QUALITY OF LIFE OF AFGHAN DRUG ADDICTED COMMUNITY

By

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Submitted in Partial Fulfillment of the Requirements for the Degree of

MSc in Rehabilitation Science

March 2021

Bangladesh Health Professions Institute (BHPI)

Faculty of Medicine

University of Dhaka

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- This dissertation is being submitted in partial fulfillment of the requirements for the degree of MSc in Rehabilitation Science.

- This dissertation is the result of my own independent work/investigation, except where otherwise stated. Other sources are acknowledged by giving explicit references. A Bibliography is appended.

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ACKNOWLEDGMENT

I would like to express my gratitude to almighty Allah who gave me the passions to complete this study. I want acknowledge my family members specially my parents and brothers who had always inspired me and provided me whatever I needed.

I am grateful with the bottom of my heart from my honorable supervisor Mr. Mohammad Anwar Hossain, Associated professor and head of department of physiotherapy, BHPI, Dhaka University, Bangladesh, for his supervision, direction, guidance, and giving feedback during study period.

I would like to express my sincere thankful to all respectable teachers, especially Prof. Dr. Omar Ali Sarkar (Principle, BHPI, Dhaka University), and Mr. Muhammad Millat Hossain (Assistant professor and course coordinator) for their collaboration, motivation and direction during of study.

Finally, I would like to acknowledge all the participants of the research for giving their valuable time, for completing this study. I am so delighted, for expressing my gratitude to everyone, who helped and supported me throughout this course (M.Sc. in Rehabilitation Science).

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List of abbreviations and acronyms

- **ATS:** Amphetamine-Type Stimulants
- **BHPI:** Bangladesh Health Professions Institute
- **CRP:** Center for the Rehabilitation of Paralyzed
- **HIV:** Human Immunodeficiency Virus
- **HRQOL:** Health Related Quality of Life
- **MOPH:** Ministry of Public Health
- **MCN:** Ministry Counter of Narcotic
- **MMT:** Methadone Maintenance Treatment
- **NGO:** Non-Governmental Organization
- **OST:** Opium substitution therapy
- **QOL:** Quality of Life
- **SUD:** Substance Use Disorders
- **SPSS:** Statistical Package for the Social Sciences
- **UNODC:** United Nation Office on Drug and Crime
- **WHOQOL:** World Health Organization, Quality of Life
- **WHO:** World Health Organization

Abstract

Background: Drug has effect on physical, mental, and social health, and also can easily effect on quality of life. Based on recent report in 2019 world drug report illegal drug use dramatically has increased in comparing to survey of 2009, number of people using drug is increased 30% higher. An estimation in 2019 showed that 271 million of people or 5.5% of the world population aging between 16-64 years had been using drugs. In 2017, (585,000) people were died because of drug use. 11 million people injected drugs, 1.4 million live with HIV, and 5.6 million people were with hepatitis. On the other hand, According to latest report of Ministry of Public Health of Afghanistan (MOPH) in 2018 and UNODC there are around 3 million people addicted to drugs (World Drug Report, 2019).

Objectives: To understand the quality of life of Afghan drug addicted community among adult persons aging between 16-64 years old. To study the impact or consequence of drug addiction on quality of life. **Methodology:** This study was quantitative design, cross-sectional study was conducted for this research. In this research, correlation were used between socio-demographic, types of drug addiction with quality of life. Face to face interview was done by standard structured questionnaire. The data were analyzed by SPSS 22.0 statistical software.

Result: The result has shown 98(79.0) of drug addicted patients were male and 26 (21.0) of patients were female. The total number of participation were 124 patients. In this study, due to some limitation such as insecurity, stigma, and patriarchy environment, female patients couldn't participated equally like male. There is a significant correlation between shisha use and Alcohol consumption with quality of life.

Conclusion: Drugs can effect on physical, mental, and social health. It can reduce the quality of life of life addicted people. In this study, there is no significant correlation between Opium, Hashish and Heroin uses with Quality of life. But there is a significant correlation between shisha use and alcohol consumption with QoL. By using Shisha and consuming Alcohol the patients found low concentrating or thinking and also found difficulty with sleeping.

Key words: Quality of life, drug addiction, types of drug addiction.

CHAPTER I	INTRODUCTION

1.1. Introduction

Drug addiction is chronic and harmful diseases that can effect on physical, mental, and social health. By using drugs the people behavior will be changed (Collins & Lapsley, 2008). Frequently using of drug change mechanism of brain that makes quitting process much more complicated and worsen to stop using drug even having strong willpower for quitting, and person would face challenges like self-control and compulsive consuming of drug. This compulsive way of using is mostly causes the "Relapse" which in most cases patient following to recovery process returning back to drug consuming (see et al., 2003). Researcher achieved the goals and various investigations have shown by using drug repeatedly effecting mental health and physical health and have found treatment through by which people are able to get recovery and start normal life.

Drug addiction and abuse is a global problem. Based on recent report in 2019 world drug report illegal drug use dramatically has increased in comparing to survey of 2009, number of people using drug is increased by 30% higher. In 2017, 271 million of people or 5.5% of the world population aged between 16-64 years had been using drugs. In 2017, (585,000) people were died because of drug use. 11 million people injected drugs, 1.4 million live with HIV, and 5.6 million people were with hepatitis in 2017 (World Drug Report, 2019).

Drug addiction is very huge problem, according to World drug survey in 2011, the number of drug addicted persons in the world estimated between149 and 272 million people. Those countries to have border with Afghanistan such as China, Pakistan, Iran, Tajikistan, Turkmenistan, Uzbekistan and Kazakhstan also have a large numbers of drug addict's community. Three decades of war in Afghanistan has destroyed the economic condition and majority of people found physical, mental, and social problem. Opium were the most harmful substance that Afghan people have been using. United nation of drug and crime office reported more than 70% of negative health related to drugs used (UNODC, 2011).

Problems such as low rate of employment, early consumption of drug as treatment (social believe), cultivation, process, and treat of drug (supply chain), having high number of refugees (Iran, Pakistan), more than three decade of civil war and, also strategic location of country as the core for world's most powerful countries have engaged the country in to crisis (Common sense for drug policy: Afghanistan Update). According to latest report of Ministry of Public Health of Afghanistan (MOPH) in 2018 and UNODC there are around 3 million people addicted to drugs, from that amount 1.6 million people are using drug regularly and other remaining are using drug irregularly (UNODC, 2018).

According to these survey, Ministry Counter of Narcotic (MCN) needs to have policy and planning for reducing amount of drug users. Ministry Counter of Narcotic (MCN) has to take attention of that policy and promote those policies to reduce the amount of drug addicted persons. By using those policies the situation of addicted people will be changed and will be improved their quality of life. On the other hand, by using drugs people will find different kind of diseases such as mental, physical, and social health Issues. Up to 85 percent of opium producing in Afghanistan, special those regions to be under the control of Taliban (UNODC, 2011).

There is various mental health illness and also several risk factors associated with drug addiction. Persons of different age, sex, social position and economic condition can become addicted to drug, considering the context of different respected societies (Altman et al., n.). This survey most focusing on quality of life of drug addicted people. So the introduction display the idea of the quality of life related to a subject assessment, which is fixed in cultural, environmental, and social circumstances. The quality of life is multidimensional domains such as physical, mental, and social health. Within each domain we have sub-domains of quality of life summarize specific aspect of quality of life. Health related quality of life (HRQOL) which evaluating the positive conditions of life, such as: feeling, emotional and life satisfaction. Doctors and public health workers have used HRQOL and welfare to quantify the impact of several diseases, and getting heal at short or long period of time. Traditionally, Life expectancy and reasons of died have been used as the main symptoms of persons health.

These signs prepare critical knowledge about the health condition of people, that they do not propose any information about the QOL (mental, physical, and social health) (Power Bullinger, & Harper, 1999). In 1995, the WHO identified the value of assessing and enhancing quality of life people (WHO, 1995. Also institutes in the National institutes of health, such as the National Cancer Institutes (NCI) - and centers inside the centers institute for illness control and prevention, for instance: severe illness prevention and health improving including the assessment and enhancing HRQOL, and well- being as priority of public health policy (HRQOL, 2010).

1.2 Study background

Today drug abuse is common problem, it is an issue that the world can cope from this very easily. Although, in treatment centers, therapists could convince patients for treatment to find the solutions, mutually clients have to cooperate with doctors for finding the best solution. Those who are addicted, it is better for them to quit or don't use drugs, wisely have should to know about the consequence of drug using. Drug has effect on physical, mental, and social health, and can easily impact on various organs of bodies. An estimation in 2019 showed that 271 million people or 5.5% of the world population aged between 16-64 years old had been using drugs Courser et al., 2013). In 2018, recently based on report of ministry of public health and UNODC there are 3 million people were using drugs in Afghanistan (UNODC, 2018).

Since 2001 Afghanistan had been the top producer of opium in the world (UNODC, 2011). And it shown opium production supplies of 95% European drugs also globally, 90% of heroin producing by Afghanistan. One study shown how to improve quality of life by opium substitution therapy (OST). Opium substitution therapy and program contributors have been noted or mentioned it one of the most significant variables were (OST) to decrease the drug uses (Feelemyer et al, 2014). As well as, one research had been done in china that was about how to realize the quality of life(QOL) of drug addicted persons, and supply scientific evidence for transferring healthy education, initiating plane of social integration, modifying therapy, and enhancing the quality of life.

Their quality of life was higher at rehabilitation center duration of treatment. In fact their quality of life were poor. Also there is important dissimilar in privileges of body scope between experienced class and control class, so there was no important difference between psychological aspect, and social condition. The quality of life female was lower than male. This study displayed that drug addicted persons after rehabilitation their quality of life will be low, it is very essential to reinforce education for drug addicted people and get comprehensive evaluation for them to improve their quality of life (Liang & Liao, 2010). With recent data and information added form India and Nigeria, the total number of peoples presumed to be suffering from drug addiction is estimated around 35.3 million. As previews discretion related to the whole population of the world (30.5 million) it's 15 times more than before. (World Drug Report, 2019; UNODC, 2019).

One research had been done in Iran in 2011 .There was a significant relation between QOL and mental health. Generally, there is mutual relationship between addiction and mental disorder. It means the mental disorder like depression and anxiety providing and facilitating the way for addiction but the consequence of addiction is some mental disorder like restlessness, muscle tension and depression. The study demonstrated the quality of life of among addicted persons were lower than non-addicted. And that study also displayed those who are addicted to drugs are very bad condition than non- addicted they required more helps and supports (Hoseinifar et al., 2011).

The amount of drug addicted people will be increased in Afghanistan .Three decade war in Afghanistan maximum people affected by this phenomenon. During that time majority of people became displaced from their home countries and immigrated to other countries such as Iran, Pakistan and etc. On the way of immigration most of men, women and children were death. Majority of immigrated people couldn't find sufficient jobs in abroad countries to support their families, when some of them deported from foreign countries to their home countries they faced so many challenges such as poverty, and unemployment. They tried to relieve their body and mental pain by using drugs. Due to, to that reasons most of adults persons addicted to drugs and their quality of life were become low (Ponzio, 2007).

