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Medical and social problems among women headed families in Baghdad

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ABSTRACT

Background: Women-headed families tend to be the most marginalized and poverty prone in any given community. One in 10 Iraqi households is headed by woman according to International Organization for Migration, though their assessments suggest that this ratio rises to 1 in 8 in displaced families.

Objective: To draw attention to the exposure and vulnerability of women headed families to key medical and social problems.

Methods: This cross – sectional study was conducted from March through February 2011. Eleven non-governmental organizations (NGOs) were chosen to be the pool of data collection, in addition to 50 primary, intermediate, and secondary schools for girls. The actual participants were 720 with a response rate of (97%). Women headed families participated in the study were distributed in different areas of Baghdad and the districts around.

Results: Hypertension is the leading disease (20%) followed by arthritis (9.6%), heart disease (7.6%), and diabetes mellitus (5.2%), the least was tuberculosis (0.1%). On the other hand, the number of sons and daughters with chronic disease was 159 (6.4%). Respiratory system disease is at the top of the list at a rate of (20.6 per 1000) while the gastrointestinal disease is at the bottom at a rate of (1.6 per 1000). 7.8% of the studied household-heading women were exposed to violence that was either verbal (75%) or physical (25%), the source was the woman's parents (42.9%), husband's family (34%), neighbors (8.9%), and others (14.3%). The percentage of problematic sons (17.9%) who show different types of behavior, (30.2%) of them not obeying their mothers, (21%) hit their brothers, (9.3%) insulting the mother, (2.3%) have problems with neighbors.

Keywords: women headed families, medical & social problems, widows & orphans

INTRODUCTION

The number of families headed by women is rising all over the world because of natural and man-made crises. It is estimated that one-third of the world's households are headed by women, while in urban areas of Latin America and Africa, figures may be as high as 50%.[1] About 80% of families with one parent in British-Colombia are headed by women according to census figures.[2] Problems facing women- headed families are: poverty, economic insecurity, social, political, powerlessness, and health problems. While problems facing their children are: poverty, social, and health problems.[3] Data from nearly 50 national demographic and health surveys show that on average a woman is head of one in five households and that these households are particularly vulnerable to poverty.[4] In Iraq, one in 10 Iraqi households is headed by woman according to International Organization for Migration (IOM), though their assessments suggest that this ratio increases to 1 in 8 once the families have been displaced.[5] In 2010 the percentage of women headed families (WHF) is 7.7% as a whole, 8.9% in urban and 4.5% in rural areas.[6] The objective of this study is to draw attention to the exposure and vulnerability of WHF to important medical and social problems.

METHODS

This cross – sectional descriptive study was conducted during the period of March through February 2011. A total of 743 household heading women were asked to participate in the study on a voluntary base after explaining the research aim. The actual participants were 720 with a response rate of (97%). The study sample was drawn from Baghdad city and districts around. Eleven NGOs and 50 primary, intermediate, and secondary schools for girls were chosen to be the pool of data collection. There are many NGOs with different activities and NGOs were chosen only if their focus was on widows and/or orphans care as a main aim. Female teachers in schools belonging to four out of six general directorates of educations in the two sides of Baghdad were chosen for data collection. The sequence of school visiting was by entering the locality and asking about the nearest school; after finishing with it, the teaching staff guided the researcher to the next school, and so on until the end of school day. Six divorced and one widowed women apologized from being interviewed; their will was respected. The sampling technique was a convenient non-random one with an added element of inclusion/exclusion criteria. Any woman who is a head of a household (according to the case definition) was included in the study if she fulfills the inclusion criteria:

- Inclusion criteria
  - Household heading women (HHW) should be the decision maker and the one who is responsible for home expenditure for more than one year.
  - HHW live in separate housing unit or in isolated partition (in parents or parents-in-law house), and have a separate food cooking and eating.
  - Household with a married son, who earns his own income but not enough and gets support from the mother.
  - HHW receiving financial support from her married son(s), but separated from them in special partition.
  - HHW that take care of her old father, mother, father-in-law, and mother-in-law who live with her.
- Exclusion criteria
  - HHW for less than one year, as this period is not enough to notice the changes and to follow the effects of women heading.
  - Women, who return back to parent's house or husband parents' house after the event of husband's absence, sharing food with them, and being financially supported by them.
  - HHW who have one or more of her sons married and lives with her in the same house but takes full responsibility.
  - HHW without children or the children live with others for different reasons, were not included in the study.

