



HAVING A BABY IN A NEW COUNTRY THE VIEWS AND EXPERIENCES OF AFGHAN FAMILIES AND STAKEHOLDERS

FINAL REPORT
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ISSUES FOR CONSIDERATION

Key issues arising from findings of the *Having a baby in a new country* study are summarised below:

Navigating health care in a new country

- I. Navigating health care is often challenging for Afghan families. Information about options for pregnancy care is difficult to access particularly in a form that is understandable. General practitioners are the first point of contact and are relied upon to provide information and to refer families to a GP providing shared antenatal care or a hospital antenatal clinic.
- II. Identification of clients of refugee-background in maternity, primary care and maternal and child health systems is constrained by patient registration and data systems. There is little guidance for health professionals about how best to find out if clients are of refugee-background and why this might be important for their care. Some providers had limited awareness of the experiences that refugees may have had prior to and after settling in Australia, and the impact of those experiences on their capacity to voice their concerns, or ability to access services.
- III. Whilst it was widely acknowledged that language services are critical, both Afghan families and care providers suggested it was common for professional interpreters not to be engaged in various settings. In particular, husbands often interpreted during labour and birth. Stakeholders noted system constraints and other factors affecting access to and use of professional interpreters including: the lack of flexible booking systems; time required for interpreter mediated appointments; and care providers' acceptance of the role husband's play in interpreting during pregnancy check-ups.
- IV. Afghan families had a strong preference for female health professionals and interpreters particularly during pregnancy and labour and birth. Being cared for by a man was considered shameful and degrading, and women reported being less likely to ask questions or seek information about their health from a male health professional, including interpreters. Families noted that they appreciated being told early on in their pregnancy that efforts are made to cater for their preference for female carers, but there may be circumstances, such as emergencies, where this is not possible. Whilst stakeholders recognised that the gender of the health professional was important to Afghan families, there was a range of views and practices in relation to respecting women's preferences.

Social determinants of health

- V. There were mixed views about the role of health professionals in relation to social health issues. Afghan participants reported that few health professionals asked about their emotional wellbeing and social circumstances. Those who had been asked about what was happening in their lives were pleased to be asked. Some would have liked to have been asked and weren't. Others didn't think that asking about social issues was the role of the midwife, nurse or doctor. Several noted that mental health and social issues were private matters best kept within the family. There was a noted reticence amongst women in speaking about social and emotional wellbeing because of shame and stigma surrounding these issues in the Afghan community.
- VI. Community-based care providers including bicultural workers and refugee health nurses were more likely to discuss social issues (e.g. social isolation, housing, unemployment for men, poverty) with clients and their approach to supporting families experiencing these issues. Hospital-based practitioners acknowledged that assessing and tracking women's social and emotional wellbeing during pregnancy was difficult, identifying a number of factors contributing to this. In particular, lack of continuity of care and poor systems for documentation and communication between care providers resulting in fragmented care provision were noted. Care providers reported not having the time to ask about what is happening in women's lives, not knowing how to talk with women about their emotional wellbeing or issues such as family violence, and feeling that they lacked skills in responding to disclosure, and knowledge of local agencies for referral.

Health system performance

- VII. Afghan participants had not accessed resources explaining what to expect from pregnancy and early postnatal care, what will happen at pregnancy check-ups, where to seek help, what tests are necessary and how to understand test results. Stakeholders acknowledged the low participation of Afghan families in childbirth education programs but saw the value of support and information that may be gained through women coming together in groups and the opportunity this could provide for more efficient use of midwife time in antenatal appointments.
- VIII. For maternal and child health nurses, assessing social and emotional wellbeing including family violence is regarded as standard practice. However, nurses noted that aspects of standard assessment tools for mental and social health were not always appropriate for Afghan families. Instead, nurse capacity to conduct home visits and have multiple contacts with the family allowed for assessment to be made informally. Care in the home or close to home with 'friendly' nurses, and provision of interpreting services was appreciated by Afghan families. Increased community demand for the service leading to reduced organisational flexibility left nurses feeling that they were not doing enough to meet the needs of Afghan and other vulnerable families.
- IX. How people experienced interactions with care providers was a salient factor in how participants reflected on what they liked or didn't like about care. The Afghan participants noted their appreciation of the level of care available to them in Australia and there were many comments about the kindness of health professionals. However some participants reported being treated with less respect or treated differently to other people or being judged or stereotyped by health care providers. Several health professionals noted that experiences of racism and judgemental behaviour towards Afghan women was evident in their organisation as well as some of the agencies that they interacted with.
- X. Women and men reported experiencing lack of flexibility in the health system in responding to individual needs, from the routine nature of care, time for appointments and the management of professional interpreter services. These reports suggest that health professionals are challenged in working with diverse communities. None of the hospital clinicians, medical practitioners or maternal and child health nurses could recall specific policies or training that guided them in working with people of refugee-background. Several suggested it would be helpful to enhance their understanding of the refugee experience, how to work with Afghan and other refugee families and the need to build their capacity in engaging with local support services.

Background

The *Having a baby in a new country: the experience of Afghan families* project was initiated in response to a lack of information about the experiences of women and men from refugee-backgrounds using maternity and early childhood health services.

One of the drivers for the project was that mainstream maternity and early childhood health services had identified a number of challenges in providing care to refugee families and were concerned about how these families were faring in terms of perinatal and early childhood health outcomes. Recent Victorian data show that women of likely refugee-background have higher rates of stillbirth, fetal death in utero, and perinatal mortality compared with Australian born women. They are also less likely to attend the recommended number of antenatal check-ups, and more likely to attend accident and emergency departments for obstetric complications.^{1,2} Victorian research has also identified significant barriers for refugee families to access and remain engaged with maternal and child health services.³

Whilst several Australian studies have investigated refugee women's experiences of maternity care,⁴⁻⁶ there is limited evidence of how refugee families including men, access and navigate the Australian maternity and early childhood health care systems and the responsiveness of these health services to people of refugee-background. Likewise, there have been no major studies exploring the experience of health professionals and other service providers who support refugee families at the time of having a baby.

The *Having a baby in a new country* project was undertaken to address the gap in available evidence about how women and men of refugee-background experience health services during pregnancy, birth and in the first months following birth. It was conceived as a 'proof of concept' study involving a community engagement framework and multi-cultural research strategies. The project was designed to generate new knowledge about: the expectations and experiences of refugee women and men having a baby in a new country; consulting and engaging with refugee communities; and methodological approaches that work in hearing the voices of refugee families.

