

Mental health of Afghan refugees in Pakistan: a qualitative rapid reconnaissance field study

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For the past 25 years, Afghans have accounted for the greatest number of displaced persons in the world. A large proportion of this population has sought refuge in neighbouring Pakistan. Many Afghan refugees have experienced unimaginable suffering due to war and its consequences. Mental health is an essential aspect of the care of refugees, yet the mental health and well-being of Afghan refugees has not been well studied. This qualitative field survey endeavours to gain some understanding of collective factors influencing mental health in a refugee camp in Karachi, Pakistan. We present ways of expressing distress, various sources of stress, and some of the coping mechanisms utilised by the refugees in this camp. On basis of these results, some recommendations are given.

Keywords: Afghan refugees, mental health, distress, coping, intervention

Refugees and mental health

The World Health Organization (1985) stated that 'war is the most serious of all threats to health'. War affects all areas of human existence and often results in the forced migration of populations as refugees.

In crisis situations such as disaster-induced displacement, relief organizations tend to be preoccupied with emergency relief logistics and mental health issues notoriously receiving low priority status. Refugees are exposed to a number of risks that may affect mental health, such as marginalization and minority

status, socio-economic disadvantage, poor physical health, collapse of social supports, psychological distress, and difficulty adapting to host cultures (Jablensky, Marsella, Ekblad, Levi, & Jansson, 1992). Any of these factors may influence the vulnerability and coping abilities of refugee populations. Mental health then, must be considered an essential aspect of refugee health.

The Afghan crisis

For the past 25 years, armed conflict has affected the people of Afghanistan. The Soviet occupation in the 1980's and the power struggles after the fall of communism in 1992 devastated the country. In 1994 the Taliban movement emerged. This movement spread through a large area of Afghanistan, and at the time of this study (1999), the Taliban controlled about two thirds of the land. With the introduction of Taliban extremism came an abrupt change in social norms in Afghanistan (Rasekh, Bauer, Manos, & Lacopino, 1998). Afghan citizens were persecuted for a number of offences, including belonging to a minority ethnic group (for example, *Tajik* or *Hazara*). Prior to the Taliban movement, women were included in the work force and free to move about. Since the decrees of the Taliban came into effect, women have been required to stay within the home (with the exception of health care professionals), to be out of male view, and to abide by a strict dress code which

requires them to be covered from head to toe in a *Burqa* (shroud). Furthermore, violations of these codes resulted in public beatings. Men were persecuted for offences such as having a short beard and laughing in public. Children were beaten in public for offences such as flying a kite. These changes 'represent a striking departure from past religious and cultural practices of Afghanistan' (Rasekh, et al., 1998). Therefore, it can be said the social fabric of Afghanistan itself underwent drastic assault.

The events following September 11, 2001 have once again changed the socio-political landscape of Afghanistan. One of the results of the Afghan conflicts is the forced displacement of over 2.7 million people. 'Afghanistan continues to be by far the largest country of origin of refugees under UNHCR care' (United Nations High Commissioner for Refugees, 2004). This has remained the case for over twenty years. Pakistan has welcomed over 1.2 million Afghan refugees (UNHCR, 1999, 2004). The majority reside in the North-west Frontier Province, Balochistan and the Punjab. Many have migrated to the country's largest city, Karachi. Some live within the general Karachi area while others remain in refugee camps established by the UNHCR and other organizations.

Despite this statistic, the published literature concerning the mental health of Afghan refugees is remarkably sparse. Thus, we set out to explore some of the factors that may impact the mental health and well-being of Afghan refugees residing in refugee camps. We focused on experiences considered to be distressing by the community, and the ways in which they were coping with their situation. We present our findings and discuss some of the implications for mental health work with refugees, especially those living in refugee or displacement camps.

Methods

The rapid reconnaissance method involves a qualitative, exploratory, field-oriented approach where the methodology can evolve during the course of the study. It is best utilized to gain basic information in a very short period of time (Patton, 1990). A proposal to conduct this brief study was accepted by the Department of Community Health Sciences at the Aga Khan University, Karachi, Pakistan and Focus Humanitarian Assistance Pakistan.