An anonymous questionnaire was constructed for the purpose of the study. The variables were modified and rebuilt according to the society norm, cultural values, and requirements of the study in relation to the aim. It was designed to be flexible allowing the researcher to follow up issues that were raised by participants through some open-ended questions.

Data were collected by filling in the instrument via direct interview with the heading women (after obtaining their consent) by the researcher. The interview was carried out for each woman separately to maintain privacy and confidentiality. The interview lasted (20 – 25) minutes for each woman.

In case of visiting the NGOs for the first time; the researcher introduces himself to the manager, showing him the approval documents and identification card. Research aim was explained, and the willingness of bilateral co-operation was sought. In case they decide to cooperate, arrangements to meet the heading women were made under the supervision of NGO head manager, either in a corner of the reception hall or in a special room. The same was done in interviewing school teachers.

The questionnaire was designed to cover the following main topics:

- Age in years and education status of the HHW.
- Residency: (rural, urban, displaced) and housing status, type of house whether a separate house, a compartment, or a slum.
- Number of sons and daughters living in the household in comparison to those born to the mother, and the reasons for the difference if present.
- Occupational status of HHW: not working, governmental employee, non-governmental worker (denote working for weekly or monthly fees, self-employee (works day by day with variable daily income), or farm work.
- Many variables such as chronic diseases in heading woman and/or her children, hospital admission for both during the last three years, history of accident were taken as indicators of morbidity.
- Mortality has been asked upon directly through an enquiry about deaths in the family since the event led to husband absence.
- Enquiry about exposure of the heading women to violence during the period she was the head of the family.
- The questionnaire also asked about sons/daughters' drop out of school (mostly for work), presence of problematic child among the household members, and types of problems. Other questions were designed to explore drug and materials abuse (drugs, smoking, alcohol) among sons.

RESULTS

A total HHW of 720 (150 teachers and 570 women attending NGOs) did participate in the study with a mean age of (42.00 ± 8.47), and a range of (18 – 65) years. Only 68 (9.4%) live in rural areas, the remaining 652 (90.6%) live in urban areas. Table 1 shows that the frequency HHW is increasing with age till reaches a peak of (44%) at the age group 40 – 49 years. Also it shows that the years after event (being a head of the household) increase with the age starting from a mean of 4.08 years rising up to 9.03 years at the age group (≥ 50). Marital status is also shown in Table 1. The mean monthly income of the studied families was US $281 + 224 (not tabulated).

Table 2 represents the occurrence of chronic diseases in HHW, 349 (48.5%). Hypertension is the leading disease

Table 1. Distribution of the studied HHW according to age groups, occupational, and marital status.

	Mean ± SD		No. (%)
Age group	Age	Yrs after event	
< 30	25.9 (2.57)	4.08 (1.20)	51 (7.0)
30 – 39	35.22 (2.72)	4.67 (1.84)	218 (30.5)
40 – 49	44.01 (2.86)	6.12 (4.19)	317 (44.0)
≥ 50	54.4 (3.77)	9.03 (6.60)	134 (18.5)
Occupational status			
Not working			459 (63.8)
Governmental work			150 (20.8)
Non-governmental work			23 (3.2)
Self employed			74 (10.2)
Agricultural work			14 (2.0)
Marital status			
Widow			652 (90.5)
husband killed			431 (66.1)
husband dead			221 (33.9)
Divorced			38 (5.3)
Wife of missing person			30 (4.2)
Total			720 (100)

Minimum age is 18 years and maximum is 65 years.

Table 2. Chronic disease & hospital admissions in studied sample.

