NGOs jobholder and others. Among them the result shows that there was high prevalence of depression with respondents of conflict exposure group. The reason behind the result can be direct presence of the people with the conflict and rebellion groups. The shelter of rebellion group (current Maoist combatants) was in the village areas where they could be safe and could precede their activities. They did not limited in keeping shelter in village area but also they conducted different violent activities, which hampered directly to the villagers. They were engaged in abduction, forcing people to join them, killing the elite people and those who were against them. The contemporary situation created the threats and suffocation among the people. Consequently, people got mental problems and depression from which they are still suffering.

In this cross sectional study BDI analysis had done with dividing the respondents within two different groups such as conflict exposure group and control group. The data was interpreted and analyzed with these groups. The result shows that there was difference between the BDI categories of conflict exposure group and control group. The differences between two groups in sum of BDI categories indicate the existence of depression among the conflict exposure group. It seems the problematic situation that has affected the daily lives of the people. It suggests for the emergence intervention to get rid from the upcoming mental health problems in the huge mass of the people. But in Nepalese context mental health is considered as the taboos and taken as minor thing. On the other hand there is only one mental hospital in the country, which is not sufficient to address the huge needs for inpatient care. Mental health services are not easily available in the rural areas and in remote places. There is a stigma in the society regarding mental problems-considering it as a sin and result of previous lives. The people cannot express their mental health issues. The infrastructure for providing mental health services is poor and inadequate.
Furthermore, human resources are not sufficient as per the growing rate of the mentally ill patients. There is no mental health legislation made from the government side. It shows the lack of proper concern of the government regarding the mental health of the people. There is no human rights issues addressed for mental health patients. The government has not allocated an adequate budget and facilities to address the mental health issues of the people. No consumer association exists in the country, which focuses on mental health services. Some connection with the health and education sector exists but there is no link with criminal justice and other sectors. The country’s mental health information system is poor. There is no separate division for mental health under the Ministry of Health.

The study two quality of life and subjective well being also shows the differences in several components of QOL. The study conducted between conflict exposure group and control group can be summarized that conflict exposure group affected the overall of quality of life as low level. A daily bread of the people was not available at that time and still it was not easy to get basic needs of life in post conflict period too. According to the result the causes behind uncertainty was from lack of awareness, which prevented them from seeking help for their physical, environmental psychological and social problem and its intervention.

Regarding the physical domains, the conflict exposure group reported the result that due to lack of proper medical infrastructure services they were deprived from medical care for their physical problems and also unable to actively involve in daily activities of their livelihood. So, they suffered from the body pain, fatigue, body discomfort etc.

In addition, their psychological states were also highly affected since most of them had some sort of psychological problem. Participants from exposure group had low level of awareness regarding post conflict mental health and there was no any facility in mental health sector. During the conflict period there was lack employment opportunities, so there was problems in new income generation because of that QOL was affected in particular area.

Although there is no difference in QOL in social domain of both groups, was social domain score in both groups was low. Their social life was highly affected since they were not allowed to participant in community activities and festivals, leading to insecurity, consequent economic loss in conflict period. But after finishing the conflict the people could pass their lives as their interest by following cultural and social activities. The hindrances prevalence before for
such activities was already resolved with peace agreement with the government. Thus, social life in post conflict period seems relatively better than other domains.

The separate analysis of QOL between male and female has been shown better condition of female in comparison to of male. The reason behind this may be the increasing empowerment of the women by involving in different organizations. Different government and non-government organization are implementing several programs and projects for upgrading the status of women in rural areas. Now a days women have been involved in different income generating activities like sewing and knotting, modern commercial agricultural activities, live stock and so on. Furthermore, some literate women have involved in job like in teaching, local co-operatives, etc. such kinds of income generating activities have developed the capacities of the women in some of the rural part of the Nepal. As this study is based on the Terai region and respondents were from the marginalized group i.e. Tharu community. Marginalized groups are taken as the priority for the mainstream of the development of Nepal especially after the restoration of democracy. On the other hand the conflict of Maoist also targeted to the marginalized group with raising voice for their rights, though their goal was different. They had taken those strategies that if they fight on behalf of the vulnerable group they would go for victory. From that time marginalized groups like women, children, ethnic group, dalits had involved in the mainstream of the development and different programs had been formulated with goal to uplift the living standard of those marginalized people.

