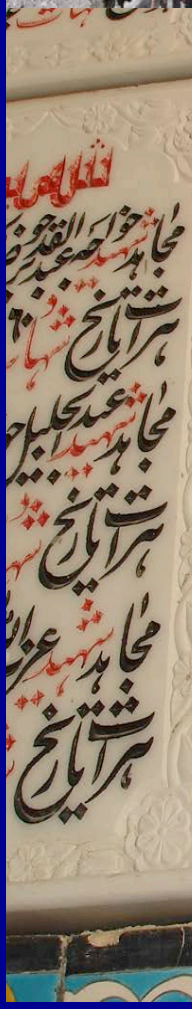
AFGHAN CULTURE



BACKGROUND INFORMATION

As a crossroads for Central Asia, Iran and India, Afghanistan is a weave of many cultural influences spanning many centuries. It was once the highly prosperous and flourishing hub of Central Asia but has since been plundered and ravaged by countless wars and power mongers leaving it devastated and in factional, political and economic strife.

Afghanistan takes its modern identity from the Durrani Empire founded in the mid 1700's. Since then it has survived 3 Anglo-Afghan wars during its monarchy, and 10 years of civil war after the Soviet invasion in 1979. The United States, China and Saudi Arabia funded and fuelled a war in opposition to the Soviets with the result that more than 6 million Afghans were displaced as refugees, mostly in Pakistan and Iran. After the Soviets withdrew in 1989 widespread factional fighting led to more people fleeing, especially professionals. The fundamentalist Taliban regime took control in 1996 and created another wave of millions of Afghans fleeing the tyranny, oppression and horrors resulting from the imposition of the fanatical laws. Many of those refugees were Tajiks and other minorities including Hazaras. The country was further depleted of resources, poverty was rife and the drug trade particularly in opium, remained a major source of revenue.

Although some refugees began returning 'home' after the fall of the Taliban, political unrest continued to intensify between government and Taliban, and amongst parties wrangling for power in the elections. 2014 now holds the deadliest record for civilians, with children reported to be the hardest hit. Many refugees continue to leave Afghanistan, either to join their displaced families or because of the dire prevailing conditions. Life is harsh with ongoing violence and a lack of resources, services and food.

New Zealand has Afghan communities established in Auckland, Christchurch and Wellington.

Afghanistan is sometimes included as part of the 'Eastern Mediterranean' region (WHO), and in New Zealand it has been categorized as 'Asian'. However, for the purposes of this resource it is included with Middle Eastern countries because of the cultural values and practices it shares with other Muslim based countries.

Photographs provided by Gary Poole and Arif Saied

COMMUNICATION

Greetings

Hello greeting	*Salaam aleikum* 'peace be upon you' (Muslims)
Goodbye greeting	*Khuda Hafiz* 'God be with you' (Muslims)

Main languages

Dari and **Pashto** (Pashtu) are the main languages spoken in Afghanistan. Dari is the Afghan form of Farsi (Persian, based on Arabic script) which is spoken in neighboring Iran. Farsi speaking interpreters can be used for Dari speaking clients when necessary. However there are enough differences in the languages for misinterpretations to occur and the practitioner needs to be aware that a discussion of some concepts may need clarification between client and interpreter.

Pashtuns (generally Sunni Muslims) form the largest ethnic group. The Dari speaking Tajik constitute 25% of the population and are associated with sedentary farming and urban dwelling, the Turkic (Uzbek and Turkmen) who live north and south of the Hindu Kush constitute about 11% and speak Farsi and an ancient form of Turkish, and the Hazara, most of whom speak Dari live centrally and represent about 1.1 million people. There are 15 other ethnic groups living in Afghanistan.

Although the religion is principally Muslim, and the language script is based on Arabic forms, Afghans are not ethnically Arabic.

Gestures and interaction

- It is appropriate to **shake hands** with men (using the right hand), though not usually with Muslim women. Physical contact with women should be restricted to necessary physical examinations as propriety is highly valued and also required
- Use **title** and **second** names
- Same gender practitioners and interpreters are preferred, and are usually imperative for gynaecological examinations
- Showing **respect,** especially for elders, is appreciated (e.g. greeting the elders first, the practitioner being on time for appointment, greeting them in their traditional way)
- Health practitioners are considered to have a high status and clients may not ask **questions** as it is considered disrespectful. It would be helpful to invite the client and their family to ask questions
- Prolonged **eye contact** is avoided between men and women, and between people considered to have a different status. A person with lower status may lower their eyes, or heads to avoid eye contact. Second generation Afghans may be more relaxed about eye contact
- **Saying 'no'** directly is not courteous in Afghani culture so an affirmative response from a client may not necessarily mean agreement or acceptance (clients will also appreciate a more indirect way of saying 'no' from the health practitioner)
- Western custom of **asking direct questions** is considered impolite and can result in reticence to engage. Asking general questions about the wellbeing of the client (and importantly, family) will assist with establishing rapport and for the client to volunteer information for further questioning