	No.	Occurrence Rate %
HHW Chronic disease ($n = 720$)		
Hypertension	144	20
Arthritis	70	9.6
Heart disease	55	7.6
Diabetes mellitus	38	5.2
Irritable bowel disease	20	2.7
Renal disease	16	2.2
Thyroid gland disease	16	2.2
Anemia	14	2
Migraine	14	1.9
Asthma	11	1.3
Peptic ulcer	8	1.1
Psychiatric state	6	0.8
Gallstone	4	0.5
Neurological diseases chronic skin diseases	3	0.4
Chronic skin diseases	2	0.2
Tuberculosis	1	0.1
Sons & daughters Chronic disease ($n = 2474$)		
Respiratory system	51	2.06
Neuropsychological system	35	1.41
Urogenital tract	17	0.69
Cardiovascular system	16	0.65
Endocrine system	13	0.53
Nutrition	12	0.49
Skin	10	0.4
Musculoskeletal system	10	0.4
Eye disease	9	0.36
Gastrointestinal tract	4	0.16

20% followed by arthritis 9.6%, heart disease 7.6%, diabetes mellitus 5.2% and tuberculosis 0.1%. The number of sons and daughters with chronic disease was 159 (6.4%). Respiratory system was at the top of the list at a rate of 20.6 per 1000 while the gastrointestinal disease is at the bottom at a rate of 1.6 per 1000.

Table 3 shows that the hospital admission rate of the HHW for the last three years was 15.6%. The leading cause for admission is "chronic diseases" 50.7%. The rate of admission of sons and daughters was 26.5%, the leading cause was "acute diseases and emergencies" 34.1%.

After the event that put the woman in a position of heading the family; 2.3% of the WHFs have lost a child. The cause of death in 60.9% was related to armed activities as shown in Table 4 which also shows that 7.8% of the studied HHW were exposed to violence that was either verbal (75%) or physical (25%), the source was the woman's parents (42.9%), husband's family (34%), neighbors (8.9%), and other sources (14.3%).

In respect to suicidal thoughts; 8.6% of the HHW have such thoughts or at least wish their life end. "Failure to meet family needs" was the major adverse situation that raises those thoughts at a rate of 38.8%, followed by "hopelessness and frustration" 30.6%, and "hard life" (30.6%).

The total number of sons and daughters at school age is 2147 with a mean of about 3 ± 1.84 in the studied WHFs. The mean of sons and daughters on track for each family is 2.05 ± 1.51; the results were highly significant ($P = 0.000$). The mean of sons and daughters delay in school for each family was found to be 0.17 ± 0.56 ($P = 0.000$), and the mean of sons and daughters dropped out for each family was 0.76 ± 2.22, ($P = 0.000$) (Table 5).

The number of WHF with children at school age who have working sons was 177(31.4%), the rate of working sons showed an increase with the increase in number of children at school age in those families, it starts at a rate of 18.5% in families with one child at school age, followed by 30% in families with two children, then 44.5% for families with three children, and 62.5% in families with (4 & more) children at school age (Table 4).

Table 6 shows the percentage of problematic sons (17.9%) who show different types of behavior, 30.2% not obeying their mothers, 21% hit their brothers, 9.3% insulting the mother, 2.3% have problems with neighbors, and 37.2% have more than one type of problematic behaviors. Sons' adverse social behaviors are reported by HHW are shown in the same table that also shows alcohol and drug abuse by some sons.

DISCUSSION

The increase in the proportion of female headed households is a global trend.[7] Between one and two million households in Iraq today are headed by women, according to ICRC estimates.[8] Approximately 11% of Iraqi households are headed by a woman; numbers are on the rise as a result of the ongoing violence. Each day a reasonable number of women are widowed and the number of families struggling to cope without a wage-earner is starting to overwhelm local social services.[9]

The rate of WHF in the current study increases with age, the peak rate 44% is at 40 – 49; this is different from what Khadim found in his study in 2006 in Baghdad,

Table 3. Hospital admissions of HHW and their children.