The authors conducted this brief exploratory study at one refugee camp in Karachi in May and June of 1999¹. The camp was chosen because of its accessibility and proximity to the Aga Khan University, the institution under which the study took place. The camp was meant to be a place of transition prior to finding more permanent housing in Karachi. It was thus known as a Transit Centre.

During the eight field visits, efforts were made by the (male) primary author and a female research assistant to build rapport with the community. Confidentiality, sensitivity, and cultural appropriateness were given the utmost attention. Participants were selected using convenience-sampling methods including chain sampling (asking one key informant to identify another) and opportunistic sampling (choosing informants based on knowledge gained throughout the study). Using translators, individual key informants were interviewed and focus group discussions were conducted in both a semi-structured and unstructured fashion. Seven refugee individual informants including five males aged 16–23 and two females in their early twenties were interviewed. The first focus group consisted of five adolescent males, aged 12–17; the second had eight males aged 15–23, and the third group had 12 middle-aged men. Two groups of eight

females, each aged 18–55 and 12–58, as well as one group of 20 women aged 14–60 were interviewed. Other sources of information included four Transit Centre volunteers, Transit Centre administrators, a medical officer and one managerial physician. Detailed field notes were kept and observations were recorded using paper. No audio or video recording equipment was used for interviews. After the fieldwork was completed, the data were reviewed along with some literature in the field of refugee mental health, and consultations were with some experts in refugee and cultural mental health. Based on this, we have organized our findings into themes, as presented in the Results below.

Results

Given the methodology utilized in this study, it would be prudent to discuss the *limitations* of the study from the outset, as it may influence the manner in which the results are interpreted. A pre-fieldwork literature review could not be conducted as access to journals and other references on refugee health were limited. Also, time constraints limited preparatory work as well as the duration and number of field visits. This was intensified by extreme heat at the field site and unfamiliar working conditions. However, these conditions also facilitated a greater understanding of the true situation within the Transit Centre.

Other inherent limitations in the study design included: difficulty in choosing the most appropriate key informants and groups, a limited opportunity for observation, and key informant bias coupled with researcher bias.

Cultural norms influenced the selection of participants. For example, members of the community would often join discussions in progress. Thus, the sample included a broad range of ages, from teenagers to the elderly.

In two of the male focus groups, the eldest individual often spoke on behalf of the rest of the group. This was not the case within the female focus group discussions. Communication was challenging, as the inherent limitation of using translators was coupled with double translation from Persian to Urdu to English on several occasions. Also, vague responses were frequent, possibly due to remnant fear of persecution by the Taliban for expressing one's thoughts and feelings, concerns about insulting the camp administration by expressing one's opinions, and difficulty in discussing traumatic events. As Rousseau, Drapeau, & Corin, (1997) noted, this vagueness is often a limitation of trauma research.

The identity of the researchers may have also influenced what information was revealed. Although (Canadian) foreigners, both researchers were recognized as members of the same Islamic sect as this Afghan community. Thus, the researchers were likely perceived as both insiders and outsiders by the community. The personal characteristics of the interviewers and interpreters may have allowed free access to certain information and limited access to other areas. Overall, it was our impression that we were presented with the collective discourse of the community as a whole, with limited access to the singular-individual experience.

Transit Centre characteristics. The Transit Centre housed approximately 1400 refugees. The community was Farsi (Persian) speaking, *Hazara* in ethnicity, Shia Muslim, and originated from the Afghan provinces of Mazar-e-Shariff, Kabul, and Pul-i-Khumry. The Centre was meant to house refugees for about three months, and then help them relocate to more permanent housing. However, many refugees had been there for longer periods of up to 18 months. The community elders and transit centre administrators expressed

concern about discussing detailed information about refugee identity and movements, due to security concerns at the time. In respecting that concern, we will not discuss these characteristics further either.