We decided to focus on one community – the Afghan community in south eastern Melbourne – as the salient issues for individual communities are not only related to refugee-background but also to cultural background and community context. In a small study with multiple groups of participants of refugee-background, we may have missed the significance of issues beyond that of the refugee experience.

The following pages report on both the processes and findings of the *Having a baby in a new country* project. Section 2 outlines the project methods. Section 3 describes the feedback from the community consultation. Section 4 describes our reflection on what was learnt in conducting the research as a 'proof of concept' project. Section 5 reports Afghan women and men's experiences of health services during and after pregnancy. Section 6 reports the findings from interviews and focus groups with local service providers who care for refugee families at the time of having a baby.

The Afghan community in south eastern Melbourne

The study was situated in the Cities of Greater Dandenong and Casey in south eastern metropolitan Melbourne. Around 45% of the population in the two municipalities were born overseas, most of whom are of non-English speaking background. The south east Melbourne region is a major area of resettlement of refugees in Australia. Close to 5% of the overall population in the Cities of Greater Dandenong and Casey have arrived under refugee and humanitarian programs. In 2011/12, 2,737 recently-arrived migrants settled in Greater Dandenong – the highest number of settlers in any Victorian municipality. Nearly a third were humanitarian entrants, largely from Afghanistan, Sri Lanka, Iran and Pakistan. Currently, around a quarter of all refugees in this region of Melbourne are from Afghanistan, including a growing number of recent arrivals.

Work undertaken with the Afghan community in the Dandenong area provided a further rationale for engaging with this community about their care during and after pregnancy. This identified that Afghan women feel physically and emotionally isolated from care during pregnancy; an identified need to support the journey that men take when having a baby in a new country⁷; health provider concerns about pregnancy among young women in refugee communities in the Dandenong area², and a general lack of data about perinatal care services for all women of refugee-backgrounds.¹

The service context

Several organisations provide maternity and early childhood health services in the south east region of Melbourne.

MATERNITY CARE

Monash Health (formerly Southern Health) is the largest provider of maternity care in the region. Over 8,000 women give birth at one of the three hospitals (Monash Medical Centre, Dandenong Hospital and Casey Hospital) each year with around 10% of these women coming from humanitarian source countries.

Public antenatal care is offered to women and their families in a variety of ways with models of care that vary in terms of the professional background of caregivers (midwives, general practitioners, specialist obstetricians); risk of complications in pregnancy and/or labour and birth (need for obstetric care and/or tertiary level facilities) and where care takes place (hospital, community clinics, home, GP practice). At Monash Health, women may have all their antenatal care through public outpatient clinics with midwives and/or medical practitioners or care with community-based midwives or medical practitioners, primarily GPs. Women seeing a GP for care may do so under shared care arrangements whereby care is shared between the GP and hospital-based doctors, or alternatively all pregnancy care may be provided by the GP, sometimes in consultation with a specialist obstetrician. Unless community-based medical practitioners 'bulk-bill' through the public health insurance scheme, Medicare, there is an out-of-pocket cost to women for pregnancy check-ups.

Monash Medical Centre is a tertiary maternity facility. Whilst all models of care are available, bookings and transfers are prioritised to women and babies who require multidisciplinary specialist care for complex or rare maternal and fetal conditions. The hospital has adult and neonatal intensive care facilities. A large proportion of women attend community-based medical practitioners for their antenatal care at Dandenong Hospital. The hospital is a significant provider of health services to refugee communities and the small midwife-led clinic at Dandenong Hospital provides care to a large number of Afghan families. Dandenong Hospital has neonatal special care facilities. Casey Hospital in Berwick provides care primarily to women at low risk of complications and specialist level care in labour and birth only if required. Women who develop complications during pregnancy are transferred to either Dandenong Hospital or Monash Medical Centre, dependent upon the level of care required and the bed availability if a hospital admission is required in pregnancy or the transfer occurs during labour.

Irrespective of the model of care, women booked as public patients at Monash Health have labour and birth care and care after birth (both in hospital and at home) provided by rostered staff at one of the three hospitals.

MATERNAL AND CHILD HEALTH

The Maternal and Child Health Program in Victoria is a universal service available to all families with young children up to school age. The service provides new parents with regular child health and developmental checks, screening and referral to additional services if required, and assessment and support related to maternal health.

In addition to general nurse and midwife qualifications, maternal and child health nurses have completed further studies in family, child and community health. Nurses work in community-based centres, many of which are community hubs for other services and community groups. Care is organised around ten 'Key Ages and Stages' consultations for mother and child, including a home visit and then consultations at two, four and eight weeks; four, eight, 12 and 18 months; and two years and three and a half years of age.

The Enhanced Maternal and Child Health Service assists families who are in need of more intensive support within their home environment. Referrals are made by the local maternal and child health nurse.

In the municipalities of Dandenong and Casey there were over 6,200 new enrolments into the Maternal and Child Health Service between July 2011 and June 2012.

HEALTHY MOTHERS HEALTHY BABIES PROGRAM

The Healthy Mothers Healthy Babies Program aims to reduce the burden of chronic disease by addressing maternal risk behaviours and providing support during pregnancy. The program targets pregnant women who are unable to access antenatal care services or require additional support because of their socioeconomic status, culturally and linguistically diverse background, Aboriginal and Torres Strait Islander descent, age or residential distance to services.

The program operates in the outer growth suburbs of Melbourne that have high numbers of births, higher rates of relative socioeconomic disadvantage and lower service accessibility. This includes the catchment area of Monash Health.

REFUGEE HEALTH NURSE PROGRAM

The Refugee Health Nurse Program responds to the poor health status and often complex health needs of arriving refugees. The program aims to increase refugee access to primary health services; improve the response of health services to refugees' needs; enable individuals, families and refugee communities to improve their health and wellbeing; and provides a coordinated health response to newly arrived refugees.

The program is based in community health services and employs community health nurses, with expertise in working with culturally and linguistically diverse and marginalised communities. Refugee Health Nurses in the south east of Melbourne work from the Cardinia Casey Community Health Service at Doveton and the Refugee Clinic at Dandenong Hospital.

The *Having a baby in a new country* project was a descriptive, exploratory study using participatory approaches to engaging the community in the research.

Objectives

The overall objectives of *Having a baby in new country* project were to:

- gain insight into the social health, health care, information and settlement needs of refugee families in the perinatal period
- explore how women and men experience health services during and after pregnancy and
- explore the experiences of stakeholders in providing perinatal and postnatal care to refugee families.

In addition, the project aimed to:

- provide opportunities for refugee community members and key stakeholders (maternity care providers, policy makers) to have input into all aspects of the research and
- work in partnership with the community and key stakeholders to identify key research questions and appropriate methodologies.