- Showing an **interest** in the culture and practices will likely enhance compliance and the relationship with the practitioner

FAMILY VALUES

- Religion plays an extremely prominent role in family life
- The family is sacrosanct
- Traditionally fathers and sons are heads of household and decision makers in all respects (although in some resettled families women may have more say in family affairs)
- The chastity of unmarried women is of great concern to the family
- Resettled families strive to maintain ties with relatives in their homelands and will often arrange marriages to this end
- There is profound respect for elders and those in authority
- Individuals are oriented towards the good of the whole family and mutual dependence is required over independence
- Privacy about family matters is imperative and so confidentiality issues will need to be well established
- The freedom and difference of family values in the West places significant stress on families who resettle as refugees, and school, health and social services can often be seen as undermining parental and male authority. Sensitivity from practitioners to the challenges faced in adapting to a new culture will be appreciated

HEALTH CARE BELIEFS AND PRACTICES

Factors seen to influence health:

- **Balance**
  Similarly to many other cultures included in this resource, it is believed that health is based on keeping the body elements in 'balance' and that certain kinds of diet, lifestyle, treatments and external factors can influence this. Maintaining the balance of the 'humours' is essential for good health and entails keeping a balance between the 'warm' (*garm)*, 'cold' (*sard)*, and 'wet' and 'dry' states of the body
- **Spiritual/religious**
  Punishment for misdeeds or for not adhering to the principles of Islam is believed to contribute to or bring illness. Unlike some of the practitioners of Buddhism who tend to take a fatalistic view, Afghans see themselves as responsible to seek treatment.
- **Supernatural**
  Evil spirits known as **'Jinn'** in Islam can cause some illnesses, (often associated with mental health problems) (See Jackon, K. (2006) Ch. 2 for more information about supernatural beliefs in Islam)
- **Western** concept of disease causation
  This is commonly accepted and may co-exist along with any of the other attributions of illness

Common Traditional treatments and practices

- **Magico-religious articles** such as amulets, charms and strings, are worn to ward off evil spirits. The amulets (that look like a piece of string) contain verses from the Qur'an and are believed to guard against the 'evil eye'. Permission to remove these articles for medical interventions needs to be gained from clients beforehand
- **Traditional medicine** (known as *attary* in Dari) comprising herbal remedies taken as powders or tea are commonly used and some of these are available in the West, especially in Middle Eastern stores. *Attary* specialists have knowledge about prescribing for particular ailments, although Kemp and Rasbridge (2004) suggest that there are few of these specialists, if any, amongst resettled populations. They also highlight that raw opium in a wrapped form (*bast*) is commonly used in folk medicine and is used to treat extreme pain, stimulate the appetite and increase sexual stamina
- Allopathic practitioners are commonly consulted. However, many **Western medicines**, including antibiotics are available over-the-counter in Afghanistan and it is common for Afghanis to self-medicate with these

Important factors for Health Practitioners to know when treating Afghan clients:

1. As many Afghan who enter New Zealand have arrived as refugees, extra sensitivity and care in treatment is necessary given the possibility of extremely difficult pre-settlement experiences (see 5**.** below)

2. The addition of 'Inshallah' ('God Willing') to statements is frequently made when expressing hope for good outcomes or for the future. It is useful for practitioners to use this phrase too as it will assist with good rapport and show an understanding of the importance of religion in the client's life.

3. In Afghanistan a referral to a specialist is not required. Clients will often 'doctor shop' and may expect to do so in New Zealand. As mentioned above, they can also buy their own medications over the counter back home. As a result clients resettled in New Zealand may need to be informed about health practice here.

4. Children should NOT be used as interpreters as it often results in information being withheld due to privacy and status issues. When it is absolutely necessary, give authority to parents by asking if the child can interpret for them.

5. When Afghan people first resettle they usually expect a tangible intervention (prescription, injections etc.). If this is not offered at consultations clients may seek treatment elsewhere, or try their own. So rationale behind treatment plans may need more explanation than with western clients. After a period of resettlement however, the local traditions are understood and accepted.