The Non-Governmental Organization (NGO) managing the camp provided all basic survival needs to the community including: security, clean water, sanitation, food, clothing, child and adult education, and medical care. Community members had access to preventive health services, primary health care, and high quality tertiary medical facilities. Overall, the conditions of the centre were excellent, but mental health per se, had not been explored. *Communicating distress.* Much of the information was communicated on a collective level. That is, the participants tended to convey experiences that echoed those of the community as a whole. Participants primarily communicated current hardships. Unless probed, there was relatively little focus on distressing experiences they had suffered prior to their arrival in Karachi, or on traumatic war experiences.

In the interviews and focus groups, the accuracy and cross-cultural translations of 'mental health' and 'mental illness' was uncertain. However, this Afghan community did not seem to view mental health as a Western medical-psychiatric model might suggest. Only those with severe psychotic illness seemed to be conceived of as having *mental* health problems. In fact, when trying to communicate that we wanted to address mental health issues, informants identified only two young men who probably suffered from severe and persistent mental illness, such as schizophrenia.

At the on-site medical clinic, a Pakistani physician was available who saw about 50 patients everyday within a six-hour period. There was little recruitment of Afghan

doctors or healers, and none were observed assisting in the clinic. One of the Transit Centre physicians explained that it would be difficult to use Afghan refugee physicians since they were not licensed in Pakistan. Some women reported that the doctors did not understand their problems. It was unknown if this was due to language, health beliefs or for other reasons.

Somatic symptoms seemed to be a common way of expressing distress. In fact, some of the most common presentations in the local clinic were medically unexplained aches and pains. There were many anecdotes of people who had symptoms undiagnosed after thorough medical investigations, and unresolved, despite standard medical management. Other common presentations were dyspepsia (heartburn), diarrhoea, minor dermatological conditions, and upper respiratory symptoms. Patients often requested injections of penicillin or ampicillin as a cure-all. This was reported to be common practice in Afghanistan. No Transit Centre (Pakistani) physicians reported other culturally-based health beliefs different from their own.

Following is a summary of the Refugees' reported experiences, which can be examined in terms of pre-migration (in Afghanistan), migration, and post-migration (in the host country) stresses (Rousseau, et al., 1997). Anecdotal examples are also included.

Stress before migration. Persecution was a common theme among the entire community. The primary reason for persecution reported was affiliation with *Hazara* ethnicity, from which the majority of refugees originated (the majority of Taliban were *Pushtun* in ethnic origin). Community members did not welcome the extreme social change in Afghanistan. Women, in particular, felt far more restricted than the norms to which they

were accustomed. The vast majority interviewed had been exposed to violence, either directly or indirectly. Prior to migration, many of the adult and teenage males had been involved in armed combat. Others usually had a family member who had been engaged in combat. The loss of loved ones was very common, either by death, detainment or migration. For example, one 17 year old boy interviewed had witnessed his mother being killed by a landmine. Witnessing extreme violence was a common phenomenon.

There were numerous accounts of detainment and torture. For example, one teenage boy reported that his father had been captured and jailed by the Taliban three times because he was suspected of being a government official. The man was interrogated, verbally abused, beaten with a weapon to the point of unconsciousness, and refused access to toilet facilities.

Although women were not asked individually or directly about rape, it was known to frequently occur and has been a definite threat. One female focus group reported that many women would disguise themselves as older to avoid rape because, as one woman stated, 'Taliban like pretty women'. One of the most horrific experiences reported was that of a teenage girl whose mother was being raped by a Taliban soldier, and then witnessing her father shooting both the soldier and her mother during the act.

Stress during migration. Participants reported similar experiences during the process of forced migration. Families had been uprooted from their land and their homes. They had lost their possessions, jobs, and schooling. Separation from family, friends, and neighbours seemed to be a particularly stressful loss. Most informants had felt a great sense of uncertainty in respect to entering the host country. Most had not known their final destination, or if they would be turned

away. They were concerned about the hostility of their new environment and had fears for their safety.

Some had travelled long distances by vehicle, while others came by foot without access to food, hygiene, or shelter. Taliban officials stopped many refugees at the border. One 17 year old boy had been sent by his father to Pakistan and was travelling with a Push-tun (but not Taliban) family by car. A Taliban soldier stopped them at the border and the boy was asked about his ethnic origin. He denied being *Hazara* but the soldier, suspicious of the boy, threatened to shoot him unless a significant amount of money was paid.