To meet the objectives the project was designed with three inter-related and complementary components. The first, a community consultation, was undertaken with a framework of community engagement inviting Afghan women and men to contribute to shaping the research.

The consultation informed the final design and methods of the second stage, interviews with Afghan women and men. To complement the views of the Afghan community as 'consumers' of health care, the third component, interviews with local stakeholders explored the views of health professionals about the challenges of working with refugee communities and how services do, and might, respond to those challenges.

Community consultation

The goals of the community consultation were to:

- establish a profile for the project in the Afghan community utilising existing channels/resources and expanding new community contacts and networks
- seek community feedback in relation to maternity and postnatal health care to assess the importance and relevance to the Afghan community and any other important issues that should be considered in designing the study
- explore approaches that would be suitable for collecting data from community participants, both men and women, that are culturally appropriate and mindful of potentially sensitive issues and
- identify settings or access points for approaching community members to take part in the research.

A purposive sampling strategy was used to identify and approach key people through existing professional and personal networks of the research team members and members of the Community Advisory Group to assist in the organisation of consultation sessions. The consultations were conducted by two community researchers, Fatema Fouladi (FF) and Sayed Wahidi (SW), in Afghan language and often attended by another member of the research team (Jane Yelland). Discussion at sessions was guided by a short list of questions covering the aims of the consultation. For example, participants were asked *What do we need to be aware of when asking people about their experience?* The community researchers also used prompts to inquire about specific issues such as confidentiality, anonymity, privacy, language, and recording of information. Feedback was recorded in notes taken by the researchers.

Interviews with Afghan women and men

The aim of this component of the study was to explore how women and men who have recently had a baby in Australia experience health services during and after pregnancy. The study also aimed to describe the social health, health care and information needs of Afghan families during the perinatal period.

Women and men who were born in Afghanistan, aged 18 years or older, and who had recently had a baby in Australia (with a baby around 4-12 months of age) were eligible to take part in this component of the study.

Recruitment of potential participants was undertaken by the two bicultural community researchers (FF, SW). The bicultural researchers worked with the Community Advisory Group and other key community members during the consultation phase to identify recruitment strategies. This included working with key agencies, services and community groups in the Dandenong and Casey local government areas to assist the team with recruitment.

Purposive recruitment methods and multiple initial contacts were used to invite people to participate to optimise recruitment and ensure diversity of potential participants e.g. length of time in Australia, ethnicity, first or second/subsequent baby. It was anticipated that such a method should result in an indicative, rather than a truly representative sample, appropriate for an exploratory study.

The community researchers returned to the community organisers, community organisations (e.g. playgroups) and local services that had assisted in the consultation and invited women and men to participate in an interview. A postcard with information about the study and details about how to take part, in Dari and English, was distributed to local groups and services to support recruitment. The postcard was also printed in the Afghan community newspaper over a four week period.

Afghan women and men were provided with a telephone number to contact the community researchers to register their interest in participating in an interview. At the time of revisiting community groups the researchers occasionally made arrangements for an interview directly with those interested in participating. This was acceptable for men. Women were more likely to want to seek the permission of their husbands before committing to participation. It was envisaged that multiple contacts with potential participants might be required so that they felt adequately informed and comfortable about participating.

People who registered interest either by telephone or in-person were provided with verbal information about

the study, and handed or mailed a copy of the project information sheet in Dari or English.

At the time of the data collection women and men were asked to consent to the research, either in writing, or verbally, if participants were not confident about reading and signing the consent form. It was recognised that in refugee populations there is often a fear of 'authority' and/or limited literacy in their own language and the signing of forms can be very confronting.

Interviews were undertaken by the two bicultural community researchers in the language preferred by the participant, usually Dari or English. Participants were also asked their preference for where the interview should take place (e.g. home, community meeting space, Foundation House) and if arrangements needed to be made for transport and/or childcare. Participants were given a \$50 supermarket/department store gift voucher to thank them for taking part. Minor editing of participant's quotes was undertaken for clarity.

ETHICAL CONSIDERATIONS

The *Having a baby in a new country* project was conducted with careful consideration of ethical issues relevant to undertaking research with people of refugee-background. We were particularly mindful of the refugee experience and the trauma many had experienced, and the levels of grief, loneliness and social isolation in the refugee community. In asking women and men to reflect on their experiences of having a baby in Australia, we acknowledged the potential for participants to be upset or distressed by our questioning or in the sharing of their story with the interviewers. To this end, a protocol was developed to guide interviewers in responding to participants who may become upset or distressed or in the event that the interviewer was concerned about the welfare of the participant or family member. The protocol also outlined the role of the community researchers in responding to requests from participants for information, advice and support.

The project (interviews with Afghan women and men, and interviews with stakeholders) was approved by the research ethics committees of the Victorian Foundation for Survivors of Torture and the Royal Children's Hospital.

INTERVIEW SCHEDULE

Design of the interview schedule involved a number of steps commencing with consultation with community members and key stakeholders to identify key themes and outcomes of interest. Drafts of the interview schedule were developed and discussed by the bicultural community researchers and members of the

partnership team. Modification of the schedule took place following piloting with six members of the Afghan community.

The themes covered in the schedule for men and for women were similar – experience of pregnancy, labour and birth, and postnatal care including after birth care in the hospital and in the community up until the time of the interview (4-12 months following birth). Questions were also asked about knowledge, use and the responsiveness of local health and support services; access to health information; and preferences for following traditional practices around the time of childbirth. Men were asked to reflect on how they viewed and experienced being a father in Australia. All participants were asked what country they lived in prior to coming to Australia, when they arrived in Australia, whether they came alone or with their spouse, the level of schooling completed, household composition, employment, access to transport, whether they can read and write in their own language and how well they and their partner speak English.

APPROACH TO ANALYSIS

All interviews were audio-taped with permission of the participants. The community researchers transcribed all interviews from the language that the interview was conducted in (80% of interviews were conducted in Dari or other Afghan language). Interviews conducted in community languages were translated by the community into English and then the audio-file transcribed into a word document. Coding was undertaken by the community researchers (FF, SW) using a coding manual devised by the research team (JY, ER, FF, SW). The research team cross-checked coding of a third of all interview transcripts. NVivo⁸ 10 was used to manage and store the interview data. Some responses to questions collecting descriptive demographic information were analysed quantitatively. Due to small numbers, quantitative findings are reported as actual numbers. We have not reported any statistical analyses (or calculation of proportions) as this could potentially lead to erroneous conclusions due to the small sample size. Actual numbers are presented purely for descriptive purposes. Women and men's reflections on their experiences of care were analysed thematically.