	No.	%
HHW Hospital admission during last 3 years		
Yes	112	(15.6)
Chronic diseases	76	(50.7)
Acute diseases and emergencies	44	(29.3)
Surgical intervention	18	(12.0)
Accident	12	(8)
No	608	(84.4)
Total	720	(100)
Sons and daughters' admissions		
Yes	192	(26.7)
Acute diseases and emergencies	102	(34.1)
Accident	77	(25.8)
Chronic diseases	68	(22.7)
Surgical intervention	52	(17.4)
No	528	(73.3)
Total	720	(100)

Admissions for OB/GYN causes were excluded.

where the highest rate was 27.7% and among the age group of 35 – 44 year. The majority of the studied WHF live in urban areas 90.6% and the remaining 9.4% live in rural areas. This agrees with the Khadim study[10] where the urban constitute 92% and the rural (8%), but disagrees with Morada study of Philippines which found that 55.3% of the WHF were in urban and (44%) in rural areas.[11] The majority of the studied HHW (90.5%) are widowed, with 60% of them become widowed due to violence. This differs from the Kadhim study[10] where widows were 41%, but is consistent with the Shlash study[12] where widows form 64%. Widowhood as a social state exceeds by far the family derangement divorce (5.5%). This is close to that of Lebanon where the rate of divorced HHW was 6%, while the rate in Yemen does not exceed 19%.[10] Sanni[13] found that 38% of the studied sample of HHW were widows and 4% divorced.

Poverty in Iraq has special characteristics which resulted from the hard situation represented by repeated wars, complete blockade, and the 2003 invasion. The Rapid Household Budget Survey 2005 results indicated that 20% of total Iraqi households (18.4% of urban and 23.1% of rural households) had incomes of less than US $130 per month.[14] In 2007, the rate of poverty was 23%; it was higher in rural 39% than in urban 16%.[15]

Most of the hospital admissions of HHW are because of chronic diseases. Many factors participate in the increase of mother admission rates: the mother usually neglects her health for the sake of her household and unless the disease becomes sever or intolerable she will not attend the health facilities or seeks health care in late

Table 4. Exposure of HHW to child loss (death), accidents, violence, or suicidal thoughts since heading the family.

	No. (%)
WHF with dead child	
Yes	23 (3.2)
Murdered	10 (43.5)
Explosion	4 (17.4)
Domestic accident	6 (26.1)
Disease	3 (13)
No	697 (96.8)
HHW accidents	
Yes	60 (8.3)
Domestic	19 (32)
Car	12 (20)
Playing	12 (19)
Explosion	8 (14)
Bullet	5 (8)
Work	4 (7)
No	660 (91.7)
HHW Violence exposure	
Yes	56 (7.8)
Verbal	42 (75)
Physical	14 (25)
Source	
Parents' family	24 (42.9)
Husbands' family	19 (33.9)
Neighbors	5 (8.9)
Other	8 (14.3)
No	664 (92.2)
Suicidal thoughts	
Yes (Reasons)	62(8.6)
Failure to meet family need	24 (38.8)
Hard life	19 (30.6)
Hopelessness and frustration	19 (30.6)
No	658 (91.4)
Total	720 (100)

Table 5. Schooling and working sons and daughters.

Schooling status	No. (%)	Mean[a] (± SD)	Mean Difference	Sig.
Sons and daughters at school age[b]	2147 (100)	2.98 ± 1.84	–	–
Sons and daughters on track	1474 (68.7)	2.05 ± 1.51	0.92	0.000[c]
Sons and daughters delayed	124 (5.8)	0.17 ± 0.56	2.80	0.000[c]
Sons and daughters dropped out	549 (25.5)	0.76 ± 1.26	2.22	0.000[c]
		No.(%) of sons at school age		
Working sons	1	2	3	4 & more
No	162 (81.8)	147 (70)	60 (55.6)	18 (37.5)
Yes	36 (18.2)	63 (30)	48 (44.4)	30 (62.5)
Total	198 (100)	210 (100)	108 (100)	48 (100)
	$\chi^2 = 46.35$, df = 3, $p = 0.000001$			

[a] Mean ± SD for each family.
[b] Sons & daughters at school age is considered as an independent variable for analysis.
[c] Highly significant.

stages. On the other hand, demanding health services may affect the household from the economic point of view; keep less money for the essential household requirements.

Causes of sons and daughters' hospital admission differ with the leading cause for admission is acute diseases and emergencies; this could be explained by: Impaired follow up of the mother being busy and loaded with household needs; low educational status of most of the households; poor nutritional status due to poverty and the stressful life they live.