Multiple causes resulted from the conflict between the state and Maoists forced people to be displaced from their places of origin where they were insecure, faced economic hardships, shortage of food, lack of health facilities, obstacles in movement, lack of education, threat on cultural practices and lack of communication. Killings of family member and relatives, pressure to join the conflicting parties, beatings, abduction and disappearance, arrest, and crossfire in village, were the causes of different mental issues and low QOL. Various forms of social, economic, cultural, political and health-related aspects resulted from the conflict were responsible for the low QOL and subjective wellbeing.

Similarly, compulsion of people to involve in unwilling activities, insult of people in front of community, lack of trust among the villagers, negative perception of Maoists towards the upper caste people and frequent announcement for changing caste from upper to lower level can be seen as significant components for emergence of mental problems. People were prohibited to
celebrate festivals and worship and they were attacked while practicing rituals.

It is important to understand conflict as having a systematic effect on the risk for mental illness, which, also including direct experience of conflict-related violence, will also include disruption to social support networks, increased anti-social behavior, poverty, a limited ability to access essential services and range of other interconnected effects.

In conflict contexts such as the one in Nepal, the links between direct, structural and cultural violence cannot be overlooked, since these forms of violence feed into each other and are interconnected. Our research recorded a high demand for mental health services, in the population affected by the conflict. This demonstrates that the need for this type of care is not being addressed by the public structures in the conflict-affected area.

The finding of this research shows that nearly 66 percent of research populations from conflict area were suffering from some level of depression and which was greater number than non-exposure population of conflict. More than six million Nepalese - 20 percent of the population - had symptoms of mental health disease in 2010, according to the government, but the issue remains neglected and underfunded, according to experts. This research also support on that fact. Conflict affects women in many ways. They were not only directly abused, maimed, tortured, raped and killed but get victimized in many different ways. This research also showed that female from conflict area was more risk in mental health issues. 82% percent of female participant had some level of depression. This result clearly indicates that further research is needed in area of female to know the clear situation of conflicts affected female in Nepal. It also indicated that a considerable number of adults were suffering from depression.

6.1.2 Strength and Implication of research

The originality of the research is to find out the post conflict mental health and quality of life by using the BDI category and QOL scale along with Subjective well being analysis. The preference has been given to the hidden aspect i. e. mental health in systematic way than other research studies conducted before. We can find plenty of literature about other factors like infrastructure, physical, economic etc in post conflict situation but mental health aspects cannot be found. So this research has focused on the post conflict mental health condition with scientific analysis of BDI, QOL and SUBI.
The main strength of this research was selection of conflict area. Bardiya is the one of the highly conflict affected area and we could take participant who were directly involve in conflict. All interview were taken in their home so this was the strongest part of this research. Using of already valid instrument, BDI is another strength of this research.

Theses finding have implication for Nepal post conflict status of mental health. It also gives clear figure out about basic mental health biography of people living in conflicts area in Nepal. Reporting of findings only about depression symptoms is insufficient in studying the post conflict mental health of displaced and potentially traumatized populations living in post conflict area.

6.1.3 Limitation and Future research

Nepal has been witnessing different kind and nature of arm conflict in the national and regional level. Maoist conflict and Terai conflict are the examples of national and regional level conflicts of the recent past. However, this study includes only the effect of Maoist armed conflict.

The study was basically focused on the Suryapatuwa V.D.C. of Bardiya district. It could not cover the other VDCs. Similarly; the study had given emphasis on the mental health issues after the internal conflict between Maoist and the government of Nepal. The study did not divide the people in caste, religion, gender and so on. Likewise, the respondents were those who directly faced the conflict as well as those who did not directly involve in the conflict.

A study requires a plenty of time to be spent in the field of research with people to study their attitude, behavior, feelings, habits, psychological problems and so on. The researcher tried to collect necessary information within the limitation of time and resources. Besides, socio-economic condition of the people in this VDC is different from other.

The researcher fulfilled all the ethical requirements related to the data collection, informed consent in native country as well as the use of BDI –II, QOL, and SUBI. One of the weakness researcher could not fulfilled was the ethical requirement that should be done in IUHW because this research implication is mainly focus in native country Nepal.

This research lacks the focus group discussion as a data collection methods from which in depth study could be done for getting more information. This will be one of the tasks for future research. Match pair cross sectional study is another methods could be done with these components (BDI-II,QOL,SUBI) used in this research topic. Because of study time limit and
geographical hindrance researcher did not able to conduct research in match pair cross sectional methods. Thus, future research studies alert these potential areas to be examined in regards to cross sectional match pair study, demographic specific study and so on.