Interviews with local stakeholders

Local service providers and other key stakeholders were identified using several means. Initial direction was provided by members of the Sector Stakeholder Advisory Group that was established at the beginning of this project. During the community consultation phase, several agencies were identified as key for the Afghan community. These agencies were contacted, key informants were identified and invited to volunteer to participate in the research. All participants were then asked to identify other key stakeholders to inform the research. The same semi-structured questions were asked of all participants and involved a reflection on their practices of working with and responding to the needs of Afghan families.

APPROACH TO ANALYSIS

All interviews were conducted by Elisha Riggs (ER) except for one conducted by JY. Interviews took approximately one hour to complete. All were digitally recorded, transcribed externally and were cross-checked for accuracy of transcription. JY also read all transcripts. The transcripts were imported and stored in NVivo10.⁸ Coding and categorising of the data was conducted using this software and completed by ER. Categorisation of the codes identified the key themes of the local stakeholders' reflections on providing care for Afghan families.

The community consultation took place during June and July 2012 with 12 consultation sessions conducted with 94 members of the Afghan community in Melbourne's south east.

Participants were appreciative of the consultation process and having an opportunity to contribute to the research. There was generally enthusiasm for the research but many made it clear that it was important that the project findings resulted in change. In the words of one community member *"Lots of promise in research and by community leaders but nothing happens later"*. Consultation participants felt that individual interviews were the best way for community members to talk about their experiences especially if any sensitive questions were asked. Privacy, anonymity and confidentiality were considered paramount in undertaking research of this kind. It was suggested that focus groups were good for general discussions but in order to discuss personal affairs and individual experience, interviews were the best approach. This was articulated with an Afghan proverb that states:

"Your issue or matter is yours if it stays with you, once it is out, it is world's affair."

In response to the question *"What are the important issues for you and/or your community that you would like the research to find out about?"* both men and women talked about depression or sadness as a major issue (sometimes discussed in terms of loneliness and separation from extended family and friends), low health literacy, and the need for better information for women and men about reproduction. Language issues were mentioned frequently, especially in relation to problems for decision-making, understanding tests and procedures, and understanding basics of the maternity care system. Gender of interpreter was noted as hindering women's capability to discuss her health.

The issues highlighted by Afghan women included: relationship problems, accessing care, cross cultural differences and experiencing personal discrimination by service providers. Men particularly discussed issues that had to be dealt with at the same time as having a baby. These included: unemployment; accessing Centrelink benefits; appropriate housing; family reunion visas; understanding the health system and supporting their partners in using services.

Consultation participants stated that community feedback about the research findings was respectful and important. Verbal dissemination of the findings was preferred particularly at existing groups or community events. A special community forum and the use of media (community magazine and radio) were also suggested as avenues for the community to hear about the findings from the project.

As a 'proof of concept' study the *Having a baby in a new country: the experience of Afghan families* project was designed to demonstrate the feasibility and value of approaches to engaging women and men of refugee-background, namely Afghan families, in community-based research. The project developed out of early discussions between the Healthy Mothers Healthy Families research group at the Murdoch Childrens Research Institute (MCRI) and Foundation House staff about what was known about outcomes for refugee women and their families at the time of having a baby, how families experience maternity and postnatal care and how best to address the challenges facing health care providers in responding to vulnerable populations. Our early discussions also identified what we saw as some of the limitations of much cross-cultural research and what we wanted to do differently.

Together the partnership spent time in considering how the two organisations would work together to carry out the work of the project, including the principles that would guide us and our roles in the partnership. Our planning included careful consideration of the ethical aspects of conducting research with people of refugee-background, how these aspects would inform the research protocol, and the role of the bicultural researchers. There was consensus that participatory approaches were essential in conducting research with refugee communities, and that community engagement needed to be critical in the design, content and interpretation of the research. We also decided to engage with community members and key stakeholders early in the project to assist us in planning the broader community engagement strategy and to advise us on scoping the research to optimise the translational potential of the outcomes. The 'concept' we aimed to demonstrate was an approach to cross-cultural research that included community engagement and consultation in determining the best ways to 'hear the voices' of the Afghan community, and an understanding of how Afghan women and men experience health care during pregnancy, at the time of birth and over the first months after having a baby.

In designing the study, we drew on the experience of using similar methods to design and conduct the *Aboriginal Families Study* in South Australia in partnership with the Aboriginal Health Council of S.A.⁹ This project has demonstrated the importance of early

and ongoing community engagement in research and benefits of keeping community and policy goals in mind right from the start.

Two advisory groups were established early on in the project. A Community Advisory Group comprised Afghan women and men from the local community. The roles of the group were: to provide community perspective on ensuring the questions and processes for collection were right; interpretation and dissemination of the findings; to facilitate further consultation and community engagement; and to provide a conduit between the partnership and the community. The purpose of the Sector Stakeholder Advisory Group was to:

- facilitate advocacy in getting the research questions right from a service and policy sector perspective
- utilise knowledge of the stakeholders to provide advice on community engagement
- contribute to interpretation of the findings and
- to utilise the learnings from the project to provide advice about service and policy development.

In recognition of the critical role bicultural researchers would play in optimising community engagement and ensuring that the voices of the Afghan community were heard authentically, Fatema Fouladi and Sayed Wahidi were employed to establish the advisory group of community members, design and lead the community consultation, recruit participants, conduct data collection and assist with analysis and interpretation of the findings. Both Fatema and Sayed were born in Afghanistan, between them spoke four Afghan languages as well as English, and had strong connections to their communities. This was to be their first experience of conducting research in their own community, and of consultation, undertaking interviews using a semi structured interview schedule, transcribing interviews and completing qualitative data analysis.

The Afghan community members consulted about the design of the project (see page 11) were clear that in asking Afghan women and men about potentially sensitive issues, individual interviews were preferable to discussion (focus) groups. The importance of ensuring anonymity and confidentiality was raised by many during consultations adding further support for interviews.

In designing the interview schedule for data collection the partnership team considered issues raised during the

community consultation (access to information; language and gender of providers; specific issues including depression and family violence), questions asked in a 2008 population-based survey of recent mothers^{10,11} and our original questions regarding women and men's experiences of services at the time of having a baby. The final schedule was semi-structured to ensure that women and men's experiences of care during pregnancy, at the time of labour and birth and in the postnatal months were covered comprehensively. We also wanted to find out about access to health information, responsiveness of health services to participants' social circumstances and use of local services.

Whilst many of the findings shed new light on how women and men of refugee-background navigate and experience the health system at the time of having a baby in a new country, the semi-structured format of the interview schedule coupled with our decision to include detailed questions covering all aspect of care, limited the capacity to explore specific issues in depth. The use of more open-ended questions and "tell me more" prompts would have encouraged participants to provide additional information about their stories.