Stress after migration. The community expressed hardship that occurred with the changes in their physical, social and cultural environment. Karachi was much warmer than Northern Afghanistan and participants also reported difficulty acclimatizing. In fact, one of the most common paediatric medical problems was blisters caused by extreme heat and humidity, 'prickly heat', or malaria. Also, the necessary layout of the makeshift homes had caused crowding and a loss of privacy. According to one informant, most Afghans had been accustomed to ample living space in their homeland.

The Pakistani language, customs, and rituals were similarly experienced as quite different. There were difficulties in communication between the Afghans and the Pakistanis, not only due to language barriers, but also in terms of cultural norms. For example, some women reported that the typical Karachi-style dress provided to them was shameful and embarrassing because the top was shorter than the traditional Afghan top and it had slits, which was unacceptable in their culture. Additionally, communicating these feelings to the administration was perceived as potentially insulting.

The Transit Centre was a very safe environment for refugees. In exchange for safety, security, refuge, and freedom from persecution, however, the Afghan refugee community had put itself in the hands of the host country and its institutions. One might describe their predicament as disempowerment. That is, the community had sacrificed their autonomy, authority and freedom to choose. Due to security reasons, most of the refugees were confined to the Transit Centre, and as a result many felt trapped there. The living quarters, for example, consisted of a large hall with bed sheets separating each family. This feeling of entrapment, then, was only reinforced by the lack of privacy and almost non-existent individual physical space. Simultaneously, however, the anticipated hardship of life outside the Transit Centre was one of the most commonly voiced concerns among all the informants. The community's primary concerns were about income, housing, language, and medical care. There were numerous anecdotes about the impoverished living conditions in Karachi neighbourhoods where many refugees found permanent housing. Also, most felt that they had not gained enough language skills in Urdu to function properly in the Pakistani community. Therefore, although the Transit Centre was a difficult place to live in, there was also a resistance to leave. Most of the key informants interviewed, however, did have hope for changes in future circumstances. Some wished to return home to Afghanistan, others wanted to migrate to the West.

Having lost their livelihood and placed themselves in a disempowered position had given rise to one of the community's most significant issues: lack of activity and occupation. As all basic necessities were provided, most were not required to work. As there were no houses, there was little housework. Skilled Afghans such as teachers, interpreters, physi-

cians, traditional healers, and others, were not utilized as NGO staff and volunteers served these functions. Much of the community remained idle with little purposeful activity.

Coping mechanisms. There were a number of ways in which the refugees were coping with their circumstances. Faith and religion seemed to be a common bond of strength among the entire community. The makeshift prayer hall and daily ceremonies provided a centre for worship as a congregation. Community and family were considered to be important sources of support. Women, in particular, formed small informal support groups where they could discuss their difficulties. Transit Centre volunteers endeavoured to keep families together and reunify separated families, an effort which the community appreciated.

As mentioned above, activity and occupation was a significant, but under utilized strategy. A small minority of refugees, particularly young men, had found work in factories and in the textile industry. A few refugees had been employed by the Transit Centre for cooking or cleaning duties. However, these activities seemed to be sporadic. Engaging the community in purposeful activity would appear to be a significant challenge. Recreational facilities were inappropriate for football (soccer), the preferred sporting activity. Teenage males were able to play volleyball, and some of the older and middle-age males occupied themselves with the game of chess. According to female informants, women could not engage in games, sport, song or dance because there was no private space for them. It was culturally unacceptable for them to engage in such activities in the presence of men. Most women spent their days caring for children but had little else. Thus, idleness was common. Anecdotally, the effects of purposeful activity were striking.

One young woman had experienced medically unexplained pain for several months and did not respond to any medical treatment. When she began making carpets, her complaints of pain disappeared quite soon.

Education was also an important coping strategy. Many adults and all children attended daily classes. It is the one activity that kept them occupied in a very fruitful way, and was thought by many informants to be necessary for their survival as a community. A few teenagers were fortunate enough to be sent to college and, according to these students, it enhanced their career opportunities and gave them a sense of pride, purpose, and hope. Along with their academic education, younger children were also given the opportunity for structured group play and art activities.