6. Compliance with prescriptions can be affected by language difficulties. Interpreters can assist with providing written instructions in the client's own language.

7. Some mental health issues (particularly depression, '*afsordagi'*) may present as somatic complaints. If the mental health component is addressed, often the somatic problem will resolve.

8. Terminal illness should be divulged to the family, NOT the client. It is customarily believed that the client's response to the news encourages deterioration of the condition. Client will need to give informed consent for medical information and issues to be discussed with a designated family member. This is expected practice.

9. When doing HOME VISITS:
   - Give a clear introduction of roles and purpose of visit
   - Always remove shoes when entering the home
   - If food or drink is offered, it is acceptable to either decline politely, or to accept. However, if food has been especially prepared it would be considered rude to refuse. (Be aware that no food or drink will be consumed by the family in between sunrise to sunset during the Ramadan period)
   - Afghanis regard their privacy highly and would appreciate assurances of confidentiality
   - Modest dress is appropriate

Stigmas

Mental illness is considered a stigma and some clients may withhold related symptoms or emphasize physical ones. It is also difficult for men to acknowledge problems that may be seen as 'weakness'. Refugees who suffer from the long-term after-effects of torture may present with physical symptoms that need further exploring. For information on mental health issues see *Jackson (2006)*, *Fate, spirits and curses: Mental health and traditional beliefs in some refugee communities*.

Diet and Nutrition

Afghan food is largely based on cereals like wheat, barley, rice and maize as well as lamb, chicken and beef, but no pork for Muslims. Curds and spices are common in cooking. *Nan-i-Afghani* is the national bread. The addition of this in a hospital diet would be appreciated. The bread is available in most stores stocking Middle Eastern or Indian foods. Families would be happy to provide this for members who are hospitalized.

Death and dying

Muslims

- When death approaches, a Muslim will recite "There is no god but Allah, and Muhammad is His Messenger"
- Traditionally Muslims need to bury their deceased within 24 hours
- Burial in a cemetery is required, not cremation
- After death the male body is washed by a male relative or Imam (holy man), and a female by a female relative or midwife, and wrapped in a white shroud
- The body is laid out in specific ways and prayers recited before it is taken to the cemetery
- A ceremony and meals commemorating the deceased are held in the home for 3 days after death. The family is visited by community, friends and relatives, and their support is paramount during this time. Men will attend the mosque but have meals at the home.

HEALTH RISKS AND CONCERNS

According to Metha's (2012) report on health needs for Asians (includes the sub-group 'Other Asians' - the group under which Afghans are stratified), the following were noted as significant [1]:

- Stroke
- Overall Cardiovascular (CVD) hospitalizations
- Diabetes (including during pregnancy)
- Child oral health
- Child asthma
- Cervical screening coverage
- Cataract extractions
- Terminations of pregnancy

Unexmundi, August 2014 lists the following as major infectious diseases in Afghanistan:

- Hepatitis A and E
- Typhoid fever
- Malaria
- Dengue Fever
- Yellow Fever
- Japanese Encephalitis
- African Trypanosomiasis
- Cutaneous Leishmaniasis
- Plague
- Crimean-Congo hemorrhagic fever
- Rift Valley fever
- Chikungunya
- Leptospirosis
- Schistosomiasis
- Lassa fever
- Meningococcal meningitis
- Rabies

In addition, many Afghans may experience health issues and mental health issues related to:

- Refugee experiences (trauma, sexual violence, extreme loss, lack of resources, long periods of journeying or waiting in interim situations, lack of family or community support, forced migration)
- Resettlement (cultural adjustment, isolation, poverty, language challenges, ethnic and racial discrimination, stigmas of mental health and disability)

[1] Note: in the Metha (2012) report, Afghans are stratified as 'Other Asian'. This resource includes Afghans under Middle Eastern cultures since it shares significant cultural and religious practices with other Muslim based cultures.

WOMEN'S HEALTH

According to Metha's (2012) report on health needs for Asian people[2] living in the **Auckland region**:

- Asian women have lower total fertility rates (TFR) in the Auckland region as compared with European/Other ethnicities
- All Asian groups had lower rates of live births than their European/Other counterparts
- Teenage deliveries occurred at significantly lower rates among the Asian groups as compared to European/Other teenagers
- Asian women have more complications in live deliveries because of diabetes compared with European/other ethnicities
- Asian women had lower rates of hospitalizations due to sexually transmitted diseases than European/other ethnicities (but across all ethnic groups in that study, women had a much higher hospitalization rates compared to men)

Pre-migration health conditions and issues for women from Afghanistan:

During the Taliban regime, women were prevented from leaving their homes to seek medical treatment. Although access is no longer denied, the continuing problems of inadequate services, extreme poverty, lack of resources including drinkable water, poor sanitation, lack of health education, and often lack of food result in exceptionally high health risks for both women and children. In 2003 Afghanistan was reported to have the fourth-worst health profile in the world. Some Afghans resettling in New Zealand will have suffered such conditions and may arrive in need of significant health care and health education.