Most of the community consultation sessions were lively with much animated discussion about the research and about the issues of importance to the community. Whilst those consulted stressed the importance of confidentiality in asking women and men about issues related to having a baby, many freely talked about what may be considered sensitive topics, for example mental health issues. The level of familiarity between consultation participants, shared language and the fact that consultation sessions were not audio recorded may have been a factor in people's comfort in participating. Men, in particular, were happy to discuss issues related to having a baby in Australia and raised concerns about separation from extended family, unemployment and other social stressors. Consultations with existing women's groups were similarly chatty. Groups where women were not known to each other were much more reserved.

The consultation proved valuable as a community engagement strategy and in ensuring that community members felt that the people conducting the study took proper note of the issues and concerns they identified. Our other learning was that many people in the Afghan community are comfortable in participating in focus groups, despite the articulated preference for interviews. Based on this experience there appear to be benefits in combining both quantitative (i.e. questionnaire) and qualitative (e.g. focus groups/in depth interviews) methods in the conduct of research with Afghan and other refugee communities. Such an approach is likely to be acceptable to families and to result in in-depth exploration of issues.

Characteristics of participants

Sixteen (16) women and 14 men participated in an interview about their experiences of having a baby in a new country when their infant was 4-12 months of age.

Table 1 outlines the characteristics of participants. All participants were born in Afghanistan. Two-thirds were of Hazara background reflecting trends in settlement of Afghan people under the humanitarian program in recent years. Half of the participants had been in Australia for five years or less, with all but three participants having lived in other countries after leaving Afghanistan and before arriving in Australia. Twenty-three of the participants had lived in Pakistan. Of the 15 who had completed secondary school, the majority had done so in Pakistan.

Questions were not asked about how people made their journey to Australia or whether they had spent time in detention, however three participants mentioned the experience of living in detention and use of health services during this time.

Several men talked of arriving in Australia before their wives. At the time of the interview twenty of the participants were living in nuclear households and ten with extended family, including the participant's siblings, their partners and children.

Of the 14 Afghan men, half were unemployed. Of the 16 women, one was employed part-time and half had husbands who were unemployed. The majority were holders of health care concession cards.

Five of the 16 women had recently had their first baby. Of the 11 who had had a baby before, five were giving birth in Australia for the first time with their other child/children born in Afghanistan or Pakistan. One woman had one previous child born in Pakistan and one in Australia; five had given birth to their previous child/children in Australia. Several participants had five or six children.

All participants were resident in the Dandenong/Casey region. With the exception of one participant who had given birth whilst in a detention facility interstate, all had accessed care during and after pregnancy from one of the three hospitals of Monash Health and local primary care services. The majority had given birth at Dandenong Hospital.

TABLE 1: Characteristics of participants (n=30)

	Number
BACKGROUND	
Hazara	21
Tajik	6
Pashtu, Afghan or Sadath	3
LENGTH OF TIME IN AUSTRALIA	
<12 months	3
1-2 years	6
3-5 years	6
6+ years	11
COUNTRY LIVED IN BEFORE COMING TO AUSTRALIA	
Afghanistan	3
Pakistan	23
Iran, Syria, United Arab Emirates	4
LANGUAGE SPOKEN AT HOME	
Dari only	12
Hazaragi, Pashto, Urdu, Arabic	11
Dari & other language	5
Dari & English	2
EDUCATION	
Completed secondary school	15
Did not complete secondary school	15
NUMBER OF CHILDREN	
One child	10
Two or more	20
HOUSEHOLD	
Nuclear	20
Extended	10
HEALTH CARE CONCESSION CARD	
Yes	26
No	4

Literacy: Afghan language and English

All of the women and men participating in the study spoke an Afghan language at home.

Participants were asked if they could read and write in an Afghan language. Five participants were not literate in local language, a further three noted that they didn't read or write an Afghan language but were literate in Urdu having attended some of their schooling in Pakistan.

All participants were asked how well they spoke English and how well their partners spoke English.

Of the 16 women, 5 didn't speak English at all or not well, 6 reported that their English was "OK", 5 said their English was "good". The women who didn't speak English well or at all reported that their husband's English was "OK". Of those women who reported that their English was "OK", two had husbands who didn't speak English at all.

Nine of the Afghan men reported that their English was "good" and four as "OK". Half of the men noted that their wives didn't speak English very well or at all.

Family separation

Two-thirds of the Afghan women and men lived with their spouse and children in a nuclear family. Living in extended families is the norm for the Afghan community and the high proportion of nuclear families in this study reflects the level of family separation for humanitarian entrants to Australia. Participants articulated the impact of this in a number of ways including the level of loneliness and social isolation, how information and advice is accessed, and the changing role of men as fathers.

For women without extended family many reported relying heavily on phone calls to their mother who remained overseas. Several noted that they would access health information, advice and discuss their concerns with their mother or trusted family member rather than with health professionals. Issues related to communication, health literacy and isolation from family underpins many experiences of having a baby in new country as articulated by Afghan families in the following pages.

Navigating the Australian health system

The time of pregnancy and early childhood is a time of intensive engagement with the health care system, and for refugee women and their families often their first experience of Australian health care over a sustained period of time. Accessing information about options for care and navigating a complex system of maternity care is difficult, and even more so for women who have recently arrived in Australia, may not be literate in their own language, do not speak English and have no extended family living in Australia.

Interview participants were asked how they located information about Australian maternity services and options available in Australia for care in pregnancy. The majority of women obtained information from their husband, other family or community members. Husbands located information from friends or the Internet.

I knew from my husband and other family friends who used to tell me about pregnancy care in Australia. They also told me that in Australia the health system offers a lot of care for pregnant woman and her child. I knew all these from my husband who has learnt about these from other people. (Female participant)

Several women noted that their husband made the decision about where to go for pregnancy care, often preferring medical care:

I was not happy about going to the doctor's clinic but my husband forced me to go there because he believes that (the doctor) is the most intelligent doctor in the region and the appointments were easily available without extended waiting period. (Female participant)

Several noted that they received little or no information from health service providers about the maternity options available to them.

No, I never knew about the system because I was new in this country and it was the first time that I was having a baby in this new country. (Female participant)

General practitioners were the first point of contact for women when pregnant and there was a noted reliance on these practitioners for information on options for care and decision-making regarding booking at a hospital for birth and enrolment in one of the models of maternity care. The majority of women were referred to GPs who were accredited shared care providers or to specialist obstetricians. In general women were

very accepting of their GP's referral, valuing medical care for pregnancy yet on the other hand unaware of alternative options for care.