1.3. Justification of the study

Nowadays drug addiction is very huge phenomenon in the world special illegal trade of these combinations have become one of the main concern in the world. For instance 90 % of foreign medication producing by Afghanistan drugs. And also 90 % of people who have addiction suffering from mental disorder including insomnia, depression and anxiety (Hoseinifar et al., 2011). In 2019 globally estimated that around 271 million people addicted to drugs, which resulted (585.000) people who died as a result of using drug. 11 million people used drug through injected way, 1.4 million people have been infected by HIV and 5.6 million with Hepatitis, comparing between 2017 and 2009 there have been 30% increases the population of people with drug dependence. In 2017, 30 million people addicted to drugs. It is harmful for bodies, minds, and behaviors. It could also reduce the quality of life (UNODC, 2019).

Consumption of opium, Shisha, heroin, and Alcohol are common among afghan community. Majority of people don't have jobs, family supporter, financial supporter and always passing their time with ignorant friends without of any policy or plan for their lives. So obviously they will become addicted. Since 2005 - 2009 the total numbers of heroin and opium consumer estimate around 120,000. According to latest report of Ministry of Public Health of Afghanistan (MOPH) and UNODC there are around 3 million people addicted to drugs. And from this amount, drug users will be increased in Afghanistan (Courser et al., 2013).

Afghanistan is one of the famous country in the world for producing opium, by producing opium will be brought a significant threat to inside and outside of Afghanistan. In recent years opium producing and consuming has been increased in Afghanistan. Because in Afghanistan most regions are under the control of Taliban they producing and sealing the opium, the government cannot control them. On the other hand, drugs can easily effect on physical health and mental health. Especially has different effect in different domains of life such as: physical, mental, and social health. Quality of life become a significant result signs in health care assessment. Clear identification has to be made between quality of life attentions and mental disorder.

As opium addiction is the initial substance to effect the people brains and behavior, majority of people admitting for therapy to focusing on quality of life of addicted people. Basically those who are addicted and also suffer from different diseases, participated in substitution treatment had a positive impact on people health, rather than those who didn't participated in substitution treatment (De Maeyer et al., 2010). In recent years, Afghan student struggled to analysis the socio-economic costs of drug consumption. The United Nations distributed a location paper in 1995 the worldwide drug deal and exactness its effect the environment, society and developing of countries. Different countries and global organizations several governments have surveyed, and investigated the title both within exact nations and wide level. Although, by these different type of variable or factors we know that they don't have good quality of life (courser et al., 2013).

Meanwhile, this study will be measure the quality of life of Afghan drug addicted community. Because in Afghanistan there is no study related to this topic. So this study will representative for more investigation and enhance the information of researchers and scholars. All drug addicted community, who used such as opium, heroin, hashish, Shisha, or other tranquillizers (for non-medical use) daily or several times a week, their quality of will be worse or bad situations (Rasikh, 2015).

On the other hand, it is difficult to research all people of Afghanistan specially, those who are affected by drugs. This research will be focused on quality of life of Afghan drug addicted community among adult person in four rehabilitation centers in Afghanistan. This study will also help other researchers and policy makers to create a comprehensive decision for those who are addicted to drugs.

- It is estimated that the numbers of people aged (16-64) years old requiring more investigation to measure their quality of life.
- Older people are more vulnerable who impaired health condition, severe diseases conditions, health requires and low quality of life due to drug uses, and required health care services for improving their QoL.
- Adult people have more responsibilities in different domains of life rather than children.

1.4 Research question:

What are the quality of life of Afghan drug addicted community?

1.5 Operational definition

Quality of life

Quality of life has not only related to standard living, to get financial and employment, but also related to multidimensional, physical, mental, and social health.

Physical dimension

It is generally related to physical examinations, empowering daily physical activities, caring, individual independency, and this part also focusing to pain, and several diseases.

Mental dimension

In this part focused to objects, concepts of life, anxieties, fears, depressions and etc.

Social interaction

This dimension indicated the people relationships to, family members, colleagues, friends and communities.

Environmental dimension

This part focused to environmental circumstance, how people could positive effect to their environment, and how much power people have to decrease the impacts of environment in to their life. (e.g., housing, finance access to care, and safety)

Drug addiction

Addiction can be defined as a chronic, and brain disease that is characterized by compulsive drug seeking and use, despite harmful results. Addiction is identifies as brain disease because drugs directly effect to brain and changes the brains and behavior.

Type of drug addiction

Different type of drugs consist opium, heroin, hashish, shisha, Alcohol, and other tranquilizers will be considered in this study.

Opium

Opium is a substance that is derived by collecting and later drying milky juice that comes from the seed of poppy plant. The substance has different color such as yellow or very dark brown. The opium has very bitter taste and those who are addicted they can easily recognized it.

Heroin

Heroin is an opioid drug made from morphine, a natural substance taken from the seed pod of the various opium poppy plants. Heroin can be a white or brown powder, or a black sticky substance known as black tar heroin. People inject, sniff, snort, or smoke heroin.

Shisha

Shisha is an oriental tobacco pipe with a long flexible tube connected to a container where the smoke is cooled by passing through water.

Alcohol

In chemistry Alcohol is an organic compound that carries at least one hydroxyl functional group bound to a saturated carbon atom.

Alcohol formula: CnH2n+1OH

Higher classification: Organic Compound

Lower classification: Polyol

CHAPTER 1I LITERATURE REVIEW

2.1 Scio- demographic conditions of drug addicts and their quality of life

Drug addicted persons with regard to gender drug addicted persons will be male and female. It should be considered there is different factors effected to Afghan people such as Islamic culture, religion, and stigma it is difficult to access female drug users (Ponzio, 2007). So in this case this study included few female and more male. World health organization (WHO) has defined the term in an extended way as perception and understanding of own individual as of his/ her position in the setting of the society and the value of respected society where he lives in harmony to personal goals, expectation and concerns .Also refer to a general assessment of an individual's well-being, which is including physical, emotional, social, stress level, sexual function and self- perceived dimension of health status. Concept of QoL is covering a bigger range of life aspects which is also depends on individuals own potential and experiences (Hassamzadeh, 2018). While assessing health related quality of life overall denomination of live must be considered such as the person's personal believes, psychological state, physical health, social relationships and feature of their environment (Ponizovsky & Grinshoon, 2007).Many research findings have showed that opiate- dependent individuals having lower quality of life than those who had been in normal state and have not been using drug. Quality of life (QOL) is considering as a fundamental index while assessing health care system (De Maeyer et al., 2010).

As result of importance of drug addiction globally, QoL of people with drug addicted has been attracted notable attention in new researches (Bizzarri et al., 2005). Quality of life of drug addicted community and comparing with those who are not addicted to drugs were mostly (90%) moderate.

There is no significant difference has been found between men and women in term of QoL and physical symptoms (Poniszovsky et al., 2007; Xiao et al., 2010; Hoseinifar et al., 2011; Masuad Rayani, 2014). In another research don by (Hoseinifar et al., 2011) compared QoL of addicted persons with Normal persons found that addicted people lived in the worse condition than non-addicted persons. They also reported that addicted people needed more help and support from society. Addicted people typically have many problems such as job finding, marriage and obtaining vehicle driving license (Karbakhsh & Zandi, 2007). On the other hand, majority of people who were using drug regularly had one of the following common socio demographic factors: early age, literacy, low working conditions and poverty. As well as, role of friends (Peers) has an essential impact on initiation of drug use. Among the drug addicted (Kaicheng & Jianbong, 2010).

One research had been done in Iran in 2011. There was a significant relation between QoL and mental health. Generally, there is mutual relationship between addiction and mental disorder. It means the mental disorder like depression and anxiety pave the way for addiction and addiction consequence is some mental disorder like restlessness, muscle tension and depression. The study revealed that QoL among addicted persons were lower than non-addicted persons. This is include with report of smith & Larson (2003) and Urok & Gal (2001). The finding of this study supported the study done by (Bizzarri et al., 2005) with respect to low QoL among addicted people. And that study also displayed those who are addicted to drugs are very bad condition than non- addicted they required more helps and supports and courage's (Hoseinifar et al., 2011).

Similar research done in Iran shown that comparison of mental health, aggression, and hopefulness of s drug users and non- drug users, so drug users had low mental health and hopefulness than non-drug users. Drug users are more aggression and less hopeful. And also addiction is physical and mental illness, drug is harmful for all aspects of life such as individual, family, community, and society health (Sheridan, 2014).

The result of drug consuming will be body pain, anger, depression, anxiety, dissatisfaction low quality of life. Drug addiction impact self-confidence, behavior, social relations and basically individual occupation. For controlling environment and communicating with others, drug addiction is not primarily step. Pleasure of life, physical power, life expectancy would be decrease among drug consumers. By the way, among drug addicts there will be different kind of stress, anxiety, poor quality of life, mental health, and psychological problem (Hoseinifar et al., 2011).

Other study found that drug addiction is severe illness that is often connected with other psychiatric diseases. In drug addiction the most common psychiatric disorders are consist: anxiety, depression, stress etc. As research shown that above 70% of drug addicted persons are suffer from drug abuse as well as anxiety, depression, personality disorder, and sexual disorder. Various researches have shown that drug addiction has the most significant co-morbidity with anxiety and depression. (Fooladi et al., 2014).

2.2Accessibility to rehabilitation service and rehabilitation

Drug addiction is very huge problem in the world, maximum patients don’t have access to rehabilitation for treatment early and on time to give best result in returning their normal live unluckily majority of persons who need that treatment service and rehabilitation have limited access to treatment (Shazzad, et al., 2013). Recent available data indicate that a huge gap still available in treatment service and provision of standardized rehabilitation programs in area of drug dependence (Pringle, Emptage, & Hubbard, 2006).

Around 5% of the adult population used an illicit drug at least once in 2010 worldwide 230 million people addicted to drugs aging between 16-64 (UNODC, 2018), including about 27 million people with severe drug problems, and there is poor health and rehabilitation services are accessible. New research and finding reveals that bad consequences of drug dependence are more adverse than before it was thought (US Department of Health and Human Services, 2016). Around the world there are about 35 million people are estimated to have drug dependence and need some serious health assistance (world drug report, 2019). Subsequently, in 2017 globally estimated that around 53 million opioids have been available there which resulted for two third of (585.000) people who died as a result of using drug.

In addition to that, in 2017 worldwide 11 million people used drug through injected way, from those 1.4 million have been infected by HIV and 5.6 million with Hepatitis, comparing between 2017 and 2009 there have been 30% increases the population of people with drug dependence. Considering those number of people with drug dependence disorder, treatment service is not sufficient "based on available data, only 45% of countries are able to offer important treatment to treat dependence on heroin and other opiates and almost half the countries where treatment is available is not exceeding than one in five persons with drug use disorders benefits from the service (World drug report, 2019). A quarter of the countries' which identify opiates as the main drug problem do not offer the range of medications recommended by World Health Organization (WHO, 2012).

In Afghanistan according to ministry of public health of Afghanistan and UNODC report there are around 3 million people are addicted to drug including heroin and its derivatives and synthetic type of heroin, considering that number of addicted persons providing health service is very poor (UNODC & MoPH, 2018). Considering that statistics, government cannot provide health services and rehabilitation for those persons and government is able to provide health and rehabilitation service annually for 50 thousand people around the country, but the number of people getting addicted and those who are using drug in return are much more than service provided by government (MoPH, 2016).

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Treatment services in Afghanistan between (2012 and 2015).