Rape and Sexual abuse is extremely common amongst refugee women in general, and Afghans are no exception. Due to the lower social status of women in Afghanistan few disclose, but those who do so report atrocities and assault within and outside marriage. Many women have been assaulted by soldiers during war situations, during flight and in the refugee camps or countries of first asylum. The witnessing of violence and assault also leave women feeling vulnerable or traumatized. It is important to explore a possible history of sexual assault although this needs to be done when trust has been established as privacy and chastity is so highly valued.

- **Pregnancy**
  - Although in 2015 maternal health remains inadequate with a high mortality rate of 400 maternal deaths per 100,000 live births, this has dropped significantly since the high of 2004
  - Iodine deficiency is common in women, resulting in low birth weight, deafness and cretinism among newborns
  - Pregnant mothers arriving in New Zealand may need assistance with nutrition education and also dietary supplementation

[2] Note: in the Metha (2012) report, Afghans are stratified as 'Other Asian'. This resource includes Afghans under Middle Eastern cultures since it shares significant cultural and religious practices with other Muslim based cultures.

- **Labour and Delivery**
  - Births are usually assisted by a midwife (a *dais)*, particularly in more rural areas
  - Gender matching with practitioners for examinations and births is necessary

- **Postnatal care**
  - Early weaning, poor complementary feeding and breast-feeding practices, and lack of nutrient-dense complementary foods are factors leading to the high prevalence of chronic malnutrition amongst newborns in Afghanistan. Young children presenting for treatment in New Zealand after resettlement may have endured such histories.

YOUTH HEALTH

Adolescent Health

- According to Metha's (2012) report on health needs for Asians[3] living in the Auckland region:

  - Alcohol consumption is less prevalent amongst Asian students as compared to NZ European students
  - Almost all Asian youth reported good health
  - Most Asian youth reported positive relationships and friendships
  - Most Asian youth reported positive family, home and school environments
  - 40% of Asian youth identified spiritual beliefs as important in their lives
  - 75% of Asian students do not meeting current national guidelines on fruit and vegetable intake
  - 91% of Asian students do not meet current national guidelines on having one or more hours of physical activity daily
  - Mental health is of concern amongst all Asian students, particularly depression amongst secondary student population

- In addition, adolescents who migrate without family may encounter the following difficulties:

  - Loneliness
  - Homesickness
  - Communication challenges
  - Prejudice from others
  - Finance challenges
  - Academic performance pressures from family back home
  - Cultural shock

[3] Note: in the Metha (2012) report, Afghans are stratified as 'Other Asian'. This resource includes Afghans under Middle Eastern cultures since it shares significant cultural and religious practices with other Muslim based cultures.

- Others who live with migrated family can face:

    - Status challenges in the family with role-reversals
    - Family conflict over values as the younger ones acculturate
    - Health risks due to changes in diet and lifestyle
    - Engaging in unsafe sex
    - Barriers to healthcare because of lack of knowledge of the NZ health system, as well as associated costs and transport difficulties

Child Health

- According to Metha's (2012) report on health needs for Asians[4] living in the Auckland region:

    - There are no significant differences in mortality rates of Asian babies compared to European/Other children
    - There were no significant differences in potentially avoidable hospitalizations (PAH) as compared to other children studied
    - The main 3 causes of PAH amongst all Asian children studied were ENT infections, dental conditions or asthma
    - The rate of low birth weights were similar amongst 'Other Asian' babies and their European/Other counterparts
    - Asian children had similar or higher rates of being fully immunized at two and five years of age as compared with European/Other children studied
    - A lower proportion of Asian five-year olds had caries-free teeth compared to the other ethnic groups studied

Pre-migration conditions and issues for Afghan children and youth:

