Fatherhood in a New Country: A Qualitative Study Exploring the Experiences of Afghan Men and Implications for Health Services

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ABSTRACT: Background: Fathers of refugee background are dealing with multiple, interrelated stressors associated with forced migration and establishing their lives in a new country. This has implications for the role of men in promoting the health and well-being of their families. Methods: Afghan community researchers conducted interviews with 30 Afghan women and men who had recently had a baby in Australia. Interviews and focus groups were conducted with health professionals working with families of refugee background. Results: Fourteen men, 16 women, and 34 health professionals participated. Afghan men reported playing a major role in supporting their wives during pregnancy and postnatal care, accompanying their wives to appointments, and providing language and transport support. Although men embraced these roles, they were rarely asked by health professionals about their own concerns related to their wife’s pregnancy, or about their social circumstances. Perinatal health professionals queried whether it was their role to meet the needs of men. Conclusion: There are many challenges for families of refugee background navigating maternity services while dealing with the challenges of settlement. There is a need to move beyond a narrow conceptualization of antenatal and postnatal care to encompass a broader preventive and primary care approach to supporting refugee families through the period of pregnancy and early years of parenting. Pregnancy and postnatal care needs to be tailored to the social and psychological needs of families of refugee background, including men, and incorporate appropriate language support, in order to improve child and family health outcomes. (BIRTH 2015)

Key words: father’s health, maternity services, qualitative methods, refugee background
Fathers play an important role in promoting the health and well-being of their families across the life course (1). During the perinatal period (pregnancy and first year postpartum), fathers’ mental health and adjustment to fatherhood are associated with women’s mental health (2), health behaviors during pregnancy (3), and breastfeeding (4). In contrast, lack of paternal involvement is associated with higher infant mortality rates (5) and poorer educational, behavioral, and developmental outcomes in children (6).

In recognition of the changing role of fathers in Western societies (3,7), there has been increased focus on understanding the experiences of men during pregnancy, childbirth, and their transition to fatherhood. Recent studies indicate that rates of distress among fathers during pregnancy and postnatally are comparable to rates for women at around 10 percent (8,9). Several meta-syntheses of qualitative studies indicate this can be an overwhelming time for fathers as they experience their partner’s pregnancy and childbirth, redefine themselves as a father, and feel the pressure to provide materially for their family (10–12). Despite this growing interest, there is a significant gap in knowledge about the experiences of fathers from diverse social, economic, and cultural backgrounds, including refugee background men.

To date, studies indicate that migrant fathers can feel undermined in their traditional role as the head of the household, as a result of increased stress finding suitable employment (13), and feel alienated and disrespected by both society and their own families (14). However, little research has been undertaken with refugee background fathers. These men are often dealing with multiple, inter-related stressors associated with experiencing war and violence, fleeing their country, and establishing a new life (15). Stressors also include physical and mental health issues; learning a new language; unemployment and underemployment; securing housing; social isolation; difficulties accessing services; and their own recovery from trauma (16–18). In addition, men may have strong beliefs, values, and traditions about the nature of fatherhood that may not be the norm in their new country. Given these complex and stressful experiences that have an affect on the fathering role, there is a pressing need to understand and address the issues to inform policy and services.

This paper reports the findings from a study that aimed to explore the experiences of Afghan women and men of refugee background having a baby in Melbourne, Australia. The paper focuses on the experiences of Afghan men and the reflections of health professionals about the role of men in maternity and early childhood care. Findings about women’s experiences of maternity and early postnatal care are reported elsewhere (19).

Methods

The project was initiated in response to 1) a lack of information about the experiences of families of refugee background using public maternity and early childhood health services, and 2) that health professionals were concerned about the disparities in perinatal and infant/child health outcomes. The study utilized a community-based participatory approach (20) and was designed with the challenges of cross-cultural research in mind. Afghan community researchers and establishing Community and Stakeholder Advisory groups were integral to the study. Full details of the study methods are published elsewhere (21,22).