	Total treatment in 2012	Government	NGOs	Total treatment in 2015
Services				
In-Patient	72	21	55	72
Out-Patient	32	0	32	46
Outreach	73	0	73	75
Harm Reduction	4	0	4	26
Village Based	5	0	5	0
Community Based	25	15	10	31
Aftercare	66	0	66	67
Shelter	N/A	N/A	N/A	6
Treatment services for targeted population				
Adults	101	31	80	131
Teenagers	20	0	20	26
Children	32	9	23	21
Treatment Capacity				
Clinical Staff	896	287	609	917
Inpatient services Number of patients	200	730	1270	2740
Annual capacity	13130	5840	7290	19000

Annual capacity of out-patients	8560	3340	5220	5220
Number of patient in home remedies program	460	0	460	260
Capacity of annual treatment at home	3920	0	3920	3920
Total capacity of treatment	25480	8960	16520	32170

Table1: UNODC Report 2015, source: Ministry of Public Health (2012), Ministry of Counter Narcotics (2015)

In the public health sector of Afghanistan different treatment services is provided including: inpatient, outpatient, home remedies, community-based treatment and treatment in drug rehabilitation services Hospitals, which has different treatment capacities (MoPH, 2018). The detailed information regarding service provided by ministry of public health of Afghanistan in two years including (2012 and 2015).

2.3 Quality of life of drug addicted people in developed countries

As well as, one research had been done in china that was about how to realize the quality of life(QoL) of drug addicted persons, and supply scientific evidence for transferring healthy education, initiating plane of social integration, modifying therapy, and enhancing the quality of life. Their quality of life was higher at rehabilitation center duration of treatment. In fact their quality of life were poor. Also there is important dissimilar in privileges of body scope between experienced class and control class, so there was no important difference between psychological aspect, and social condition. The quality of life female was lower than male. This study displayed that drug addicted persons after rehabilitation their quality of life will be low, it is very essential to reinforce education for drug addicted people and get comprehensive evaluation for them to improve their quality of life (Liang & Liao, 2010).

2.4 Quality of life of drug addicted people in developing countries

Quality of life of drug addicted people in developing countries might be lower than developed countries and one study found in Birjand of Iran country, and shown drug addicts have many personal challenges, including the evaluation of important things in their lives. They struggling to keep their dignity and self-confidence while faced or encountered with negative attitude of community and losing their physical activities. That will be effected to their selves. Strengthen addicted people by spiritual attitude, religious beliefs and supporting them to improve their quality of life. The institutionalization of religious and spiritual beliefs and performing regarding action basically can help such people to increase their self-esteem, dignity and quality of life (Salmabadi et al., 2016).

Who are addicted and using different type of drugs such as: Alcohol, opium, Hashish, Shisha, and other tranquilizers have significantly affect to their physical health, mental health, and social relationship, and different studies have been displayed the high level of mental illness among drug addicted persons. Generally, study displayed that opioid reduce mental health of persons. One study reported in Iran that most of people who addicted to drugs they found unhealthy behavior such as lack of exercise, restlessness and not brushing teeth etc. One more research has been done in Iran, also supporting previous studies, it means those who are addicted to drugs they will find mental health problem, unhealthy behavior. Every time drug users have mental, physical, and social problems. Easily they cannot solve their troubles (Hoseinifar et al., 2011).

2.5 Impact of drug addiction on quality of life

However, one research has been shown at center of Copenhagen K, Denmark by title of psychoactive drugs and quality of life that displayed quality of life of drug addicted including:(heroin, methadone, morphine, alcohol or other tranquilizers) are 10% lower than those who had never used drugs or psychoactive drugs(Ventegodt & Merrick, 2003). The drugs addicted persons are more dangerous for their personal life and society that has many impacts on families and community. The drug addicted persons are have very low QoL in different domains of life such as physical, and mental health. Some studies have reported and measure QoL of drug addicted persons.

For instance, those who are using more drugs during days, months, or years, definitely their quality of life will be lower rather than, those who are using drugs (Laudet, 2011). The HRQOL of people, and who are frequently using drugs their QOL will be lower than non-drug addicted people (González- et al., 2009).

2.6 Treatment with use of methadone can play a significant role to improve QoL of drug addicted people

One study published and reported that quality of life is not significantly different between drug addicts and non- addict's participation. It looks that treatment with use of methadone can play a good role to improve quality of life (Aghayan et al., 2018). Methadone maintenance treatment (MMT) for drug addiction is safe and effective but most of people using and because of inaccessibility, low- finance and stigma basically attached to maintenance therapies. Initial trials in the U.S have displayed that methadone maintenance in physician office-based sitting yields positive effects and some advantage of care and large methadone clinics. Treatment of Heroin addiction is including methadone maintenance treatment, training of primarily care, could reach many more patients, and higher access rates, to reduce the effect of heroin and improve their quality of life.The study was identify the most significant steps to hamper and decline the prevalence of drug addiction in the society and cooperating with addicted people to determine their mental health and quality of life. Those who were addicted and participated in this study their quality of life and mental health were lower than non- addicted people (Larti et al., 2017).

On the other hand, five years after started methadone treatment, drug addicted persons reported low quality of life (QoL) scores in different domains. So important negative effect of psychological distress was identified. Severity psychological disorders, taking medication for psychological disorder, and lack of ability to change living situation were associated with lower quality of life. Drug addicted persons, and their quality of life measured by their psychological well- being and number of psychological variables. What it found highlighted the significant point of treatment and supported the methadone maintenance treatment, which went beyond negative physical result of drug addiction (De Maeyer et al, 2011).

2.7 Concept of QoL

Quality of life has not only related to standard living, to get financial and employment, but also related to multidimensional, physical, mental, social, well-being, education and leisure time. Conceptual study of quality of life is very essential for each dimension of life. For analyzing the concept of quality of life, which recently used in drug addiction. Quality of life components, as understanding of the illness, have been associated with treatment and disease's progress. We realize that, the quality of must be included in the regular assessment (Roncero et al., 2011).

To understand the quality of life of drug addicted community. Have to give awareness, and carrying out education for ignore people, those who don't know the detriments of drug uses. One research has been done in China on 2010. That has shown low quality of life among drug addicts community after rehabilitation. It is essential to strengthen the propaganda for comprehensive measuring of drug addicts, and improving their quality of life (Liang & Liao, 2010). It was indicated that perceived satisfaction and having control over aspect of life mediates the correlation between the quality of life and drug addicted community. Thus it is important that to help drug addicted people to increase control over their life, create opportunities to minimize the level of dissatisfaction in significant domains of life and guide them to gain satisfaction from other domains with the aim to increase their QoL (Bishop, 2005).The term QoL is defined extensively within the literature thus it is necessary to define the term based on the framework in which the concept of QoL is included (Bishop, 2005).

Literature defined QoL as an individual's understanding about their well-being that is derived after analyzing the degree of satisfaction achieved in significant aspects of life for that individual. QoL defines patient's experience in aspect of functioning that are essential for them but are not captured by traditional symptom assessments such as the addiction severity index and type of drug addiction (Donovan et al., 2005). In fact, there no globally accepted biomedical introduction of QoL, but there is compromised that it combines the individual's subjective view of a broad range of functional and personal variables (Bonomi et al., 2000a).

This research have conceptualized one type QoL, such as: socio-demographic and, how the type of drugs addiction affect bodies consumer, will be assessed by WHOQOL-BREF. The world health organization quality of life BREF instrument (WHOQQOL-BREF).

The WHOQOL-BREF assesses individual's quality of life overall, not only in relation to health issues. The scope of the inquiry might be suggested by the following questions, selected from among total of 124. Clients are instructed to keep in mind their "standards, hopes pleasures and concerns" as they respond to each with a rating of 1 to 5.

- How well are you able to concentrate?
- Have you enough money to meet your needs?
- To what extent do you have the opportunity for leisure activities?
- How satisfied are you with your capacity for work?
- How satisfied are you with your personal relationship?
- How satisfied are you with your access to health services?
- To what extent do feel your life to be meaningful?

The full WHOQOL-BREF is posted at

www.who.int/substance_abuse/research_tools/whoqolbref/en/.

Internal factors such as: socio- demographic, type of drug addiction, and health can be considered as objective element of QoL whereas individual's perception of his/ her life in general, or of specific aspects of life are considered as the subjective measure. It was mentioned that measuring QOL in a subject manner would result in more valuable information about the Quality of life of afghan drug addicted community (Laudet, 2011).

CHAPTER III METHODOLOGY

Research methodology is a systematic method to overcome a problem. It is shows how to research is to be carried out and aims to give work plan of research. This chapter describes the following procedures:

3.1 Conceptual framework

Independent variable	Dependent variable
Socio-demographics Gender Age Marital status Home area Occupation Educational status Monthly family income Number of family members **Type of drugs addiction** Opium Hashish Heroin Shisha Alcohol	→ **Quality of life**

3.2. Study Objectives

3.2.1General objectives

To study the quality of life of Afghan drug addicted community among adult persons aging between (16-64) years old.

3.2.2 Specific objectives

- To determine association of socio demographic background with drug addiction
- To study the impact of drug addiction on quality of life
- To study the consequence of drug addiction on quality of life of Afghan community.

3.3Study Design

A quantitative study, cross sectional design was conducted for those patients who admitted to inpatient rehabilitation center in four hospitals that are located in different area of Kabul province of Afghanistan. This study has been done from (July-Nov 2019). This research has measured the quality of life of Afghan drug addicted community, and cross sectional study is the best option to measure QoL of drug addicted persons. In addition, it is affordable method that can be conducted by the researcher.

Design of study is a general snapshot which can guide the researcher during data collection phase. It can be used for collecting data and information systematically based on need assessment of the appropriate research to make insure the highest validity and reliability of the results. Quantitative research is a kind of experimental research that research mostly focus on observation the variables to provide a logic or theory based on findings. Most of findings are expressed in umbers and researcher present own result by showing tables or charts. They also shows which variables can bring effect on the responds. This kind of research can be used for measuring and analyzing behavior of responds through numerically and objectively. We can transfer variables to numeric easily that can be analyze by SPSS software. Cross sectional study can shows the ratio between variables, QoL, and type of drug addicted persons.

3.4 Study Population

Individuals with any kind of drug addiction who has admitted in hospital from July 2019-Nov, 2019. In Afghanistan there is no validate data about QoL of drug addicted persons and no investigation or survey has been done to measure the QoL. In 2003 one study done by Ventegot & Merrick, had been conducted in Copenhagen K, Denmark that displayed quality of life of drug addicted people including:(heroin, methadone, morphine, alcohol or other tranquilizers) are 10% lower than those who had been never used drugs or psychoactive drugs. As well as, in 2010 one research had been done in china that was about how to realize the quality of life(QoL) of drug addicted persons, and supply scientific evidence for transferring healthy education, initiating plane of social integration, modifying therapy, and enhancing the quality of life. Also, one research had been done in Iran in 2011 .There was a significant relation between QOL and mental health .But that study has been done long time ago and there is no any update about the QoL of drug addicted persons in Afghanistan. Because of that research selected the sub-population which is the number of person with drugs addicted, and admitted inpatient rehabilitation centers in different hospitals in Kabul from (July -Nov 2019).

3.5 study area/ site

The study area was in different area of Kabul province such as phoenix hospital, Janglak hospital, Dehbori hospital, and khoshhal Khan Hospitals. From all these rehabilitation centers first researcher get information about many patients admitted in these centers for treatment. Then those who was within 16-65 years old the researcher interviewed with them and got more information about adult persons those who are addicted to drugs.

3.6 study period

This study has been done from (July-Nov 2019).