Diseases for which stress is known to be a risk factor like hypertension, diabetes, heart disease are prevalent in the studied WHF. Hypertension occurs at a rate of 20% which is lower than the rate for women in the general population which is 38.3%.[16] Arthritis also occurs at a high rate (9.6%); this is probably attributed to the abuse of their joints in hard labor to cover the needs of their families. Irritable bowel disease is again of a relatively high rate at 2.7%; its relation to anxiety and stress is well known. The prevalence of diabetes mellitus in the studied HHW is 5.2% which is near that of general population where it was reported to be 5.9%.[15]

The prevalence of chronic diseases among sons and daughters is 22%; this is slightly lower than the rate of chronic disease in the Khadim 2006 study where it was 28%. Respiratory diseases are at the top of the list, this could be explained by: overcrowding, bad environment

Table 6. Social problems & violence among sons.

n = 720	Yes (%)	No (%)	HHW don't know (%)
Smoking	147 (20.4)	561 (77.9)	12 (1.7)
Alcohol drinking	30 (4.2)	663 (92.1)	27 (3.7)
Sleeping outside home	17 (2.4)	703 (97.6)	–
Problems with police	9 (1.3)	711 (98.7)	–
Drug abuse	9 (1.3)	709 (98.5)	2 (0.2)
Begging	4 (0.6)	716 (99.4)	–
insulting his mother	12 (9.3)		
hit brothers	27 (21)		
not obeying	39 (30.2)		
problem with neighbors	3 (2.3)		
Combination	48 (37.2)		
Total	129 (17.9)	591 (82.1)	

condition, poor nutrition status, and difficulties in accessibility to health services.[10]

About one third (31.4%) of the WHF send their sons for work to earn money to support the family The problems of working sons become serious when work is at the expense of education, or when the working child is still very young and thus is vulnerable for child delinquency. About a quarter of the studied WHFs have a child dropped out from school; this could be attributed to many causes:

Inability of HHW to ensure requirements for schooling and money needed for transportation to school, especially if it is far from the house.
Economic needs for an additional income force the HHW to send their sons for work.
HHW force their daughters to quit education early to wait for her marriage.

The HHW daily struggle revolves around obtaining food and paying for shelter, schooling and medical care. Sometimes their only option is to send their young boys out to earn an income for the family. As a result, the new generations will pay for today's difficult times.[8] In a study conducted in Baghdad, 22% of the WHF have their children dropped out of school. This is due to many reasons; high expenditure required (43.2%), the school is far away from the residency (16.4%), and pushing children for work to earn an additional income (36%).[10] Shlash found that 35.5% of the students drop out of school for many reasons; most important of which are the education expenses (60%).[12]

Son and daughter members of a WHF are at risk for social problems. The studied social problems such as problems with police, sleeping outside home, begging, smoking, alcohol drinking, and drug abuse are reported at a low rate. This is definitely underestimated, as it is considered as a social stigma and usually not reported by mothers. Problems of sons and daughters inside the household takes different types of action directed mainly to his/her mother and/or brothers and sisters.

The rate of violence among HHW was 7.8%, with three quarters of in the form of verbal violence. This type of violence may pass unnoticed, because this is greatly affected by society culture. Physical violence is more readily reported by women, because it is an intended action with a residual emotional and/or physical pain and mark. Women in the studied WHF were exposed to verbal and physical violence. More than two third of the violence (76.8%) originated from the women's family and husband's family. Women may be reluctant to report violence, especially from an intimate person for reasons such as affair a fear 1of reprisal, because they haven't defined their experience as "violence" or "abuse" even to themselves. The consequence is underreporting of violence. Suicidal thoughts were found in 8.6% of the HHW. It reflects the size of problems facing these women. Suicide is the top cause of death globally for women aged from 20 – 59 year.[4]

Enormous efforts are needed to get a clear and broad picture about the real size of this problem, as well as the immediate and long-term impact on the WHF and hence on the whole community. Also establishing a directorate of women welfare (DWW) that is linked to the ministry counsel is a good step to cope with the increasing number of the WHF.

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