I had all the appointments at the doctor's clinic where I had my check-ups with a doctor. My GP sent me there. For hospital booking I had to go to the hospital. (Female participant)

Language services and communication

There was some diversity in women's experience of language services during check-ups in pregnancy. Several women noted that their husband interpreted for them.

We have never had interpreters because we never needed one (husband interpreted) and they also said that it was very expensive on the government as well so we never asked for one. (Female participant)

No I didn't need an interpreter ...my husband would come with me for all the appointments and would ask them about anything that he wanted to know. (Female participant)

Others reported that an interpreter was booked for the first antenatal appointment at the hospital clinic. Two women (attending antenatal care with a GP) requested an interpreter and were connected to a telephone interpreter.

For many women the issue of the gender of the interpreter was of major concern.

I was not comfortable with male interpreters at all; therefore, I had to keep all the questions to myself because it was embarrassing to ask the doctor about any feminine issue through him. (Female participant)

Several women reported that when provided with an interpreter, their dialects were different and communication and understanding were difficult.

He was good but he was a Dari speaker and I was Hazaragi speaker and this difference of the language had made it difficult for me to understand everything that he said. (Female participant)

Antenatally, professional interpreters were less likely to be offered or available for routine clinical screening at subsequent visits (i.e. after the booking visit).

When I did my glucose test I had no interpreter booked for that appointment. After consuming the fluid my condition was very bad. I was fainting but I was not able to let the staff know about my condition. I had to wait until I was better. If I had an interpreter I could have let them know about my condition. (Female participant)

Some women also reported having young interpreters was not helpful, noting that the interpreters were uncomfortable with issues of a sensitive nature and were not knowledgeable in the content area.

I do want to suggest that for the maternity ward the hospitals should employ interpreters who have the experience of giving birth to a child. Their experience will assist them to communicate more freely. (Female participant)

Women who attended pregnancy check-ups mediated by a female professional interpreter who spoke their language were overwhelmingly positive about the experience.

...they always had interpreters ...the interpreters were all very good they were doing their best to make communication between two people who were not able to understand each other's language. (Female participant)

Yes, I had interpreter booked for every appointment and if due to any reasons the interpreter was not there or I was late, the midwives used to cancel my appointment and reschedule it with an interpreter. So I had all my appointments with an interpreter except for one time when my husband did interpreting for me. The interpreting service was great and the interpreters were skilled professionals. (Female participant)

Twenty participants indicated that they required language services to assist them in understanding what was happening in labour and birth. A female interpreter was present for part of one woman's labour, and a telephone interpreter was accessed for another. Most husbands were with their wives during labour and for women who required language services there was a reliance on their husbands or family and friends to interpret. Women appreciated the use of simple language, but often could not understand what was being said, with several women noting that their husband's English was insufficient at this time.

Yes, I did (need an interpreter) but there was none. They relied on my husband's insufficient English for communication. (Female participant)

They were trying to explain things for me but I mostly didn't understand. I would only reply back with yes or no. They were trying to communicate with me through my husband but his understanding of English language was not so good to be able to understand everything. (Female participant)

During labour and at birth my husband did all the interpreting for me although his English was not good enough for interpretation ... but they didn't even call telephone interpreter. (Female participant)

Two women reported that their husband was not present during the labour or at the time of their baby's birth and specifically requested an interpreter. Professional interpreters were not provided and their husbands were called on the telephone to interpret.

Yes, I needed one but they didn't had any. So they called my husband and he was interpreting for me over the phone as there was no interpreter available. Even though I asked for one I guess they thought that since my husband was interpreting they wouldn't call an interpreter. (Female participant)

Everyone received a home visit after the birth of their baby. Many received more than one visit from a midwife or maternal and child health nurse at home. If an interpreter was used for pregnancy appointments, on-site interpreters were usually booked for home visits. In some cases telephone interpreters were used and women felt comfortable with this as they could discuss sensitive issues with the nurse without others in the room.

... that (home visit) nurse always used telephone interpreter who interpreted for me professionally. Through the interpreter I was comfortable to ask the nurse about anything ... I am happy with the work of interpreter and the nurse who visited me at my home after birth of my baby, because through her I was able to understand everything. (Female participant)

Interactions with health professionals

Going to those appointments had provided me with a very good opportunity to come out of my house and meet with people (doctor and midwife) ... seeing people during those lonely days had a positive impact on my health. (Female participant)

Women and men were generally positive about their interactions with health professionals and their experience overall. This was particularly the case when the experience of having a baby in Australia was compared to the experience of care in pregnancy, labour and birth in Afghanistan or Pakistan. Many commented that health professionals were kind, respectful and provided "humane care". Aspects of care most valued by participants included clear explanations about what was happening in relation to the health of the woman and the baby and about procedures and tests, particularly when simple language was used and the health care provider checked with women and their partners that they understood.

Yes, they were very nice and very slow, and I understand them easily. If we did not understand, we asked for clarification to understand properly, because this is for the benefit of our baby. (Female participant)

Participants were also appreciative when health professionals showed interest in them and their family, and were available when they needed them especially during labour and birth and in the postnatal period.

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)

There was significant gratitude for the support provided by maternal and child health nurses.

I can discuss with the maternal child nurse everything because I can trust her and she never deceive me. In her I found my mother. So yes, I can discuss with the nurse anything about my life. (Female participant)

Both men and women were asked a series of questions about experiences of being treated unfairly or discriminated against by health professionals at any stage during pregnancy, at the time of giving birth or since the baby was born. Six women and one man reported interactions with health professionals that were perceived as disrespectful, rude or stereotyping.

Yes, the nurse did ... she was mimicking my words and tone in a very childish way. She was thinking of me as inferior to her otherwise she wouldn't treat me like she did. I think she was thinking of me as a refugee woman who could not speak for her own right, so whatever she did would go un-noticeable. (Female participant)

I rather found (the GP) racist because the doctor normally spent about an hour with those pregnant patients who could speak the doctor's language but at my turn the GP always asked me to leave only after 10 minutes. That would mean that I had to keep my queries to myself. (Female participant)

One man reported his distress and his wife's distress at the reaction of a care provider when the couple arrived at hospital in an ambulance.

...the hospital told me you can bring in your wife (in labour). I rang the ambulance and they picked up me and my wife. In the corridor the nurse's behaviour was not good, she belittled us, she told us you should come by your own car or taxi but we called an ambulance. Her behaviour annoyed me and my wife. We did not have full information, we are new refugees, we don't have our own car. (Male participant)

Not having a choice of female care provider and being cared for by a male were seen as disrespectful and distressing.