6.2 Recommendation
The evidences provided in this study have shown to alert for considering mental health and wellbeing as significant part of human life span. In particular for the most conflict-affected groups of the population, mental health services has to be integrated into the general health services system of the country.

As BDI result found to be distinct between conflict exposure and control group the concerned sector should pay attention towards the mental health care facilities especially in conflict-affected areas.

Based on the findings of the study, the following remedial measures are recommended to increase access, availability and utilization of mental health services.
1. There are very few researches on the prevalence of mental health problems in conflict-affected area. Therefore, a research on this would keep importance on assessing the mental health situation.
2. This research also showed that female from conflict area was more risk in mental health issues. 82% percent of female participant had some level of depression. This result clearly indicates that further research is needed in area of female to know the clear situation of conflicts affected female in Nepal. Female Social awareness on mental health should be a priority programme from government or NGOs. Making mental health a cross cutting issue would benefit general population in accessing knowledge and information on mental health.
3. The result shows with conflict exposure group that of 10-year long conflict affected the overall quality of life as low level. A basic need of life the people was not available at that time and still it was not easy to get in post conflict period too. Capacity building and increase basic Needs of conflict-affected people for improving their Quality of life is another recommendation of this research.
4. Mental health care facilities should be developed and have an active and dynamic Interaction with the communities they serve. Mental health services have to be made available at the regional, district and peripheral levels. They have to be integrated into general health services...
at all levels including primary health care. Mental health resources have to be distributed in accordance with the mental health policy, and adequate supply of essential psychotropic drugs should be maintained.

5. Subjective wellbeing of the people suggested in the study that conflict affected group who had fear of threat, abduction resulted unhappiness and unpleasant situation among the people. The people basically cannot satisfy with their lives and living condition, so there should be some level of programs regarding wellbeing issue.

6.3 Conclusion
The occurrence of a massive depression in the populations in conflict situations is widely documented by this research. The study done by using the BDI-II between conflict exposure group and control group is reported the more prevalence of depression in first group. As research shows high range on moderate and severe depression category among the conflict exposure group suggested that how much conflict affected the people. However, research also provides evidence about the resilience of more than half of the population in the face of the worst depression in post conflict situations in Nepal. There is no doubt that the populations in war and conflict situations should receive mental health care as part of the total relief, rehabilitation and reconstruction processes. But this research concludes that such relief is still not enough to reduce post conflict mental health impact. The intensive intervention program should be implemented related to mental health especially in conflict-affected areas.

Conflict produced long-term damage to mental health, quality of life and human well-beings issues that extended effects beyond the period of post conflict. This research has evidence, that conflict may increase the risk of mental health and disability through the breakdown of norms and practices of social order, with increases in different social psychological issues. These results are intriguing, but not conclusive. The emergence of low quality of life in psychological, environmental, physical aspects is also responsible for the unpleasant and pitiable well being of the people. However, increasing empowerment of the women by different governmental and non-governmental organizations, social lives of the women is relatively enhancing than other factors. Certainly it needs to comprehend better micro-level political, social, and epidemiological processes. It must understand better possible intervention to get rid from the mental health problems.
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Gourevitch, P. (1999). We wish to inform you that tomorrow we will be killed with our families: stories from Rwanda. New York: Picador


Karki Arjun K. (2001). The Politics of Poverty and Movements from below in Nepal, A dissertation for PhD, University of East Anglia


Doctoral dissertation, Amsterdam: Vrije Universiteit


Sell, H. and R. Nagpal: 1992, Assessment of Subjective Well-being: The Subjective Well-Being Inventory (SUBI) (World Health Organization, Regional Office for South-East Asia, New Delhi, India).


Appendix A

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

Name………………………………………………………………Age/Sex…………………………

Occupation…………………………………………Study……………………………………

1.

0  I do not feel sad.
1  I feel sad
2  I am sad all the time and I can't snap out of it.
3  I am so sad and unhappy that I can't stand it.

2.

0  I am not particularly discouraged about the future.
1  I feel discouraged about the future.
2  I feel I have nothing to look forward to.
3  I feel the future is hopeless and that things cannot improve.

3.

0  I do not feel like a failure.
1  I feel I have failed more than the average person.
2  As I look back on my life, all I can see is a lot of failures.
3  I feel I am a complete failure as a person.