3.7 Sample size

As the exact population of drug addicted patients are unknown for researcher, so he calculated sample size by using the Cochran formula. This method is conducted when researcher has no more information about population which allows us to calculate samples given an appropriate level of accuracy be considering the level of confidence and estimate of proportion of the present population. This formula can be used when we face to large population. So researcher started to collect sample from July 2019- Nov 2019, for achieving the entire sample size by using the Cochran formula as follow:

$$n_0 = \frac{Z^2pq}{e^2}$$

Note:

- e is appropriate level of accuracy(margin of error),
- p is estimate proportion of the entire population,
- q Is 1-p

As we have no information about our subject, we assume maximum variability to the formula, be this we mean p = 0.5. From another side we say 95% confidence with 5% accuracy or standard of error in this study. In that Z value of 95% confidence is equal to 1.96 per normal table. Finally we will have:

[(1.96)2 (0.5) (0.5)] / (0.05)2 = 385

About 385 patients in our target population could be appropriate to give the confidence level that we need. As far as we know this study conducted in different rehabilitation centers in Kabul province that is able to give rehabilitation service and treatment for addicted persons to small amount patient in specific period of time. Security issue, low numbers of female, and severe patients those who are not able to answer the questions all issues had been mentioned, limited us to achieve a huge number of patients. So that is why the researcher conducted this study with taking all sample which admitted in different rehabilitation centers form July 2019-Nov 2019. At the end of this time we collected 124 sample in our target entire population and these issues are mentioned as the limitation of study in discussion part.

3.8 inclusion and exclusion criteria

3.8.1 Inclusion criteria

- Clients who registered their name in rehabilitation center for treatment
- Both male and female are included
- Clients who are cognitively able to understand the study and signed consent form
- Clients who are between 16-64 years old

3.8.2 Exclusion criteria

- Childs with drug addiction less than 16 years old
- Patients with communication disabilities
- Sever patients with some psychological problems or some other cases who were not able to sit for interview
- Stigma also will be prevent most of female to interview with a researcher specially in religious country like Afghanistan

3.9 Sampling technique

Convenience sampling method is a kind of non- probability technique that include the sample by selecting from that part of the population which is close to hand or is accessible and ease for the researcher. As researcher had no access to the list of target population and, deficiency of resource, security issue, and low number of females willing to participate in this study. All clients will select by non-probability sample technique that refer to the centers for treatment in Kabul Afghanistan. It was difficult to conduct probability sampling technique. So that is why the researcher chose convenience sampling method for this study. Convenience sampling technique has several advantages which make it desire method for collecting data such as, ready availability, cost effectiveness, ease of research and expedited sample collection. For this purpose the researcher collected all samples from different rehabilitation centers located in Kabul province of Afghanistan from (Jul -Nov 2019). Within this period everyday morning researcher collected all patients who admitted to center by considering inclusion and exclusion criteria.

3.10 Data collection tools

Following method were selected to conduct the data collection:

- structured questionnaire and format was used for descriptive information
- pilot study

3.10.1 Structured questionnaire development

The researcher developed a close ended structured questionnaire to collect relevant data on patient's demographic and drug addicted conditions, type of drug addiction related information and referral method to rehabilitation center. This form was developed since no more information found in the literature to address all issues which are necessary to be found related to the objectives of a study. Assistant was sought from a statistician as well as from an expert with clinical and research experience in the field of psychology. The above mention variables will have been extracted from the centers of treatment for drug addiction to measure quality of life of Afghan community.

3.10.2 Pilot study

A pilot study was conducted to enhance the reliability and validity of data collection instrument. In addition it was necessary for the researcher to learn how to administer the instrumentation from which unnecessary errors during administration could be identified and resolved. This study included persons with drug addicted in different rehabilitation centers for drug addicted treatment. 5 individual with drug addiction were selected from that department to participate in the pilot study. The result of pilot study was used to make alternation into the structure of the main questionnaire to correct some part of it regarding to the achievement of the objectives. The time was allocated for the pilot study was between 15 to 20 minutes that was same to the main questionnaire.

3.11 Data management and analysis process

All data from the questionnaire was analyzed by the statistical package for social science (SPSS) version 22.0 and reflected as descriptive statistic of frequency, mean, standard deviation and percentages. Researcher used qi-Square Test to see the association between descriptive variable such as: socio- demographic and type of drug addiction to measure the QoL of drug addicted persons. As we are going to collect the observational descriptive data to identify those are addicted and effect their quality of life. Less percentage of addicted persons might be have good quality of life and majority of persons with addicted may be have low QoL.

3.12 quality control and quality assurance

Quality control and quality assurance were applied regarding to the data life cycle, but the main focus of the researcher was on those data that was accessible to collect from patients. Quality control and quality assurance are used to explain activities which prevent errors from entering or staying in a data set. These activities ensured the quality of data before it was collected, entered or analyzed, and monitoring and maintaining the quality of data throughout the study. The researcher ensured the quality assurance in research by comprising all the methods, procedure and resources that are extend to make assurance about the maintenance and monitor with which the investigator has conducted. The researcher took responsibility to apply a clear research project. Data collector got training about how to fill the questionnaire and how to ask the question appropriately to ensure the competence of data collection. The researcher maintained the research records according to the supervisor guideline. Samples and materials were handled and maintained carefully by the researcher.

3.13 Ethical consideration

The proposal was checked by the BHPI review board/ committee of CRP and it will be approved by BHPI, under Dhaka University. On the other hand, the proposal also checked by the Mistry public health Afghanistan, national public health institute, institutional review board. Permission was attained the patient records for participant name and phone number. A written information sheet was shared to participants to inform them about the aims and significant of the study, then if the client was agree to participate in the study, his/ her consent will be taken by the data collector. On the day of data collection, participants were informed about their rights and assured that all information provided will be treated as confidential material and used strictly only for this study. In addition, participant were informed that they had right to withdraw anytime for personal reasons. They also got information about their right not to respond to questions that they think it is sensitive. No personal information of clients disseminated in public and the entire documents were being confidential. All data and relevant documents maintained and shelved in a restricted area by the researcher.

Table 4.1: Demographic characteristic of patients

	N (%)
Marital status	
Unmarried/ single	44(35.5)
Married	78(62.9)
Divorced	2(1.6)
Home area	
Urban	89(71.8)
Semi-urban	20(16.1)
Rural	15(12.1)
Occupation	
Service holder	10(8.1)
Business	11(8.9)
Day laborer	51(41.1)
Farmer	8(6.5)
Unemployment	44(35.5)
Educational level categorical	
Illiterate	36(29.0)
Primary school	53(42.7)
Secondary school	28(22.6)
Bachelor degree	7(5.6)
Monthly family income	
Low income <= (10k)	33(26.6)
Medium income (10k-15k)	48(38.7)
High income (15 k +)	43(34.7)

Table 4. 1 shown 44(35.5) of patients were single/unmarried in this study and 78(62.9) of them were married it means the highest number of patients were married and 2(1.6) of them were divorced in this study. The table shown main areas that patient's live. 89 (71.8) were living in urban area which is included the most frequency of patients. 20 (16.1) of patients were living in semi-urban area which included the moderate frequency of patients. 15(12.1) of patients were living in rural area which is included the lowest frequency of patients.

The Table shown different type of job status among drug addicted patients which were participated in this study. The lowest number of patients 8 (6.5) their careers were farmer and most of patients 51 (41.1) their jobs were day-laborer. And 10(8.1) of patients their occupations were service-holder .Also those patients were business men/ women their frequency were 11(8.9). After day-laborer the 44(35.5) of patients were unemployed. It shown at second ranking most of patient were unemployed.

According to mentioned statistic, 36 number of patient had no education (Illiterate) that is equal to 29 percent of total clients. In this study those who had educated to primary had the highest level of frequency 53 (42.7). Frequency of this part increased sharply from illiterate 36 (29.0) level to primary 53 (42.7) level by 17 (13.7). The secondary level their frequency were 28(22.6). After that the graph displayed it is decreased dramatically from primary school level to secondary school level by 25 (20.1). Then it remained level off up to the next level which means bachelor and above. The lowest frequency 7 (5.6) of patients were bachelor. The table shown 3 main level of monthly family income in this study, the low income (<=10k) of patients who participated were 33(26.6).And the highest number of patients had medium income (10k-15k), it means 48(38.7) of patients their monthly family income were "between" ten thousand Afghani to fifteen thousand Afghani per months. But 43(34.7) of patients had the highest income (15k+), it gives that meaning to us that 43 patients of this study their family members were receiving above 15 thousand Afghani per months.

Frequency of gender distribution in different age categories:

The figure 4.1 shown 98(79.0) of drug addicted patients were male in this study and 26 (21.0) of patients were female. Difference in frequency between them is 72 (58.0). The total number of patients were (124). We can see two independent variables (age and gender) distributed in three categorized age group. Most of drug addicted persons 73(58.9) had age from 16 to 32 which 50 of them were males and 23 of them were females. Lowest age category 3(2.4) for ages above to 50 which three of them were males. As we see the age of drug addicted patients are decreased sharply from younger people to older one, for instance age category 33-49 is decreased from 48(38.7) to 3(2.4) by 42(36.3) and also there was no female in category 50-66. In addition, 98(79.0) of drug addicted patients who participated in this study were men and 26(21.0) of them were women.

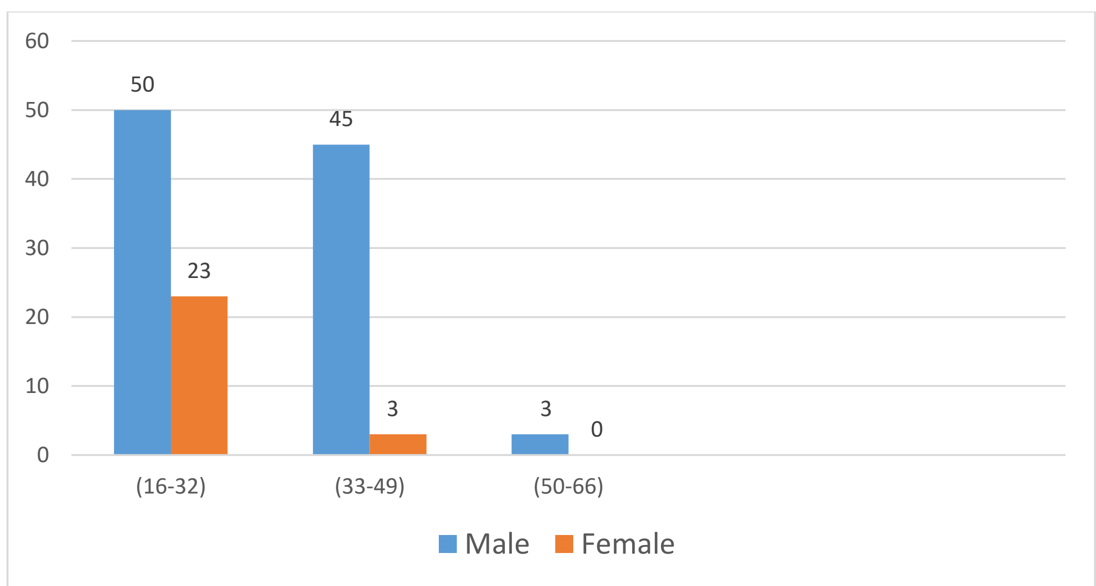

Figure 4.1: Frequency of gender distribution in different age categories

Types of Drugs adduction:

Table 4.2 List of type of drugs addiction

Type of drugs	Responses	%
Opium	28	22.6
Hashish	28	22.6
Heroin	97	78.2
Shisha	68	54.8
Alcohol	7	5.6

Table 4.2 shown that 97(78.2) of patients were addicted to heroin, it shows the highest number of patients were addicted to heroin. But the lowest number 7(5.6) of patients were addicted to alcohol, because maximum people in Afghanistan don't have legally access to alcohol, however heroin, opium and other drugs producing in Afghanistan, special those regions are to under the control of Taliban producing more heroin, opium and other tranquilizers, so that is why this study shows most of people addicted to heroin, opium, hashish, and shisha rather than alcohol. From other hand this study displayed 28(22.6) of patients were addicted to Opium and Hashish. There was no differentiate according to frequency and percentage between opium consumers and Hashish consumers. And also 68(54.8) clients were consumed Shisha.