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

...the biggest problem for me was being treated by a male doctor and questioning and answering the doctor through a male interpreter. That put a limit to my options of sharing my queries and health problems with a doctor. The hospital had never offered me any option to have female interpreter rather than male and you know due to conservative upbringing we can never be comfortable around a man (who is not related) especially if it involves female body part and discussion regarding that. So, my first experience of having a child in this new country had a lot of difficulties associated at every phase. (Female participant)

The preference for female care providers, as well as interpreters, was a recurrent and strong theme. For many the gender of health professionals and interpreters was critical to how women engaged with care, including their comfort in disclosing health or family concerns, asking questions or seeking clarification; and how confident and comfortable they felt about future health care visits.

One of the things I and my wife were worried about was the matter of male and female doctors. My wife and I wanted the doctor to be a female not male, but unfortunately it was male doctor, and she also wanted the interpreter to be a female but he was male. It was very shameful and uncomfortable for my wife. She told me she asked for a female interpreter but they didn't listen to her. She couldn't tell her personal problems to a male interpreter as in our culture it's not right. She was very upset about that. (Male participant)

Whilst many understood the constraints of the health system in relation to choice regarding gender of the provider, some had a sense that care providers (including community-based providers and hospital-based staff) didn't fully understand the importance that many Afghan women place on female health professionals and interpreters.

Being treated by a male doctor and having male interpreters were the only thing that I didn't like during my pregnancy care. During my appointments and tests I have persistently requested for female staff and they have kindly considered it but had also warned me that in an emergency I should prepare myself for treatment by a male doctor. I agreed but only for emergency situation. (Female participant)

I'm not sure they realised how important (having female health professionals) was. (Female participant)

Trust was noted as an important positive element in women and men's relationship and interactions with care providers.

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

How participants perceived the relationship with health care providers was a salient factor in not wanting to complain or cause offense to a health care professional as they are considered an expert and their advice is not to be questioned. This impacted on what was shared with health care professionals and access to information. For example one woman reported not receiving a 6 week check-up with a GP and knew that her friends had pap smears at this appointment. The participant did not want to inquire about this with her GP for fear of offending her doctor.

Experiencing the health system

IN PREGNANCY

Whilst most women and men reflected on their experience of their care in terms of their interactions with health professionals, issues related to the availability and organisation of care were also raised.

Several women commented on the limited capacity of services to offer choices that accommodated their needs. For example, one woman reported she was not given the option of midwifery clinic care *"I was sent to a female doctor for pregnancy care because the midwifery clinic was over crowded."* Women also reported that they could not be admitted to hospital when they arrived to give birth as the hospital was *"too full"*. They were told to either go home and return later, or sit in the waiting room.

Some participants commented that the time allocated for antenatal appointments was too short.

Although my doctor never allowed me to spend enough time with her, but in looking at the test result and my queries about treatments she would talk me through some remedies or replacement that could assist me to overcome my (vitamin) deficiency. I needed time to understand this... but time restrictions never allowed me to obtain this information from her. (Female participant)

Of the seven female participants who had heard about childbirth education classes provided by the hospital, most said they *"weren't invited"*. Several noted they would have liked to attend classes.

No, we did not attend any of the group programs because we didn't know about them. We would be interested (in attending) but we didn't know (about the program). (Female participant)

For those women who had heard of childbirth education classes, there were significant barriers. Women commented they could not attend due to being too busy with home duties, caring for their other children, or because their husbands were not available to drive them to the classes. Lack of language services was another barrier to attendance:

Actually there was program in the hospital, how to grow a baby, but there is no interpreter, so you could not participate. If you could understand English you can participate, but she (my wife) couldn't and there was no interpreter. So by the lack of interpreter my wife could not attend and I was busy those days. (Male participant)

When the interviewers asked participants about attendance at childbirth education there was a diverse range of responses. Some participants perceived that a childbirth education program would not be necessary as it was “just for women having their first baby”. Others noted that they had previous experience of caring for the babies of extended family members or friends, or it was not appropriate for men to be involved in discussions with others about private issues such as pregnancy, labour and birth.

The one woman who had attended childbirth education interstate, noted:

... the greatest benefit of this class was presence and involvement of husbands because it was a couple oriented (whole day) education session. There were three different sections of the session. That class was very effective to make husbands understand what their wives were going through such as they were being asked to carry different weights equivalent to weight a pregnant women carried during her pregnancy. After attending this class I have seen positive changes in my husband. He had become more caring and had more understanding of my condition.
(Female participant)

POSTNATAL HOSPITAL STAY

Most women stayed between 1-2 nights in hospital following birth with some staying up to 5 nights (usually following a caesarean section). One woman was discharged the same day as giving birth (unplanned discharge). The majority were satisfied with the hospital care provided after the birth. Both men and women appreciated that the baby was checked and ‘tested’ regularly, that when help was needed someone was there, and that the staff were kind and comforting. Many commented on the cleanliness of the ward. More negative comments about the hospital stay were made by the men particularly in relation to staying with their wife. A number of men couldn’t stay as long as they would have liked given that there were other children at home to care for. Some men wanted to stay overnight, especially those whose wives spoke limited English. The absence of extended family was noted as a particular problem in that there were no female relatives to support women in hospital after birth and no family members to care for other children to enable men to be with their wives. There were additional issues raised about the restricted visiting hours and women not understanding why they could not leave hospital earlier.

POSTNATAL CARE AFTER LEAVING HOSPITAL

Maternal and child health services appeared to have more flexibility to provide longer appointment times and visit women at home. Participants commented on how much they appreciated the length of appointments and “having time to talk”; being visited at home; that clinics were located close to home; and having the opportunity to get to know the maternal and child health nurse over a number of visits.

I missed my appointment with them because my husband was at work so they contacted me and organised a time to come at my home to have the check-up done. It was good they came to my home. They are very good people.
(Female participant)

Health literacy and access to health information

One of the aims of the *Having a baby in a new country* project was to examine families information needs; where and how Afghan women and men access information about pregnancy, birth and having a young baby; and what form this information takes.

Of note, only three of the participants reported receiving written health information in their own language during pregnancy, with the majority reporting that information was given verbally by health professionals at antenatal visits. As noted earlier in the report, many talked of accessing information related to pregnancy or child health via the Internet.

*First of all we go to the nearest hospital - we call them. If we can't get much information from them, we go directly to the internet, to Google. We found from searching Google we can easily get information for my wife's health, and how to look after the baby, and about the hospital and any other issues.
(Male participant)*

Whilst few reported that health care providers used pictorial information in paper or digital form, those that did were appreciative of this approach, some noting that the picture the midwife generated was very helpful in understanding how the baby was growing or what would happen in labour.