Setting

The study was conducted in the municipalities of Greater Dandenong and Casey in Melbourne, Australia (2012–2013) which are major areas of settlement for people from refugee backgrounds. Afghan men, women, and children comprise one of the fastest and largest growing populations in these municipalities (23).

Recruitment

Community researchers comprising female and a male were employed to facilitate the involvement of both men and women. The community researchers liaised with the Community Advisory Group, local services, and community groups to identify participants. Purposive and snowball sampling strategies were used to invite Afghan women and men who had had a baby in Melbourne in the previous 12 months to participate in an interview. Interviews were conducted when their infant was approximately 4–12 months of age. Purposive and snowball sampling strategies techniques were also used to recruit health professionals providing care to refugee families and other key stakeholders to participate in an interview.

Data Collection

A semi-structured interview guide comprising closed and open-ended questions was used to ask community participants about their experiences with maternity and early childhood health services. Men were asked to reflect on their role as a father in Australia. Health professionals and other stakeholders also participated in a semi-structured interview to explore the ways that ser-
vices identify and respond to the needs of refugee families, including fathers.

Data Analysis

All interviews and focus groups were audio-recorded and if applicable transcribed verbatim into English. Descriptive frequencies were calculated for demographic items. Thematic analysis of all open-ended questions was completed. Four members of the research team (ER, JY, SW, and FF) were involved in coding and categorizing the data which was synthesized to identify key themes (24). After three interviews (community and health professionals) were completed, we began coding, and stopped data collection when data saturation was achieved. The NVivo software program was used to manage the data (25). Quotes have been selected to illustrate key findings.

Ethics

Ethics approval was obtained from the Victorian Foundation for Survivors of Torture and The Royal Children’s Hospital.

Results

Following extensive community consultation, the community researchers (SW, FF) conducted interviews with 14 men and 16 women, all of whom were born in Afghanistan. Half had been in Australia for 5 years or less, with all but three spending time in another country, mostly Pakistan before coming to Australia. Two-thirds identified as Hazara. Between them, the participants spoke six languages other than English, including Dari, Pashto, and Arabic. Half had not completed secondary school. All spoke an Afghan language at home. Five reported that they were not literate in their spoken language.

Nine of the men reported that their English was “good,” four said their English was “OK,” and one said that his English was “not good.” Half of the men were unemployed. Most men had a Victorian drivers licence. Nearly all families had health care concession cards, an indicator of financial disadvantage. The majority lived in nuclear households. For four men, it was their first experience of being a father and five men had children born in other countries.

Thirty-four health professionals, including midwives, general practitioners (GPs), maternal and child health nurses, obstetricians, other health professionals and bicultural workers participated in interviews and focus groups.

Fatherhood in a New Country

Men were asked about their life as an Afghan man, and father, in Australia. The importance of safety, particularly for starting a new family was evident.

The difference for me here compared to Afghanistan is that I feel a lot safer here than Afghanistan. (Male participant)

Men reported that in Afghanistan males did not traditionally attend any aspect of maternity care, especially the birth. Generally men reflected that they were pleased they had the opportunity to be with their wives.

In Afghanistan I wouldn’t go to appointments with my wife… but here I can spend the time with my wife. (Male participant)

Being involved in pregnancy care challenged traditional values and beliefs. Several men talked about their changing role as fathers in Australia compared to Afghanistan.

Actually here all the time I was with my wife but in Afghanistan, my family, my father, mother and other relatives would take care of my wife and child, but here I play a hundred roles during pregnancy and appointments. I accompany her, but in Afghanistan the culture is different. Sometimes it is difficult. (Male participant)

If it was in Afghanistan there would be no role for me as my mother would take care of it all—I wouldn’t even know about it. (Male participant)

Men reported that in Afghanistan it would be considered dishonorable or shameful for a man to attend his wife’s delivery, but in Australia men’s involvement was necessary and expected.