Relation between Shisha use and QoL:

Figure 4.2 shown relation between Shisha use and quality of life. Low number 3(4.4%) of patients said by using shisha their quality of life is very good. 2(3.6%) of clients told by non- using shisha their QoL is very good. In this research 12(17.6%) of participated clients said by using shisha their quality of is good. 14(25.0%) of patients said by non- using shisha their QoL is good. 13(19.1%) of patients said by using shisha their QoL is neither poor nor good. The same amount of shisha users said their QOL is very poor. 22(39.3%) of clients said when they were not using shisha they felt their QOL is neither poor nor good.

In this study 3(23.2%) number of clients said when they were not using shisha they felt their QoL is poor. The highest number 27(39.7 %) of patients also said by using shisha their quality of is poor. 5(8.9%) of patients said by non-using shisha their Qol is very poor. It shows a significant relation between shisha use and lower Qol.

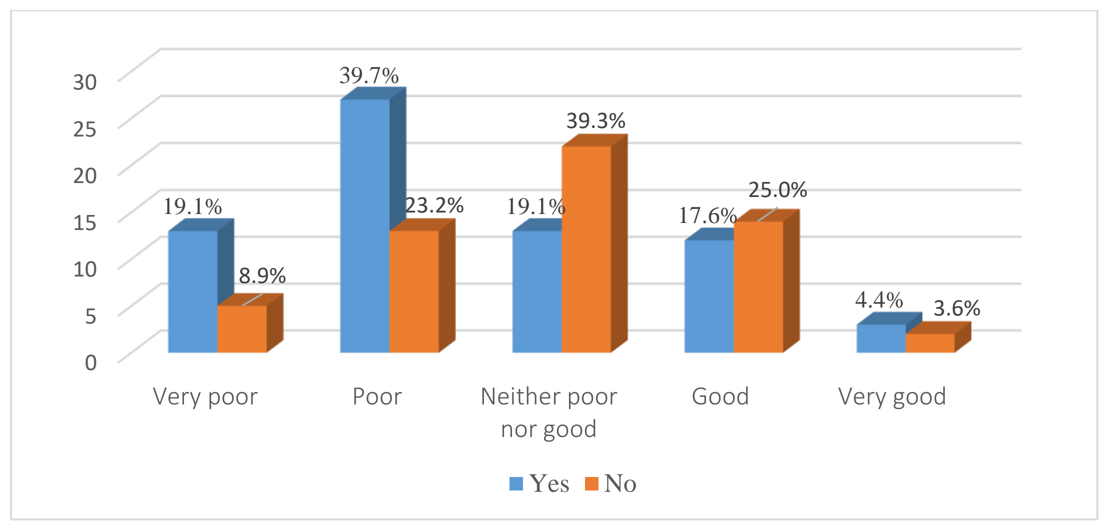

Figure 4.2 Relation between use Shisha use and QoL (X2 test, p-value=0.03).

Relation between Alcohol consumption with QoL:

Figure 4.3 shown the relation between Alcohol consumption and quality of life. Those who participated in this study and they were also consumed alcohol 2(28.6%) of patients from total said by consuming alcohol their QoL is neither poor nor good. The same amount 2(28.6%) of patients said by drinking alcohol their quality of life is very good. The 3(42.9%) number of clients said by drinking alcohol their QoL is good. Meanwhile, by consuming alcohol in two other levels (very poor, and poor levels) the frequency and percentage were zero. In this study those who said by non-consuming alcohol their quality of life will be in different level. 18(15.4%) of patients said by non-drinking alcohol their QoL is very poor. The highest number 40(34.2%) of patients said by non-drinking alcohol their QoL is poor. The lowest number 3(2.6%) of patients said by non-consuming alcohol their QoL is very good. 23(19.7%) of patients said by non-drinking alcohol their QoL is good. 33(28.2%) of clients said without of drinking alcohol their QoL is neither poor nor good.

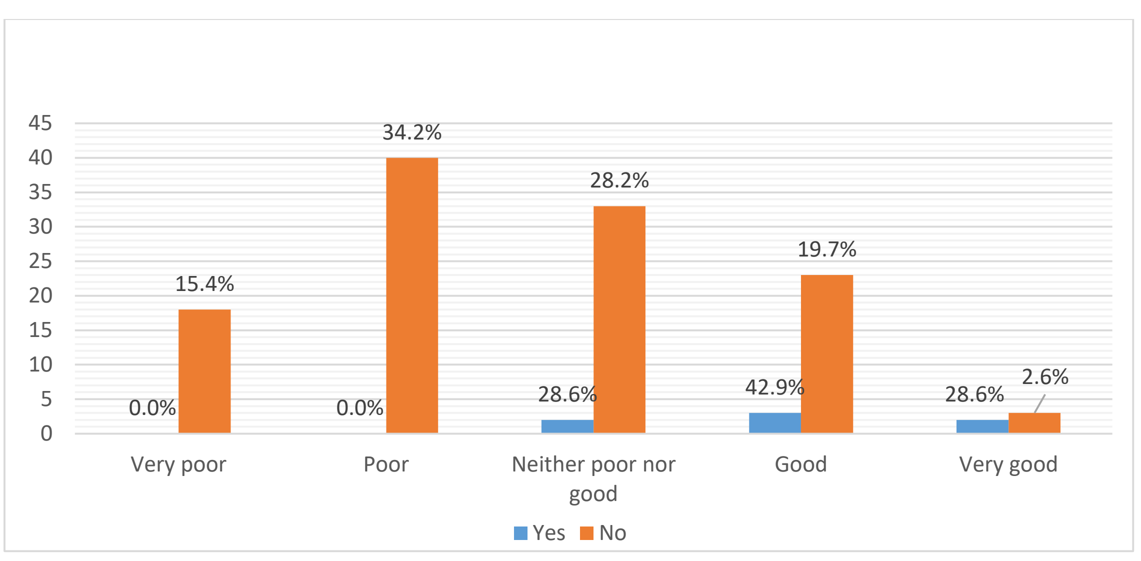

Figure 4.3 Relation between Alcohol consumption with QoL (X2 test, p-value= 0.03).

Relation between Shisha use and QoL:

Table 4.3 Relation between Shisha use and various aspects of life.

Shisha	**1** Not At all	**2** A little	**3** Moderate Amount	**4** Very Much	**5** Extremely	Total
Able to Concentrate: (X2 test, p-value= .008).						
Yes	9(13.2%)	33(48.5%)	15(22.1%)	4(5.9%)	7(10.3%)	68(100%)
No	2(3.6%)	15(26.8%)	19(33.9%)	10 (17.9%)	10(17.9%)	56(100%)
Feel safe in your daily life: (X2 test, p-value= .03).						
Yes	18(26.5%)	25(36.8%)	14(20.6%)	4(5.9%)	7(10.3%)	68(100%)
No	6(10.7%)	18(32.1%)	11(19.6%)	12(21.4%)	9(16.1%)	56(100%)

This table 4.3 shown a significant relation between shisha use with concentrating and feel safe in daily life. By using shisha the patients had different levels of concentrating. For instance in concentrating part how much they had concentrating to personal, and social life. For the personal relations showed that who participated in this study and using shisha not at all level is 13.2 % (n=9),a little level 48.5% (n=33) , moderate amount level 22.1% (n=15), very much level 5.9% (n=4), and extremely level 10.3% (n=7). Meanwhile, this table shown a little level had the highest amount of patients and very much level had the lowest number of patients. But, those who participated in this study and they were not using shisha and the table shown not at all level 3.6% (n=2), a little level 26.8% (n=15), moderate amount level 33.9% (n=19), very much level 17.9 % (n=10), and extremely level 17.9 % (n=9). In this study very much level and extremely level had same percentage and same frequency. There was no discrepancy between them. Moderate amount level had the highest number of patients and not at all level had the lowest number of patients.

So table 4.3 also shown a significant relation between Shisha uses and feel safe in daily life. In this table 7(10.3%) of patients said by using shisha they felt extremely safe in daily life. 4(5.9%) of patients said by using shisha they felt very much safe in daily life. 14(20.6%) of clients told by using shisha they had moderate amount of feeling to be safe in daily life. The highest number 25(36.8%) of patients said when they were using shisha they felt a little safe in daily life. 18(26.5%) of clients who participated in this study and said by using shisha they felt not at all safe in daily life. While 9(16.1%) of clients said by non-using shisha they felt extremely safe in daily life.12 (21.4%) of patients said by non-using shisha they felt very much safe in daily life. 1(19.6%) of clients said by non-using shisha they felt moderate amount safe in daily life. The highest number 18(32.1%) of patients said without of using shisha they felt A little safe in daily life. The lowest number 6(10.7%) of patients told without of using shisha they felt not at all safe in daily life.

Factors associated between shisha use and Alcohol consumption with QoL:

Table 4.4 Factors associated between Shisha use and alcohol consumption with different aspects of life.

Shisha	**1** Not At all	**2** A little	**3** Moderately	**4** Mostly	**5** Completely	Total
Enough energy for daily life: (X2 test, p-value= .007).						
Yes	1(1.5%)	29(42.6%)	25(36.8%)	4(5.9%)	9(13.2%)	68(100%)
No	1(1.8%)	7(12.5%)	28(50.0%)	6(10.7%)	14(25.0%)	56(100%)
Need information in daily life: (X2 test, p-value= .001).						
Yes	16(23.5%)	27(39.7%)	19(27.9%)	2(2.9%)	4(5.9%)	68(100%)
No	3(5.4%)	25(44.6%)	14(25.0%)	6(10.7%)	8(14.3%)	56(100%)
Opportunity for leisure activities: (X2 test, p-value= .001).						
Yes	17(25.0%)	28(41.2%)	13(19.1%)	8(11.8%)	2(2.9%)	68(100%)
No	3(5.4%)	14(25.0%)	25(44.6%)	10(17.9%)	4(7.1%)	56(100%)
Alcohol:-						
Accept your bodily appearance: X2 test, p-value= .007).						
Yes	0(0.0%)	0(0.0%)	1(14.3%)	4(57.1%)	2(28.6%)	7(100%)
No	4(3.4%)	26(22.2%)	54(46.2%)	13(11.1%)	20(17.1%)	117(100%)
Enough money to meet your needs: X2 test, p-value= .002).						
Yes	1(14.3%)	0(0.0%)	3(42.9%)	0(0.0%)	3(42.9%)	7(100%)
No	16(13.7%)	46(39.3%)	37(31.6%)	12(10.3%)	6(5.1%)	117(100%)
Need information in daily life: X2 test, p-value= .002).						
Yes	0(0.0%)	1(14.3%)	4(57.1%)	2(28.6%)	0(0.0%)	7(100%)
No	19(16.2%)	51(43.6%)	29(24.8%)	6(5.1%)	12(10.3%)	117(100%)

Table 4.4 shown the relation between shisha uses and enough energy for daily life. Those who participated in this study and they were also using shisha the lowest number 1(1.5%) of patients said they had not at all enough energy for their daily life. In this category 1(1.8%) of patients said by non-using shisha they had not at all enough energy for their daily life. The highest number 29(42.6%) of clients said by using shisha they had a little enough energy for their daily life. 7(12.5%) of patients said by non-consuming shisha they had a little enough energy for their daily life. The discrepancy between this two groups were 22(30.1%). 25(36.8%) of clients said by using shisha they had moderately enough energy for their daily life. The highest number 28(50.0%) of clients said by non-using shisha they had moderately enough energy for their daily life. 4(5.9%) of patients told by using shisha they had mostly enough energy for their daily life. In this category 6(10.7%) of patients said by non-using shisha they had mostly enough energy for their daily life. Meanwhile, in completely level only 9(13.2%) of patients said by using shisha they had completely enough energy for their daily life. But those who said by non-using shisha they had completely enough energy the number of patients were 14(25.0%)

Table 4.4 also shown the relation between shisha users and information they need in their daily life. Who participated in this study and they were also using shisha, how much need information in their daily life? This study shown not at all level 23.5% (n=16), a little level 39.7% (n=27), moderately level 27.9% (n=19), mostly level 2.9% (n=2), and completely level 5.9% (n=4). The discrepancy between not at all level and a little level were 11.8% (n=11). They highest number of clients were in moderately level and the lowest number of patients were in mostly level. On the other hand, those who participated in this study and they were not using shisha and the information they need in their daily life. Not at all level 5.4 % (n=3), a little level 44.6% (n=25), moderately level 25.0 % (n=14), mostly level, 10.7% (n=6), and completely level were 14.3% (n=8).