4.

0  I get as much satisfaction out of things as I used to.
1  I don't enjoy things the way I used to.
2  I don't get real satisfaction out of anything anymore.
3  I am dissatisfied or bored with everything.

5.

0  I don't feel particularly guilty
1  I feel guilty a good part of the time.
2  I feel quite guilty most of the time.
3  I feel guilty all of the time.
6.  
0  I don't feel I am being punished.  
1  I feel I may be punished.  
2  I expect to be punished.  
3  I feel I am being punished.  

7.  
0  I don't feel disappointed in myself.  
1  I am disappointed in myself.  
2  I am disgusted with myself.  
3  I hate myself.  

8.  
0  I don't feel I am any worse than anybody else.  
1  I am critical of myself for my weaknesses or mistakes.  
2  I blame myself all the time for my faults.  
3  I blame myself for everything bad that happens.  

9.  
0  I don't have any thoughts of killing myself.  
1  I have thoughts of killing myself, but I would not carry them out.  
2  I would like to kill myself.  
3  I would kill myself if I had the chance.  

10.  
0  I don't cry any more than usual.  
1  I cry more now than I used to.  
2  I cry all the time now.  
3  I used to be able to cry, but now I can't cry even though I want to.  

11.  
0  I am no more irritated by things than I ever was.  
1  I am slightly more irritated now than usual.  
2  I am quite annoyed or irritated a good deal of the time.  
3  I feel irritated all the time.  

12.  
0  I have not lost interest in other people.
1 I am less interested in other people than I used to.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14. 0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

15. 0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16. 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get
   Back to sleep.

17. 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
1. My appetite is not as good as it used to be.
2. My appetite is much worse now.
3. I have no appetite at all anymore.

19. I haven't lost much weight, if any, lately.
1. I have lost more than five pounds.
2. I have lost more than ten pounds.
3. I have lost more than fifteen pounds.

20. I am no more worried about my health than usual
1. I am worried about physical problems like aches, pains, upset stomach, or constipation.
2. I am very worried about physical problems and it's hard to think of much else.
3. I am so worried about my physical problems that I cannot think of anything else.

21. I have not noticed any recent change in my interest in sex.
1. I am less interested in sex than I used to be.
2. I have almost no interest in sex.
3. I have lost interest in sex completely.
Appendix B.  WHO Quality of life –BREF

Name…………………………………………………………………Age/Sex…………………………

Occupation………………………………………………Study……………………………………

Please read each question, assess your feelings, and circle the number on the scale that gives the best answer for you for each question.

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<thead>
<tr>
<th>(Please circle the number)</th>
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<tbody>
<tr>
<td><strong>Very poor</strong></td>
</tr>
<tr>
<td>1</td>
</tr>
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</table>

1. How would you rate your quality of life?

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<tbody>
<tr>
<td><strong>Very dissatisfied</strong></td>
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<tr>
<td>1</td>
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</table>

2. How satisfied are you with your health?

The following questions ask about how much you have experienced certain things in the last two weeks.

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<tbody>
<tr>
<td><strong>Not at all</strong></td>
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<tr>
<td>1</td>
</tr>
</tbody>
</table>

3. To what extent do you feel that physical pain prevents you from doing what you need to do?

4. How much do you need any medical treatment to function in your daily life?

5. How much do you enjoy life?

6. To what extent do you feel your life to be meaningful?
7. How well are you able to concentrate?

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<tbody>
<tr>
<td>Not at all</td>
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<td>1</td>
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8. How safe do you feel in your daily life?

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<tbody>
<tr>
<td>Not at all</td>
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9. How healthy is your physical environment?

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<tr>
<td>Not at all</td>
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</table>

The following questions ask about how completely you experience or were able to do certain things in the last two weeks.

10. Do you have enough energy for everyday life?

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<tbody>
<tr>
<td>Not at all</td>
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<td>1</td>
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11. Are you able to accept your bodily appearance?

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<th>(Please circle the number)</th>
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<tbody>
<tr>
<td>Not at all</td>
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<td>1</td>
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</table>

12. Have you enough money to meet your needs?

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<tr>
<th>(Please circle the number)</th>
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<tbody>
<tr>
<td>Not at all</td>
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<td>1</td>
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</table>

13. How available to you is the information that you need in your day-to-day life?

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<tbody>
<tr>
<td>Not at all</td>
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<td>1</td>
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</table>

14. To what extent do you have the opportunity for leisure activities?

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<th>(Please circle the number)</th>
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<tr>
<td>Not at all</td>
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15. How well are you able to

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<tbody>
<tr>
<td>Very poor</td>
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</table>
The following questions ask you to say how **good** or **satisfied** you have felt about various aspects of your life over the last two weeks.