Also it is shame, for the man to go with the wife during pregnancy. Here in Australia, men and women have equal rights, and men are obligated to go to the hospital for every appointment, but not in Afghanistan. This is a big difference, yes. (Male participant)

This was a considerable transition for Afghan men and given the lack of extended family close-by, they were required to fulfill multiple roles. This shift for men came with additional challenges related to employment and financial security. Having financial security to support their wives, newborn baby, and other children was important to all of the men. Yet employment also proved to be a dilemma for men who were anxious about their availability to support their wives.

I don’t have a job. If I had a job I couldn’t help my wife. (Male participant)
Supporting Women During Pregnancy, Labor, and Birth

All men reported being involved in some way in supporting their wives during pregnancy, labor, and birth in Australia. Men were positive about their involvement,

I was happy. I wanted to help her, because being a father has responsibilities to take care of them, my culture tells me to take care of my children and family. (Male participant)

Without extended families in Australia, men talked of the expectations placed on them to assist their wives to attend appointments and have the necessary pregnancy tests.

It was my first child. I was kind of worried. I was kind of happy. I was alone with her and she was new in Australia, she was not aware...where to find the GP and the need to do an ultrasound. I was the only one able to assist. (Male participant)

Men noted that their role was important in providing emotional support to their wives.

The fact that I was there with my wife during labor [was good], because I had never seen someone giving birth so I could understand her pain and also my wife was happy that I was there standing by her. (Male participant)

I had a big role in this. I kept her company and was always there with her to help her and support her. (Male participant)

Health professionals recognized the role that men play in facilitating women’s access to and engagement in health services.

Antenatally it’s quite easy to engage the men to help them get the women to services, so I know if I want the women to come then I have to engage him to get her to the service. (Midwife)

Some health professionals reported that engaging men at appointments was particularly important as this enabled trust to be established. Trust was very important for families to remain engaged, complete ongoing tests, and subsequent early childhood health checks post birth. For men, trust was an important and positive element in their relationships and interactions with care providers.

Everything is good in pregnancy care because we trust them. (Male participant)

However, an overarching concern for men was having access to female care providers and being interpreters for their wives. Not having a choice of female care provider and being cared for by a male were seen as disrespectful and worrying.

The only disrespect was that we couldn’t choose the doctor to be female during labor. My wife was uncomfortable and worried. They [health professionals] said it’s no issue for us and shouldn’t be for you guys. (Male participant)

Many men indicated that supporting their wives in communicating with care providers was an important part of their role. Men often filled the role of interpreter at pregnancy visits. Interpreting support and the provision of transport were recurrent roles when men talked about their responsibilities in helping women to access pregnancy and postnatal care.

As a father it’s my duty to help my wife and be with her...she couldn’t drive or speak English so I went with her to help her. (Male participant)

Language support in labor was usually provided by husbands, although their level of English was often insufficient.

During labor and at birth my husband did all the interpreting for me although his English was not good enough for interpretation. (Female participant)

Many men reported they made appointments for their wives and there was a noted reliance on husbands to drive women to appointments.

I would be less responsible there [in Afghanistan] as my wife would be able to speak the language and go see the doctor as here I have to go with her and drive as well. Even during labor. (Male participant)

The importance of men’s involvement remained evident even when the health professionals spoke the language of the family.

I don’t utilize the husbands as interpreters. I utilize them because they’re the one who have to take these females for the ultrasound appointment...So I make sure that he knows and he puts it in his mobile phone, he knows where to take them and which place to go. He has to ring and make the appointment because she can’t. So we don’t exclude them, they are really important in our consultation because without them we can’t do much. In that way they are doing a lot. (Medical practitioner)

A few women could drive a car, speak English, and attend appointments independently. Their husbands were less likely to attend health appointments than the husbands of women requiring assistance. This often resulted in the husband not engaging in his wife’s or infant’s care and missing out on health and service information. Some men were unclear about their role beyond providing transport and language support and queried if they would...
have been welcome to attend their wife’s appointments otherwise.