The table 4.4 also shown relation between shisha uses and what extent they have opportunity for their leisure activities. Those who participated in this study and said by using shisha they have mostly or a little opportunity for leisure activities, and that was different. Not at all level 25.0% (n=17), a little level 41.2% (n=28), moderately level 19.1% (n=13), mostly level 11.8% (n=8), and completely level were 2.9% (n=2). The highest number of patients were in a little level and the lowest number of patients were in completely level. The discrepancy between a little level and not at all level were 16.2% (n=11). But those who participated in this research and said by non- consuming shisha they had different extent of opportunity for their leisure activities. Not at all level 5.4% (n=3), a little level 25.0% (n=14), moderately level 44.6% (n=25), mostly level 17.9% (n=10), and completely level were 7.1% (n=4). The highest number of patients in non-using parts were in moderately level and the lowest number of patients were in not at all level. Because they had various opportunity for leisure activities.

Table 4.4also shown factors associated between alcohol consumption with experiencing or able to do certain things. Those who participated in this study and said by consuming alcohol they had various levels of experiencing how to accept their bodily appearance. Not at all level 0.0% (n=0%), a little level 0.0% (n=0), moderately level 14.3% (n=1), mostly level 57.1% (n=4), and completely level were 28.6% (n=2). The highest number of clients were in mostly level and two levels had zero frequency. But those who said by non-consuming opium they had various levels of experiencing how to accept their bodily appearance. Not at all level 3.4% (n=4%), a little level 22.2% (n=26), moderately level 46.2% (n=54), mostly level 11.1% (n=13), and completely level were 17.1% (n=20). The highest number of clients who said by non-consuming alcohol able to do certain things were in moderately level and the lowest number of patients located in not at all level. The discrepancy between a little and not at all levels were 18.8% (n=22). This table also shown the relation between alcohol consumption and they had enough money to meet their needs. 1(14.3%) of patients said by using alcohol they had not at all enough money to meet their needs.

3(42.9%) of clients said by consuming alcohol they had moderately enough money to meet their needs. The same amount 3(42.9%) of patient said by consuming alcohol they had completely enough money to meet their needs. It shown the highest number of patients located in two levels (moderately, and completely levels). Although, by non- consuming alcohol 16(13.7%) of patients said they had not at all enough money to meet their needs. The highest number 46(39.3%) of clients said without of consuming alcohol they had a little enough money to meet their needs. 37(31.6%) of patients said by non-consuming alcohol they had moderately enough money to meet their needs. 12(10.3%) of patients said without consuming alcohol they had mostly enough money to meet their needs. Dramatically, the amount of patients became alleviate and the lowest number 6(5.1%) of patients said without of consuming alcohol they had completely enough money to meet their needs.

Table 4.4 also shown the relation between alcohol consumption and information they needed in their daily life. Who participated in this study and were consuming alcohol, how much they needed information in their daily life? This table shown 14.3% (n=1), moderately level 57.1% (n=4), mostly level 28.6% (n=2), and completely level were 0.0% (n=0). The number of patients in this part special in not at all and completely levels were same without of any discrepancy. Due to, there were no frequency and no percentage. They highest number of clients were in moderately level. On the other hand, those who were including in this study and they said by non-consuming alcohol how much information needed in their daily life. Not at all level 16.2% (n=19), a little level 43.6% (n=51), moderately level 24.8% (n=29), mostly level, 5.1% (n=6), and completely level were 10.3% (n=12). In this part the highest number of clients were in a little level, and the lowest number of patients were in mostly level that they needed information in their daily life without of consuming alcohol.

Table 4.5 Factors associated between Shisha use and Alcohol consumption with various aspects of life.

Shisha	**1** Very Dissatisfied	**2** Dissatisfied	**3** Neither satisfied Nor dissatisfied	**4** Satisfied	**5** Very Satisfied	Total
Satisfied with yourself: (X2 test, p-value= .016).						
Yes	12(17.6%)	23(33.8%)	14(20.6%)	10(14.7%)	9(13.2%)	68(100%)
No	2(3.6%)	12(21.4%)	13(23.2%)	12(21.4%)	17(30.4%)	56(100%)
Alcohol :-						
Satisfied with your sleep: (X2 test, p-value= .000).						
Yes	0(0.0%)	0(0.0%)	0(0.0%)	1(14.3%)	6(85.7%)	7(100%)
No	7(6.0%)	28(23.9%)	33(28.2%)	32(27.4%)	17(14.5%)	117(100%)
Satisfied with yourself: (X2 test, p-value= .007).						
Yes	0(0.0%)	0(0.0%)	0(0.0%)	2(28.6%)	5(71.4%)	7(100%)
No	14(12.0%)	35(29.9%)	27 (23.1%)	20(17.1%)	21(17.9%)	117(100%)

The table 4.5 shown the relation between shisha uses and satisfied with their selves. Those who said by using Shisha they had different level of satisfaction with their selves. In this study very dissatisfied level 17.6%% (n=12), dissatisfied level 33.8% (n=23), neither dissatisfied nor satisfied level 20.6% (n=14), satisfied level 14.7% (n=10), and very satisfied level were 13.2% (n=9). In this section the discrepancy between very dissatisfied and dissatisfied levels were 16.2% (n=11). The tremendous amount of patients were in dissatisfied level .The lowest number of patients were in very satisfied level. And other section shows those who participated and said by non-using shisha they had different level of satisfaction with their selves.

Very dissatisfied level 3.6% (n=2), dissatisfied level 21.4% (n=12), neither dissatisfied nor satisfied level 23.2% (n=13), satisfied level 21.4% (n=12), and very satisfied level were 30.4% (n=17). The highest number of clients were located in very satisfied level and the lowest number of patients located in very dissatisfied level. Meanwhile, the dissatisfied and satisfied levels had the same amount of patients. Table 4.5 shown the relation between alcohol consumption and experiencing or able to do certain things. Second factor shows the relation between alcohol consumption with their sleeping. Very dissatisfied level 0.0% (n=0), dissatisfied level 0.0% (n=0), neither dissatisfied nor satisfied level 0.0% (n=0), satisfied level 14.3% (n=1), and very satisfied level were 85.7% (n=6). In this category those who said by consuming alcohol they had different levels of agreement with their sleeps. By consuming alcohol three levels had the same amount of patients such as (Very dissatisfied, dissatisfied, and neither dissatisfied nor satisfied levels).It means in this three levels there were zero frequency. The highest number of patients those who said yes, were in very satisfied level. Nevertheless, those who participated in this study and said by non-using Alcohol they had different level of responds and agreement about their sleeping. For instance, in this research very dissatisfied level 6.0% (n=7), dissatisfied level 23.9% (n=28), neither dissatisfied nor satisfied level 28.2% (n=33), satisfied level 27.4% (n=32), and very satisfied level were 14.5% (n=17). The highest number of patients who said no, were in neither dissatisfied nor satisfied level and the lowest number of patients were at very dissatisfied level. The difference between very dissatisfied and dissatisfied level is 17.9% (n=21).

The table 4.5 also shown the relation between alcohol consumption and how much they had satisfaction with their selves. Very dissatisfied level, dissatisfied and neither dissatisfied nor satisfied levels had zero frequency and percentage. Satisfied level 28.6% (n=2), and very satisfaction level were 71.4% (n=5). It means the highest number of patients located in very satisfaction level and most of them had very satisfaction with their selves when consuming alcohol. Those who said by non- consuming alcohol they had different levels of agreement such as: very dissatisfied level 12.0% (n=12), dissatisfied level 29.9% (n=35), neither dissatisfied nor satisfied level 23.1% (n=27), satisfied level 17.1% (n=20), and very satisfied level were 17.9% (n=21).

CHAPTER 1V DISCUSSION

Research has been shown, the quality of life of Afghan drug addicted community. Impact and consequence of drug addicted also mentioned in this study. And what I found was little different, because some participants was drunk/treated when they answered the questions. According to frequency and percentage between opium consumers and Hashish uses. 68(54.8) clients were shisha users. Only 5 (17.9%) patients said by using opium their quality of life is very poor, rather than non- using opium. But 13(13.5%) of clients said by non-using opium their quality of life is very poor. It shows most of them had good feeling in treatment centers and had better feeling duration of treatment. And also those who participated in this study and addicted to drugs such as: Heroin, and Hashish said by using these substance their quality of life is good rather than non-using drugs. It seems, patients didn't answer honestly. Those who are using different type of drugs for instance, (opium, Hashish, Shisha, Heroin, alcohol, and etc.) obviously will affect to their physical health, mental health, and social health. The consequence of drug addicted will be pain, muscle tension, low concentrate, and lack of physical activity, unsafe, low energy, and dissatisfaction. Definitely for wise people it is clear by consuming drugs, their quality of life will be low and incomparable with normal people. Addicted people have misconception about family, community, and QoL.

Despite, through what researcher found in this study, it gives the meaning that there is no significant correlation between Opium, Hashish and Heroin uses with Quality of life. But there is a significant correlation between shisha uses and alcohol consumption with QoL. This study shown, those who were using shisha their quality of life is low. And also those who are consuming alcohol their quality of life is low. Because the result of shisha use and alcohol consumption were shown low concentrating, thinking and difficulty with sleeping. One study had been shown the quality of life of drug addicted community lower, rather than those who are not using drugs.

Quality of life of drug addicted community and comparing with those who are not addicted to drugs were mostly (90%) moderate. There is no significant difference has been found between men and women in term of QoL and physical symptoms (Poniszovsky et al., 2007; Xiao et al., 2010; Hoseinifar et al., 2011; Masuad Rayani, 2014). From those studies, one study had been done in china that was about how to realize the quality of life (QoL) of drug addicted persons, and supply scientific evidence for transferring healthy education, initiating plane of social integration, modifying therapy, and enhancing the quality of life. Their quality of life was higher at rehabilitation center duration of treatment (Liang & Liao, 2010). In fact their quality of life were poor. Drug addiction is very huge problem in the world, maximum patients don't have access to rehabilitation for treatment early and on time to give best result in returning their normal live unluckily majority of persons who need treatment services and rehabilitation have limited access to treatment (Shazzad, et al., 2013). Also there is important dissimilar in privileges of body scope between experienced class and control class, so there was no important difference between psychological aspect, and social condition. (Liang & Liao, 2010).