- According to UNICEF, Afghanistan ranks as 16th in the world in terms of under-five mortality, and although still high in infant mortality rates, these have dropped significantly since 2012
- The major causes of child mortality in Afghanistan include diarrhoea, acute respiratory infection, malaria and micronutrient deficiencies
- Many young children and adolescents have been subjected to violence themselves or have been witness to the atrocities leveled at their families and communities during the war, and in refugee camps. They may bear their experiences unnoticed. Parents managing the challenges of resettlement as well as their own pre- and post-relocation traumas are often unable to attend to, or to manage the distress of their children. Sometimes children do not tell their parents in order to avoid added stress on the family, or because they believe they are in some way to blame. Symptoms of trauma may present as behaviour problems, withdrawal or learning difficulties as well as various somatic presentations. Practitioners and teachers need to be alerted to possible pre-location conditions
- Most resettled children will be faced with role changes in the home, pressures from peers to integrate more quickly than they or their families may be

[4] Note: in the Metha (2012) report, Afghans are stratified as 'Other Asian'. This resource includes Afghans under Middle Eastern cultures since it shares significant cultural and religious practices with other Muslim based cultures.

comfortable with, and with the stigma of 'difference'. Assistance and sensitivity from authority figures will be helpful in the schools

- Some Islamic traditions that differ from western ones, and the difficulty in explaining these in a new language, may deter children from attending social or school functions (e.g. no cross-gender touching for adolescents, ablutions required during fasting and before prayers, prayer time schedules, the requirement for *halaal* food etc.)

SPECIAL EVENTS

Norouz, the Afghan New Year, is usually held on 21 March

Ramadan	(fasting month)
Eid al-Fitr	(celebration after fasting)
Eid Al-Adha	(important holiday for making pilgrimages to Mecca)
Moulid	(celebrates birth and death of Prophet Mohammed, occurs during month after Ramadan)

SPIRITUAL PRACTICES

(See Chapter 3 Introduction to MELAA Cultures, pgs 7-11 for more information related to religions and spiritual practices).

Muslims constitute the majority of Afghans (about 99 percent). About 80% of the population is Sunni, and about 19% is Shiite Muslim. There are an estimated 3,000 Afghan Christians. The *mullah* is the (male) religious leader or teacher. The Qur'an is the holy book. Tajiks tend to interpret the Islamic practices less strictly than the Pashtuns, and there is some variance in the adherence to rituals and religious laws amongst the diverse ethnicities.

A few Muslims practice **Sufism,** a mystical form of Islam.

There are a few Hindus and Seiks in Afghanistan but they tend to migrate to India rather than New Zealand.

REFERENCES AND RESOURCES

1. Jackson, K. (2006). *Fate, spirits and curses: Mental health and traditional beliefs in some refugee communities*. New Zealand: Rampart

2. Kemp, C., Rasbridge, L. (2004). *Refugee and Immigrant Health. A handbook for Health Professionals*. Cambridge: University Press.

3. Maqsood, R.W. *Thoughts on Modesty. Islam for Today*. Retrieved July 2006. Available at: http://www.thecall.ws/uploads/http://www.thecall.ws/uploads/Thoughts_On_Modesty.pdf

4. Mehta S. Health needs assessment of Asian people living in the Auckland region. Auckland: Northern DHB Support Agency, 2012.

5. No author. *Culture of Afghanistan*. Retrieved September 2006. Available at: http://en.wikipedia.org/wiki/Culture_of_Afghanistan

6. No author. *Ethinic Groups of Afghanistan*. WebMedia iNteractive. 1997 – 2002. Retrieved September 2006.

7. No author. *State of the World's Children*. UNICEF Statistics. Retrieved February 2015 from:http://data.unicef.org

8. No author. *U.S.-Afghan Health Partnership.* Retrieved September 2006. Available in 2015 at http://en.wikipedia.org/wiki/U.S.Afghanistan_Strategic_Partnership_Agreement

9. Perumal L. Health needs assessment of Middle Eastern, Latin American and African people living in the Auckland region. Auckland: Auckland District Health Board, 2010.

10. Saeid, A., Community Manager RASNZ. (January 2007). P*ersonal consultations on Afghan culture and practice in general, and on practice amongst resettled community members in New Zealand*. Auckland.

Useful Resources

1. RAS NZ (Refugees As Survivors New Zealand) can provide assistance to mental health practitioners on clinical issues related to refugee and cultural needs, and contacts for community leaders/facilitators. They can be contacted at +64 9 270 0870.

2. ARCC can provide information on resettlement issues and contacts for community leaders. Contact +64 9 629 3505.

3. Refugee Services can be contacted on +64 9 621 0013 for assistance with refugee issues.

4. A number of health fact sheets can be found in **Dari** and **Pashtu** for download in pdf. at: http://www.healthtranslations.vic.gov.au/

5. The http://www.ecald.com website has patient information by language and information about migrant and refugee health and social services.