Addressing Father’s Needs and Concerns

Although men were involved in practical ways during pregnancy, their own needs and worries were rarely attended to. The majority of men were not asked by health professionals about their circumstances including financial worries, legal and housing problems (Table 1).

We don’t normally do a lot of talking or asking questions of the men. (Midwife)

While some health professionals noted the important role that Afghan men play in supporting their wives there was little recognition that men may require information or advice or have questions. A few men were able to rely on social networks to resolve issues concerning them.

I would call someone else to get help if I didn’t understand and try to find some way solve my problems. (Male participant)

Men were keen that health professionals take an interest in them and what was happening in their lives.

Yes [we would have liked to have been asked], we started our life from zero, and wanted information on how to start work. (Male participant)

When support was provided by health professionals this was appreciated.

Table 1. Number of Afghan Men Reporting That a Health Professional Asked About Their Emotional Health and Social Circumstances During Their Wife’s Pregnancy and Postpartum Care, Melbourne Australia 2012–2013 (n = 14)

<table>
<thead>
<tr>
<th>Did anyone ask you</th>
<th>Yes I was asked (number)</th>
<th>No one asked (number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>About your family here in Australia or overseas?</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>About the health of your wife and the new baby?</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Whether you felt sad or depressed?</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>If you had financial worries?</td>
<td>1</td>
<td>13</td>
</tr>
<tr>
<td>If you had housing problems?</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Whether there was violence at home?</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>If you or anyone at home had legal problems?</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>If you had relationship problems?</td>
<td>2</td>
<td>12</td>
</tr>
</tbody>
</table>

The nurses were very kind and nice and they worked very hard to serve us, I think if there was anything in the world that could be done they would do it for us... their support gave me good feeling and I could provide moral support to my wife. (Male participant)

Clinicians were asked whether they provide information to men during appointments. Responses included giving men information about: quitting smoking, first aid, a men’s telephone helpline, and pamphlets on parenthood and mental health. Written information was mostly provided in English.

We give them information if they’re a smoker, how to cut down and quit. We had a booklet about being a dad but it’s all in English and we do have information booklets that we give out in different languages about pregnancy and labor…but nothing for the men. (Midwife)

Fathers were consulted when women had test results that also required testing of their partner, for example, positive chlamydia screening, but rarely engaged otherwise.

If it’s positive [test result] then we have to involve the partners…but generally there’s nothing that’s targeted specifically toward the fathers. (Midwife)

Care providers felt that it was not their role to address the needs of men, or that they were not equipped with the information the men were seeking.

There’s things that we have no control over like English classes, finding jobs, driving instruction. (Community-based care provider)

A small number of community-based workers provided information to men on finding employment, learning English, and connecting men to local social groups—these were based on language groups, such as an Arabic men’s group.

Discussion

Forced migration to a Western society creates new and unfamiliar roles for men entering fatherhood (26). Our findings show that men of refugee background are the key support for their wives, who have often left behind female friends, family, and relatives who would have traditionally fulfilled roles during pregnancy and childbirth (27). Having a baby in Afghanistan is celebrated by the community but is very much women’s business, with mothers and mothers-in-law supporting women. In contemporary Australian society, fathers’ involvement in pregnancy care, childbirth, and childrearing is anticipated. For men in this study being involved in pregnancy, childbirth, and infant care was difficult, and for
some shameful. It is likely that men recovering from dislocation and trauma may be strained when the major life events of resettlement and having a baby intersect.

Generally, Afghan men were positive about their interactions with health services, particularly when health professionals took an interest in them. However, it was evident that care was frequently not responsive to issues related to settlement in a new country, and stresses associated with adapting to new roles. Health professionals need to be aware of these stresses and develop skills and strategies to respond (28). For example, utilizing credentialed interpreters and asking about and acknowledging fathers’ concerns is an important step. Health professionals also need to be aware of local support services for referral, and have access to appropriate resources and translated information to support them in tailoring care to meet the needs of refugee families.