In drug addiction the most common psychiatric disorders are consist: anxiety, depression, stress etc. As research shown that above 70% of drug addicted persons are suffer from drug abuse as well as anxiety, depression, personality disorder, and sexual disorder. Various researches have shown that drug addiction has the most significant co- morbidity with anxiety and depression. (Fooladi et al., 2014). For controlling environment and communicating with others, drug addiction is not primarily step. Strengthen addicted people, by spiritual attitude, religious beliefs and supporting them to improve their quality of life. The institutionalization of religious and spiritual beliefs and performing regarding action basically can help such people to increase their self-esteem, dignity and quality of life (Salmabadi et al., 2016). On the hand, in developing countries such as Iran, Quality of life of drug addicted people might be lower than developed countries and one study found in Birjand of Iran country, and shown drug addicts have many challenges including the evaluation of important things in their lives. The efforts of keep honor and self-control when encountered with negative behaviors of people and losing their potential. That will be effected to their selves (Salmabadi et al, 2016).

The mental disorder like depression and anxiety cleaning the way for addiction. The addiction consequences will be some mental disorder like restlessness, muscle tension, pain, anger, dissatisfaction, anxiety, depression, low mental health, and quality of life. Drug addiction impact self-confidence attitudes, social relations, and personal occupation. The study revealed that QoL among addicted persons were lower than non-addicted persons. And that study also displayed those who are addicted to drugs their condition is very bad rather than non- addicted people, and they required more helps and assistants (Hoseinifar et al., 2011). For comparing mental health, aggression, and hopefulness of drug users and non- drug users. Drug users had low mental health and hopefulness rather than, non-drug users. And also drug is harmful for all aspects of life such as individual, family, and community health (Sheridan, 2014). Quality of life (QoL) is considering as a fundamental index while assessing health care system (Maeyer et al., 2010). As result of importance of drug addiction globally, QOL of persons with addicted to drugs have been attractive notable attention in new researches (Bizzarri et al., 2005).

Total 124 patients participated in this study. 97 of patients addicted to heroin, it shown the highest number of patients addicted to heroin. But the lowest number 7 of patients addicted to alcohol. 28(22.6) of patients addicted to Opium and Hashish. There was no differentiate. And also 68(54.8) clients were used Shisha. But this study shown 98(79.0) of drug addicted patients were male, and 26 (21.0) of them were female. Difference in frequency between them is 72 (58.0). In Afghanistan due to, stigma, patriarchal, and low-confidence low number of female participated.

Limitation of the study:

- Insecurity in Afghanistan and barriers for data collection.
- This study considered only one province of Afghanistan but that is not representing from the whole population of Afghanistan who are addicted.
- Difficulty in finding proper female participant.
- Determination of a proper sample size and collecting the data.

CHAPTER V CONCLUSION AND RECOMMENDATION

By this study the researcher has measured the quality of life Afghan drug addicted community. Drugs had affected on physical health, mental health, and social health. Therefore, this study had found out those who are addicted to drug they had misconception about QoL. Drug addicted people had lack of, concentrating or thinking and also had difficulty with sleeping. The result has shown 98(79.0) of drug addicted patients were male and 26 (21.0) of patients were female. The total number were 124 patients. In this study, due to some limitations for instance, (insecurity, stigma, and patriarchy environment,) female couldn't participated equally like male. Despite, this research has shown that there is no significant correlation between Opium, Hashish and Heroin uses with Quality of life. But there is a significant correlation between shisha uses and alcohol consumption with QoL. This study has shown, those who are using shisha, and consuming Alcohol their quality of life is low. By using Shisha and consuming Alcohol the patients found low concentration or thinking and also found difficulty with sleeping.

Finally, I recommended for those who want to do research related to drug addiction, it is better to realize the quality of life (QoL) of drug addicted community, with transferring education, and modifying treatment services in Rehabilitation centers. Because majority of people recruiting in various organizations based on their relatives or political system. So it is my suggestion for the health sector of Afghanistan to digitalize recruitment process to remove corruption and select young and professional's generation, who are recently graduated from different universities and they will be provide more facilities and better services for patients. The expert people will provide best treatment for patients to improve their quality of life.

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ANNEXES

ANNEX I: Informed consent (English)

BANGALSESH HEALTH PROFESSIONS INSTITUTE, MRS PROGRAME of 2018-2019)

Dear Participant,

I invite you to participate in a research study entitled: "**Quality of life of Afghan drug addicted community**". I am currently enrolled in the (*MRS 5TH Batch*) at Bangladesh Health Professions Institute (BHPI), and am in the process of writing my Master's Thesis.

Your participation in this research project is completely voluntary. You may decline altogether, or leave blank any questions you don't wish to answer. There are no known risks to participation beyond those encountered in everyday life. Your responses will remain confidential and anonymous. Data from this research will be kept under lock and key and reported only as a collective combined total. No one other than the researchers will know your individual answers to this questionnaire.

If you agree to participate in this project, please answer the questions on the questionnaire as best you can. It should take approximately *(20- 25 minutes)* to complete.

Thank you for your assistance in this important endeavor.

Sincerely yours,

ANNEX II: Informed consent (Persian)

موافقت نامه

انستتیوت صحی بنگلادیش، برنامه ماستری علوم توان بخشی (2019 -2018)

اشتراک کننده عزیز!

از شما صمیمانه دعوت به عمل می آید که در تحقیق تحت عنوان **بررسی کیفیت زنده گی جامعه معتادین در افغانستان** اشتراک نماید. من فعلا محصل بر حال انستتیوت صحی بنگلادیش بوده و در حال حاضر مصروف نوشتن پایان نامه تحصیلی ام در مقطع ماستری میباشم.

قابل ذکر است که اشتراک شما درین تحقیق کاملا اختیاری می باشد. شما اختیار دارید که تمام سوالنامه ویا یک بخش از ان را که نمی خواهید جواب ندهید. و هم چنان اشتراک درین تحقیق در زنده گی روز مره تان کدام مشکل را مواجه نکرده و جواب تان کاملا محفوظ، رمزی و پوشیده خواهد ماند. معلومات تنها به صورت نتیجه کلی گرازش داده خواهد شد و هیچ کس به استثنای محقق از جوابات شخصی که شما به سوال نامه ارایه کرده اید نخواهد دانست.

درصورت موافقت به این پروزه تحقیقی، لطفا به سوال نامه تا حد ممکن به شکل درست پاسخ دهید. مجموعا پاسخ به این سوالنامه حدوا بیست و پنج الی سی دقیقه وقت را در بر خواهد گرفت.

تشکر از همکاری تان!

ANNEX III: (English)

Questionnaire

Part I – Demographic Data

1.1 Sex

1. Male
2. Female

1.2 What is your age?..

1.3 What is your marital status?

1. Unmarried/Single
2. Married
3. Divorced

1.4 Home area

1. Urban
2. Semi- Urban
3. Rural

1.5 Occupation:

1. Service Holder
2. Business
3. Day laborer
4. Farmer
5. Unemployed

1.6 What is the highest education you received?

1. Illiterate
2. Primary school
3. Secondary school
4. Bachelor Degree

1.7 Monthly family income?

…………………………………………

1.8 Number of family members?…………………………………......................

1.9 Type of drugs addiction?

1. Opium
2. Hashish
3. Heroin
4. Shisha
5. Acohol

1.10 What was the reasons that you started drugs?

1. Immigration
2. Lack of knowledge about complications of drugs
3. Low cost of drugs
4. Family problems
5. Unemployment

1.11 Did drugs effect on your quality of life?

1. Yes
2. No

1.12 How often are you using drugs?

1. Daily one time
2. Daily several times
3. One time a week
4. Several times a week

1.13 When you are using drugs, have any impacts on your health?

1. Yes
2. No

Part 2 – QUALITY OF LIFE SCALE (QOL)

The following questions ask how you feel about your quality of life, health, or other areas of your life. I will read out each question to you, along with the response options. Please choose the answer that appears most appropriate. If you are unsure about which response to give a question, the first response you think of is often the best one.

Please keep in mind your standards, hopes, pleasures, and concerns. We ask that you think about your life in the last four weeks.

		Very poor	Poor	Neither poor nor good	Good	Very good
1.	How would you rate your quality of life?	1	2	3	4	5

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

		Not at all	A little	A Moderate amount	Very much	Extremely
3.	How well are you able to concentrate?	1	2	3	4	5
4.	How safe do you feel in your daily life?	1	2	3	4	5
5.	How healthy is your physical environment?	1	2	3	4	5

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

		Not at all	A little	Moderately	Mostly	Completely
6.	Do you have enough energy for daily life?	1	2	3	4	5
7.	Are you able to accept your bodily appearance?	1	2	3	4	5
8.	Have you enough money to meet your needs?	1	2	3	4	5
9.	How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
10.	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	satisfied	Very satisfied
11.	How satisfied are you with your sleep?	1	2	3	4	5
12.	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5

13.	How satisfied are you with your capacity for work?	1	2	3	4	5
14	How satisfied are you with yourself?	1	2	3	4	5
2.	How satisfied are you with your health?	1	2	3	4	5

Do you have any comments about the assessment?

……………………………………………………………………………………………

……………………………………………………………………………………………

…………………………………………………………...………

ANNEX IV: (Persian)

Questionnaire

پرسشنامه

بخش اول

11. جنسیت

1. مرد

2. زن

1.2 چند ساله هستید؟...

1.3 حالت مدنی: 1. مجرد 2. متحل 3. بیوه

1.4 سکونت فعلی :

1. شهر

2. نیمه شهری

3. روستایی

1.5 شغل:

1. پیش خدمت

2. تاجر

3. مزدور کار

4. دهقان

5. وغیره

1.6 بالا ترین درجه تحصیل شما چیست؟

1. بی سواد

2.دوره متوسطه

3. بکلوریا یا دوازده پاس

4. لیسانس

5. وغیره

1.7 درامد خانواده شما ماهانه چی قدر است؟...

1.8 اعضای فامیل شما چند نفراست؟...

1.9 از چی نوع مواد مخدر شما استفاده میکنید؟

1. تریاک

2. حشیش

3.هیروین

4.شیشه

5.زیاتر ازیک

10. کدام دلایل باعث شد شما به مواد مخدر روی بیاورید؟

1. مهاجرت

2.نبود اطلاعات کافی درباره عوارض مواد مخدر

3. بنابر پاین بودن قیمت مواد مخدر

4. شما اگر مواد مخدر را بنابر کدام دلایل دگه استفاده میکنید لطفا ذکرکنید

....