Physical escape from the Transit Centre may have also been a coping mechanism. Physicians working at the Transit Centre reported that many refugees demanded to be sent to the nearby hospital, despite no medical indication for such a referral. Since the conditions at the hospital were impressively comfortable, the physicians suspected that this was a form of temporary escape and a way of coping with the feelings of entrapment arising from the difficult environment.

Prior to the fieldwork, it was suspected that opiate abuse might be a maladaptive coping strategy for some refugees. No one, however, reported use of opium (*hafeem*) or other drugs, and there did not seem to be any cause for concern at this Transit Centre. Some key informants reported however that opium addiction might be found in refugees from the province of Badakshan, where the crop is commonly grown.

Discussion and conclusions

The existing literature suggests that social and community based interventions may be

the most helpful. Studies within various populations suggest that supporting a community's inherent coping mechanisms is important. Several studies also support the idea that better mental health outcomes result from keeping family and community networks intact (Desjarlais, Eisenberg, Good, & Kleinman, 1995; Summerfield, 1996; Summerfield, 1999). Family and community cohesion was important to this community. The Transit Centre environment providing common areas for worship, meals and social interaction, as well as efforts to keep families intact, facilitated this collective strength. However, this close-knit shared space, in turn, may have limited the singular space available to the individual. Perhaps it is a trade-off of one for the other.

Several studies support the notion of community and individual empowerment. In one study of Cambodian refugees, (Mollica, Cui, McInnes, & Massagli, 2002) demonstrated that refugees that were working were less likely to suffer depression, compared to those unemployed. In the same study those engaged in religious practice had significantly fewer mental health problems. The authors conclude: 'This study suggests the extraordinary capacity of refugees to protect themselves against mental illness despite experiencing horrific life experiences and ongoing poverty and violence.'

Another area of importance is education, which has also been shown to improve mental health. In fact, it is becoming apparent in the field of international health that the education of women seems to be the single most important determinant of health worldwide. This may be equally true of mental health and there is evidence to support this view in refugees (Mollica et al., 2002).

The issues prioritized by the community in this study were difficulties encountered after

migration. In particular, the issues of empowerment, purposeful activity and anticipated hardship were the most salient concerns elicited.

Numerous Pakistani volunteers tried to meet the needs of this refugee community. It seemed, however, that this generosity might have also contributed to removing autonomy and control from the refugees. Summerfield (1996) emphasizes that interventions should enhance refugees capacity to reinstate control of their own lives. However, refugee camps, with their emphasis on confinement, control and minimal involvement of residents in decision-making, too often breach this basic principle.

Simmonds (1983) emphasizes the mobilization of community resources. There could be greater involvement of Afghans in daily Transit Centre activities such as cooking, maintenance, and other tasks. Afghan professionals could be utilized to assist Pakistani professionals in areas such as education and health care. This would enhance the use of purposeful activity as a coping strategy in its own right.

Simple adjustments to the Transit Centre, such as the creation of a separate space for women to engage in recreation separately from men, may also facilitate more activity. Such interventions might serve to share responsibility and engage refugees in the active participation of their management, rather than being the passive recipients of aid. The uncertainty and anticipated hardship of living in Karachi outside the Transit Centre was one of the most distressing and anxiety-provoking issues. The community's concerns about housing, employment, health care, and language are quite justified. There is no ideal solution but programs that focus on practical skills such as Urdu language, vocational skills, or, simply, how to use the public transport system, for example, may be useful.

One Transit Centre volunteer suggested field trips to various sites in Karachi (such as a market or a school) in order to demystify the fears of life outside the Transit Centre. Employment or schooling outside the Transit Centre seemed to be helpful and could also be utilized. The underlying goal is to facilitate the extension of the refugees' network outside the Transit Centre; that is, to promote an in-out situation where the community has a more graded integration into their host society. In summary, social and community based approaches that address natural coping strategies; family cohesion, education and empowerment are likely to be the most helpful interventions.

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