Men, women, and health professionals are placed in difficult positions when men fulfill multiple roles; however it is often through the fulfillment of these duties that men are engaged.

Having husbands navigate health care services on behalf of their wives can be potentially disempowering for women as it does not build their confidence to access services independently. It can also inhibit direct discussions of sensitive issues with clinicians. This is especially important in the context of family violence or when women have past experiences of sexual assault. Hence, it is important for health professionals to consider ways to support the individual and the couple relationship, and ensure that both men and women are engaged in appropriate ways. This is critical, given that paternal and maternal emotional and mental health are intimately linked to child outcomes (8).

Our findings uncovered distress caused to men and women when services were unable to provide female caregivers and/or female interpreters. Women and men should be comfortable and confident in requesting their preferred gender of clinicians and interpreters as standard care. Internationally, these factors are recognized as a challenge requiring reorientation of health services (29).

Clinicians need skills in identifying and responding to the needs of refugee families, and to build empathy and understanding of the complex needs stemming from recovery from trauma and flight to a new country (17). Our findings show that men were seeking support from services, as they were unsure where else they could find assistance. Historically, antenatal care has focused on maternal health and well-being and surveillance of the fetus. The development of health professionals’ skills in understanding the refugee experience, particularly trauma and the issues related to settlement, is important to assessing social health and well-being particularly in opening up conversations about issues that men and women may not typically consider part of antenatal and early childhood care. The study findings point to the need for services to take a family inclusive approach to enhance paternal and maternal health literacy (30,31), improve maternal, and paternal mental health (2), and infant health outcomes (32–34).

To our knowledge, this is the first study to investigate Afghan refugee fathers’ experiences of health care in their country of settlement. Our strategy of working with a male community researcher was central to giving Afghan men a voice about what was important to them. Nonetheless, we are mindful of several limitations. The study focused on one refugee community in one region of Melbourne. While it is difficult to assess the generalizability of the results, discussions with stakeholders suggest that many of the issues identified apply to other communities and settings. The study only briefly touched on men’s expectations of care and support from services, health needs, and concerns related to fatherhood. There is a pressing need for more research on these and other issues related to fathers’ health, well-being, and parenting needs.

Conclusion

Families from refugee backgrounds flee persecution and war to seek safety and security. Navigating a new health care system while dealing with the challenges of settlement is difficult. This study highlights the challenges men of refugee background experience in supporting their wives during and after pregnancy. Our findings suggest that there is a need to move beyond a narrow conceptualization of antenatal care, to encompass a broader preventive and primary care approach to supporting refugee families, through the period of pregnancy and early years of parenting. Pregnancy and postpartum care needs to be tailored to the social and psychological needs of families of refugee background including men, and incorporate appropriate language support, to meet minimum standards of care for refugee families necessary for improving child and family health outcomes.

Acknowledgments

We acknowledge funding support of the Victorian Foundation for the Survivors of Torture (Foundation House) Research Program which is funded by the Sidney Myer Fund and William Buckland Foundation, and the support of the Victorian Government’s Operational Infrastructure Support Program. JY is supported by a National Health and Medical Research Council Career Development Fellowship (2014–2017), SB is supported by an Australian Research Council Future Fellowship.
(2012–2015), and RG is supported by an MCRI Career Development Award. We thank members of the Afghan community who generously shared their wisdom and experiences in the community consultation and in the interviews; and members of the Community Advisory Group including Fahima Ashuri, Farida Bezhan, Mohammad Abbasi, Najila Naier, Nida Iqbal, and Tahira Alizadha. Our thanks to the many health professionals who participated in interviews and focus groups and to members of the Sector Stakeholder Advisory Group: Anne Colahan, Jeannette Cameron, I-Hao Cheng, Alexia Miller, Ilona Nicola, Kerrie Papacostas, Margie Powell, Sally Richardson, Euan Wallace, and Sue Willey.

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