11. آیا مواد مخدر کدام تآثر روی کیفیت زندگی شما گذاشنه است

1. بلی

2. نخیر

12. اغلبآ چند وقت بعد از مواد مخدر استفاده میکنید؟

1.   روزانه یک بار

2. روزانه چندین بار

3.   هفته یک بار

4. چندین بار درهفته

13. وقتی از مواد مخدراستفاده میکنید آیا کدام تآثرات روی صحت شما میگزارد؟

1.بلی

2. نخیر

بخش دوم- مقیاس کیفیت زندگی

سوالات زیر از شما سوال میکند که چی درک از کیفیت زندگی صحت ویا بخش های دیگر از زندگی خود دارید. من هرسوال را برای شما خواهم خواند همراه با جوابات آن لطفآ گزینه که بنظر شما مناسب تر است انتخاب کنید و اگر شما مطمن نیستید که کدام پاسخ را ارایه کنید اولین پاسخ که به ذهن تان می آید اغلب بهترین پاسخ خواهد بود.لطفآ استندردها آرزوها لذت ها و نگرانی های خود را به خاطر بسپارید. ما از شما میخواهیم که در چهار هفته گذشته به زنگی خود فکر کنید.

		خیلی بد	بد	نه خوب ونه بد	خوب	بسیار خوب
1	شما چگونه کیفیت زندگی خودرا ارزیابی میکنید؟	1	2	3	4	5

		خیلی نا راضی	ناراضی	نه راضی ونه ناراضی	راضی	خیلی راضی
2	شما چقدراز سلامتی خود راضی هستید؟	1	2	3	4	5

پرسشهای پاین از شما سوال میکند که در چهار هفته گذشته چقدر موارد خاص را تجربه کرده اید.

		هچ	کم	مقدار متوسط	زیاد	خیلی زیاد
3	شما چقدر میتوانید بخوبی تمرکز کنید؟	1	2	3	4	5
4	شما چقدردر زنگی روزمره خود احساس امنیت دارید؟	1	2	3	4	5
5	محیط فزیکی (بدنی)شما چقدر سالم است؟	1	2	3	4	5

پرسشهای پاین از شما سوال میکند در مورد این که چگونه کاملاً تجربه کرده اید یا توانسته اید کارهای خاص را در چهار هفته گذشته انجام دهید.

		هچ	کم	نسبتاً	بیشتر	کاملا
6	آیا شما برای زندگی روزمره خود انرژی کافی دارید؟	1	2	3	4	5
7	آیا شما قدرت سازش با جسم ظاهری خود را دارید؟	1	2	3	4	5
8	آیا شما برای تامین نیاز های خود پول کافی دارید؟	1	2	3	4	5
9	اطلاعات که شما در زندگی روزمره نیاز دارید چقدر در دسترس شما قرار دارد؟	1	2	3	4	5
10	تا چه اندازه شما فرصت برای فعالیت های اوقات فراغت دارید؟	1	2	3	4	5

		بسبار ناراضی	ناراضی	نه راضی ونه ناراضی	راضی	بسیار راضی
11	آیاشما چقدر از خواب خود راضی هستید؟	1	2	3	4	5
12	آیا شما چقدر از توانایی خود در انجام فعالیت های روز مره راضی هستید؟	1	2	3	4	5
13	آیاشما چقدر از توانمندی های خود برای کار راضی هستید؟	1	2	3	4	5
14	ایا شما چقدر از خود راضی هستید؟	1	2	3	4	5

آیا کدام پشنهادات انتقادات و نظریات در باره ارزیابی دارید

؟...

....

ANNEX V: Permission letter

Ref. CRP/BHPI/MRS/07/2019/0295

Date 06/07/2019

To Whom It May Concern

This is to inform that **Mohammad Ali Farhat,** is a student of Part II of M.Sc in Rehabilitation Science program at the Bangladesh Health Professions Institute (BHPI), an academic institute of Centre for the Rehabilitation of the Paralysed (CRP), under the Faculty of Medicine of the University of Dhaka, Bangladesh.

As per the course curriculum the above mentioned students needs to complete an individual thesis. Thus he requires to conduct data collection and research related activities during the period of 20th July, 2019 to September, 2019. Therefore, this is our request to help him through necessary procedures to complete data collection for this thesis on time.

Sincerely,

Prof. Dr. Md. Omar Ali Sarker
Principal
BHPI

বাংলাদেশ হেল্‌থ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)
Bangladesh Health Professions Institute (BHPI)
(The Academic Institute of CRP)

Ref. CRP/BHPI/MRS/07/2019/0290

Date: 06/07/2019

To Whom It May Concern

This is to certify that **Mohammad Ali Farhat,** passport no.**P00753875,** country of citizen: **Afghanistan,** is a student of M.Sc. in Rehabilitation Science program of Bangladesh Health Professions Institute (BHPI). His student ID is **181180131**, his session is **2018-2019**. BHPI has been running M.Sc in Rehabilitation Science program under the project of Regional Inter-professional Masters program in Rehabilitation Science (MRS) funded by SAARC Development Fund (SDF). It is noted that **Mohammad Ali Farhat** has been awarded **"SAARC Development Fund Scholarship"** which covers his tuition fee, accommodation and food cost for both two years of his study in this program. **Mohammad Ali Farhat** is not engaged in any job or private practice here. He has been staying here in the international hostel of CRP.

According to the Academic calendar, of MRS Part II, his data collection period will be from July, 2019 to September, 2019. His data collection place will be in Afghanistan.

We wish his every success in life.

Muhammad Millat Hossain
Assistant Professor, Course and Project coordinator,
Regional Inter-professional Masters program in
Rehabilitation science (MRS), BHPI, CRP

Prof. Dr. Md. Omar Ali Sarker
Principal
BHPI

সিআরপি-চাপাইন, সাভার, ঢাকা-১৩৪৩, বাংলাদেশ, ফোন ঃ ৭৭৪৫৪৬৪-৫, ৭৭৪১৪০৪ ফ্যাক্স ঃ ৭৭৪৫০৬৯
CRP-Chapain, Savar, Dhaka-1343, Tel : 7745464-5, 7741404, Fax : 7745069, E-mail : contact@crp-bangladesh.org, www.crp-bangladesh.org

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Date: 07/02/2019

To:
The Principle
Bangladesh Health Professional Institute (BHPI)

Through:
Course Coordinator, MRS Program,
BHPI, CRP, Savar, Dhaka

Subject: Application for approval of data collection during July, August & September, 2019

Dear Sir,
With due respect, we the following students of Afghanistan would like to inform that we have completed part I of our MRS course and there is a short break from (03- 27) July, 2019 before starting second part. In this regard we Afghan students of MRS 5th Batch (2018- 2019) having plan to visit our home country. We would like to conduct thesis data collection from 20th July up to September, 2019. It will be the most convenient to collect data during this period since this is summer time and will be helpful for accessing the research participants. Otherwise, later in winter data collection will be difficult.

Therefore, we hope and pray that you would provide us permission to collect data as per the mention period.
Sincerely,

Sl. No.	**Name of Students**	**Country**	**Signature**
1	Mohammad Azim Behrooz	Afghanistan	[signature]
2	Mohammad Ali Farhat	Afghanistan	M.F [signature]
3	Abdul Basit	Afghanistan	[signature]
4	Aminullah	Afghanistan	[signature]
5	Ahmad Jawed Safi	Afghanistan	[signature]

Recommendation from the thesis supervisors:

Sl. No.	Name of the thesis supervisors	Signature
1	Md. Fazlul Karim Patwary	[signature]
2	Mohammad Anwar Hossain	[signature]
3	Md. Julker Nayan	[signature]
4	Md. Forhad Hossain	[signature]
5		

ANNEX VI: Institutional review board (IRB) and ethical approval (Bangladesh)

বাংলাদেশ হেল্‌থ প্রফেশন্স ইনস্টিটিউট (বিএইচপিআই)

Bangladesh Health Professions Institute (BHPI)

(The Academic Institute of CRP)

Ref. CRP-BHPI/IRB/07/19/1305 *Date:* 06/07/201

To,
Mohammad Ali Farhat
M.Sc. in Rehabilitation Science (MRS)
Session 2018-2019, Student ID: 181180131
BHPI, CRP-Savar, Dhaka-1343, Bangladesh

Subject: Approval of thesis proposal "Quality of Life of Afghan Drug Addicted Community".

Dear Mohammad Ali Farhat
Congratulations,
The Institutional Review Board (IRB) of BHPI has reviewed and discussed your application to conduct the above mentioned thesis, with yourself, as the Principal Investigator. The fallowing documents have been reviewed and approved:

S.N.	Name of Documents
1.	Thesis Proposal
2.	Questionnaire
3.	Information sheet and consent form.

The study involves answering a questionnaire to address Quality of Life of Afghan Drug Addicted Community in Afghanistan that takes about 20 to 25 minutes to answer. Since, there is no likelihood of any harm to the participants. The members of the Ethics committee have approved the study to be conducted in the presented form at the meeting held at 9.00 AM on 18th February, 2019 at BHPI.

The institutional Ethics committee expects to be informed about the progress of the study, any changes occurring in the course of the study, any revision in the protocol and patient information or informed consent and ask to be provided a copy of the final report. This Ethics committee is working accordance to Nuremberg Code 1947, World Medical Association Declaration of Helsinki, 1964-2013 and other applicable regulation.

Best regards,

Millathossain

Mohammad Millat Hossain
Assistant Professor, Dept. of Rehabilitation Science
Member Secretary, Institutional Review Board (IRB)
BHPI, CRP-Savar, Dhaka-1343, Bangladesh

সিআরপি-চাপাইন, সাভার, ঢাকা-১৩৪৩, বাংলাদেশ, ফোন ঃ ৭৭৪৫৪৬৪-৫, ৭৭৪১৪০৪ ফ্যাক্স ঃ ৭৭৪৫০৬৯
CRP-Chapain, Savar, Dhaka-1343, Tel : 7745464-5, 7741404, Fax : 7745069, E-mail : contact@crp-bangladesh.org, www.crp-bangladesh.org

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ANNEX VII: Institutional review board (IRB) and ethical approval (Afghanistan)

Islamic Republic of Afghanistan
Ministry of Public Health
Afghanistan National Public Health Institute
Institutional Review Board

د افغانستان اسلامی جمهوریت
د عامې روغتیا وزارت
د افغانستان دعامې روغتیا ملي انستیتوت
د اخلاقیات بررسی بورد

Date: September 07, 2019

IRB Code No: E.0919.0067

To: Mohammad Ali Farhat
M.Sc. in Rehabilitation science (MRS)
Bangladesh Health Professions Institute (BHPI)

Subject: Exempt of proposal entitled **"Quality of life of Afghan Drug Addicted Community"**.

Dear Farhat,

The research proposal entitled **"Quality of life of Afghan Drug Addicted Community"** is exempted from Institutional Review Board Examination Because this study is Approved by IRB of BHPI with the reference number of (CRP-BHPI/IRB/07/19/1305), we are pleased to accept your request for exemption and approve the study.

We reserve to the rights to monitor and audit your study and any violation of ethical norms during the course of study shall lead to withdrawal of given approval.

The duration of approval for a study to begin the research project is valid for one year and the exact date of research project implementation (start and end) should be informed to IRB secretary.

You are bound to share the result of your study with MoPH prior any dissemination plan.

Sincerely,

Bashir Noormal *MD, MPH*
Director General
Afghanistan National Public Health Institute (ANPHI) &
Chairman, Institutional Review Board (IRB)
Ministry of Public Health

Telephone No.: +93202109101-3
Email Address: anphi@moph.gov.af
Postal Address: 5th & 6th Floors of the Central Blood Bank, building Cinema Pamir area, Kabul-Afghanistan

نمبر تیلفون: +93202109101-3
ادرس الکترونیکی: anphi@moph.gov.af
ادرس پستی: منزل پنجم و ششم تعمیر بانک خون مرکزی عقب پولی کلینیک مرکزی، واقع سینمای پامیر کابل افغانستان

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