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<tbody>
<tr>
<td></td>
<td>Very dissatisfied</td>
<td>Dissatisfied</td>
<td>Neither satisfied nor dissatisfied</td>
<td>Satisfied</td>
<td>Very satisfied</td>
</tr>
<tr>
<td>16.</td>
<td>How satisfied are you with your sleep?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>17.</td>
<td>How satisfied are you with your ability to perform your daily living activities?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>18.</td>
<td>How satisfied are you with your capacity for work?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>19.</td>
<td>How satisfied are you with your abilities?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>20.</td>
<td>How satisfied are you with your personal relationships?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>21.</td>
<td>How satisfied are you with your sex life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>22.</td>
<td>How satisfied are you with the support you get from your friends?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>23.</td>
<td>How satisfied are you with the conditions of your living place?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>24.</td>
<td>How satisfied are you with your access to health services?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>25.</td>
<td>How satisfied are you with your mode of</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
transportation?

The following question refers to **how often** you have felt or experienced certain things in the last two weeks.

26. How often do you have negative feelings, such as blue mood, despair, anxiety, depression?

<table>
<thead>
<tr>
<th>(Please circle the number)</th>
<th>Very dissatisfied</th>
<th>Dissatisfied</th>
<th>Neither satisfied nor dissatisfied</th>
<th>Satisfied</th>
<th>Very satisfied</th>
</tr>
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<thead>
<tr>
<th>(Please circle the number)</th>
<th>Never</th>
<th>Seldom</th>
<th>Quite often</th>
<th>Very often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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</table>
Appendix C. The Subjective Well Being Inventory (SUBI)

All information given by you will be treated as confidential and will be used only for research purposes.
Name……………………………………………………………………..Age/Sex…………………………
Occupation………………………………………………………Study………………………………..

1. Do you feel your life is interesting?
   Very much       1
   Some extent     2
   Not so much     3

2. Do you think you have achieved the standard of living and the social status that you had expected?
   Very much       1
   Some extent     2
   Not so much     3

3. How do you feel about the extent to which you have achieved success and are getting ahead?
   Very good       1
   Quite good      2
   Not so good     3

4. Do you normally accomplish what you want to?
   Most of the time 1
   Sometimes        2
   Hardly ever     3

5. Compared with the past, do you feel your present life is:
   Very happy       1
   Quite happy      2
   Not so happy     3

6. On the whole, how happy are you with the things you have been doing in recent years?
   Very happy       1
   Quite happy      2
   Not so happy     3
7. Do you feel you can manage situations even when they do not turn out as expected?

Most of the time 1
Sometimes 2
Hardly ever 3

8. Do you feel confident that in the case of a crisis (anything which substantially upsets your life situation) you will be able to cope with it/face it boldly?

Very much 1
To some extent 2
Not so much 3

9. The way things are going now do you feel confident in coping with the future?

Very much 1
To some extent 2
Not so much 3

10. Do you sometimes feel that you and the things around you belong very much together and are integral parts of a common force?

Very much 1
To some extent 2
Not so much 3

11. Do you sometimes experience moments of intense happiness almost like a kind of ecstasy or bliss?

Quite often 1
Sometimes 2
Hardly ever 3

12. Do you sometimes experience a joyful feeling of being part of mankind as of one large family?

Quite often 1
Sometimes 2
Hardly ever 3

13. Do you feel confident that relatives and/or friends will help you out if there is an emergency, e.g. if you lose what you have by fire or theft?

Very much 1
To some extent 2
Not so much 3
14. How do you feel about the relationship you and your children have?

<table>
<thead>
<tr>
<th>Rating</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very good</td>
<td>1</td>
</tr>
<tr>
<td>Quite good</td>
<td>2</td>
</tr>
<tr>
<td>Not so good</td>
<td>3</td>
</tr>
<tr>
<td>Not applicable</td>
<td>4</td>
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</table>

15. Do you feel confident that relatives and/or friends will look after you if you are severely ill or meet with an accident?

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<tr>
<th>Rating</th>
<th>Code</th>
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</thead>
<tbody>
<tr>
<td>Very much</td>
<td>1</td>
</tr>
<tr>
<td>To some extent</td>
<td>2</td>
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<tr>
<td>Not so much</td>
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16. Do you get easily upset if things don't turn out as expected?

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<th>Code</th>
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<tbody>
<tr>
<td>Very much</td>
<td>1</td>
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<tr>
<td>To some extent</td>
<td>2</td>
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<tr>
<td>Not so much</td>
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17. Do you sometimes feel sad without reason?

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<th>Rating</th>
<th>Code</th>
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<tbody>
<tr>
<td>Very much</td>
<td>1</td>
</tr>
<tr>
<td>To some extent</td>
<td>2</td>
</tr>
<tr>
<td>Not so much</td>
<td>3</td>
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18. Do you feel too easily irritated, too sensitive?

<table>
<thead>
<tr>
<th>Rating</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very much</td>
<td>1</td>
</tr>
<tr>
<td>To some extent</td>
<td>2</td>
</tr>
<tr>
<td>Not so much</td>
<td>3</td>
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19. Do you feel disturbed by feelings of anxiety and tension?

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<tr>
<th>Rating</th>
<th>Code</th>
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<tbody>
<tr>
<td>Most of the time</td>
<td>1</td>
</tr>
<tr>
<td>Sometimes</td>
<td>2</td>
</tr>
<tr>
<td>Hardly ever</td>
<td>3</td>
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20. Do you consider it a problem for you that you sometimes lose your temper over minor things?

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<th>Rating</th>
<th>Code</th>
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</thead>
<tbody>
<tr>
<td>Very much</td>
<td>1</td>
</tr>
<tr>
<td>To some extent</td>
<td>2</td>
</tr>
<tr>
<td>Not so much</td>
<td>3</td>
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</table>
21. Do you consider your family a source of help to you in finding solutions to most of the problems you have?

Very much 1
To some extent 2
Not so much 3

22. Do you think that most of the members of your family feel closely attached to one another?

Very much 1
To some extent 2
Not so much 3

23. Do you think you would be looked after well by your family in case you were seriously ill?

Very much 1
To some extent 2
Not so much 3

24. Do you feel your life is boring/uninteresting?

Very much 1
To some extent 2
Not so much 3

25. Do you worry about the future?

Very much 1
To some extent 2
Not so much 3

26. Do you feel your life is useless?

Very much 1
To some extent 2
Not so much 3

27. Do you sometimes worry about the relationship you and your wife/husband have?

Very much 1
To some extent 2
Not so much 3
Not applicable 4

28. Do you feel your friends/relatives would help you out if you were in need?

Very much 1
29. Do you sometimes worry about the relationship you and your children have?

Very much 1  
To some extent 2  
Not so much 3  
Not applicable 4  

30. Do you feel that minor things upset you more than necessary?

Very much 1  
To some extent 2  
Not so much 3  

31. Do you get easily upset if you are criticized?

Most of the time 1  
Sometimes 2  
Hardly ever 3  

32. Would you wish to have more friends than you actually have?

Very much 1  
To some extent 2  
Not so much 3  

33. Do you sometimes feel that you miss a real close friend?

Very much 1  
To some extent 2  
Not so much 3  

34. Do you sometimes worry about your health?

Very much 1  
To some extent 2  
Not so much 3  

35. Do you suffer from pains in various parts of your body?

Most of the time 1  
Sometimes 2  
Hardly ever 3  


36. Are you disturbed by palpitations/a thumping heart?

Most of the time 1
Sometimes 2
Hardly ever 3

37. Are you disturbed by a feeling of giddiness?

Most of the time 1
Sometimes 2
Hardly ever 3

38. Do you feel you get tired too easily?

Most of the time 1
Sometimes 2
Hardly ever 3

39. Are you troubled by disturbed sleep?

Most of the time 1
Sometimes 2
Hardly ever 3

40. Do you sometimes worry that you do not have close personal relationship with other people?

Very much 1
To some extent 2
Not so much 3
Appendix D  Map of Nepal

Bardiya District

Legend
- Market Centre
- VDCs Served by Market Centre
  - Bardiya Market Centres
  - Tota Market Centres
  - Sansar Market Centres
  - Mankoshi Market Centres
  - Tharuwaran Market Centres
  - Kajipur Market Centres
  - Bhumgarh Market Centres
  - Ayange Market Centres
  - Samatthi Market Centres
  - Sikidabasa Market Centres