Overall, women reported that the tests they had as part of their antenatal appointments were well explained by midwives, however, less often explained by the GP. Some noted that they didn't receive test results unless there was a problem "No, they never explain the result of the test as they explained the test itself." A number of women were referred to a specialist diabetes clinic following glucose tolerance testing. Women identified this clinic as providing good information about managing diabetes during pregnancy and appreciated the level of care and clarity of explanations.

Men and women identified several key people and places as sources of health related information. Women generally asked their husband, their mothers who lived overseas, or friends before seeking information from their doctor or maternal and child health nurses. Men reported asking friends who had been in Australia for longer than them. Most participants reported that the family doctor was the main source of information about the health of their children.

Women (and men) appreciated being provided with any information regarding their options for care, pregnancy, their newborn child and the services available. For

example, some were provided with information regarding nutrition in pregnancy, breastfeeding, caring for a newborn or health issues (the latter in Dari). However there was no consistency about what information families were given, or from whom.

Psychosocial inquiry and support

It is increasingly recognised that the social circumstances and stressful life events experienced during and after pregnancy impact on the health of women and their infants. Australian guidelines promote screening for depression in pregnancy and postpartum and assessment of social health issues. Psychosocial assessment check-lists are emerging both in the maternity and maternal and child health systems, at a local and state-wide level.

The women were asked if a health care professional had asked them about a range of issues (e.g. if they had felt sad or depressed; had housing issues; or relationship problems) during pregnancy and since the birth of their baby. Around two-thirds (10/16) reported that a doctor, midwife or nurse asked about their family in Australia and overseas; eleven had been asked about sadness or depression predominantly by maternal and child health nurses; six reported being asked if they had relationship problems; and three women were asked about violence at home. Very few women were asked about housing, financial or legal concerns. (Table 2) Overall women reported that maternal and child health nurses were more likely to ask about their social circumstances than midwives or GPs.

TABLE 2: Number of women reporting that a health professional asked about emotional health and social circumstances during pregnancy or after the birth (n=16)

	Doctor asked	Midwife or nurse asked	No-one asked
About your family here in Australia and overseas?*	4	9	6
Whether you felt sad or depressed?*	1	11	5
If you had relationship problems?*	1	6	10
If you had financial worries?	0	3	13
If you had housing problems?	0	2	14
Whether there was violence at home?*	1	3	13
If you or anyone at home had legal problems?	0	1	15

* Total number >16 when women reported both a doctor and midwife/nurse asked

All of the men had been in contact with health professionals whilst attending appointments with their wives at some point during and/or after pregnancy. Men were far less likely to be asked about their concerns at these appointments. A small number of men reported that no-one asked them about their circumstances. Four were asked about their family and about the health of their wife and new baby. Three were asked whether they felt sad or depressed. Only one man was asked about financial worries, none were asked about housing or legal problems.

Participants were asked whether they would have liked to be asked about things happening in their lives, and if they had received help with issues such as housing issues or financial worries. Some participants reported that they wished they had been asked by a health professional about what was happening in their life.

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

I think they didn't ask me all these questions because they might think that it was related to my personal life and was not related to health. But I would have liked them to ask me about my parents and family and other things in my life that concerns me, but I cannot encourage myself to initiate conversation about my life. (Female participant)

I wish my family doctor should have at least asked me about these issues, particularly about my housing problem because (the doctor) already knew about my housing issue as she had signed the related document for me. But the doctor never asked me anything about any of these issues. ...I never discuss my family matters with health professionals but my housing problem had left me helpless so I brought it up with my family doctor. The response and practical assistance disappointed me as I didn't see any change or get any help in my living condition and I am still living in two bedroom unit with five children. (Female participant)

The majority, however, didn't feel that inquiry about social circumstance was the role of health professionals. They saw these issues as private and personal matters best discussed with other family members.

Yes, I can talk to them (health professionals in pregnancy) about my health problem but don't feel comfortable sharing with them my personal and domestic affairs.

*What could be the reason for that?
(Interviewer)*

*I don't think of any practical reason but one thing that I understand is that it is not part of their job to listen to our family problems.
(Female participant)*

I have only visited her (maternal and child health nurse) twice at her centre and I never knew that I could talk to her about my personal concern and worries, so I didn't talk to her about anything. (Female participant)

Women reported that their husbands and/or mothers were the family members they would most likely discuss 'social' issues with and recognised the limitations of raising these issues with extended family and other community members:

I often share it with family friends up to certain extent because I cannot trust them to discuss particular affairs of my life. (Female participant)

I always discuss it with my husband and my family overseas. I can also talk about it with the MCH nurse. My husband is the first point of contact then my family overseas then community member only if I was desperate enough to share with them but I cannot

discuss my family matters with community members because I cannot trust them and I am afraid of being a topic of gossip in the community. (Female participant)

Of the participants who reported that a health professional had inquired about social issues the majority noted that this had been helpful.

The midwives and nurses were the best emotional support for me during entire time because I was going through the toughest phase of my life. The MCH nurse often calls me at home to check that everything is ok with me and my life ... she has not only been a verbal support for me but had also linked me with support services. (Female participant)

Participants were asked if they had used services or attended groups during pregnancy or in the months following birth. Women were more likely to report being connected to local services and groups where families meet with their infant or other children. Ten of the 16 women had participated in playgroups with other Afghan families and half or the women reported attending new parents groups. The majority of men were not familiar with groups for new parents however a third were aware that their wife was attending a playgroup with other Afghan families. With the exception of Centrelink, AMES settlement services and the Migrant Resource Centre very few women and men had used local services (such as Foundation House, Refugee Health Nurse, Afghan women's groups) or were aware of their existence.

TABLE 3: Use and familiarity with local support services during pregnancy and months since birth

	WOMEN			MEN		
	Have attended/ used service	Familiar with service	Didn't know about service	Have attended/ used service	Familiar with service	Didn't know about service
AMES settlement services	9	4	3	4	1	9
Foundation House	3	0	13	2	1	11
Refugee Health Nurse	0	1	15	0	4	9
New parents groups	8	0	8	1	2	11
Playgroup with Afghan families	10	1	5	1	5	7
Afghan women's groups	1	0	15			
Migrant Resource Centre	7	6	3	1	3	9
Afghan Association	0	1	15	1	2	10
Asylum Seekers Resource Centre	1	1	14	0	3	10
Healthy Mothers Healthy Babies	3	0	13	1	2	9
English classes other than AMES	4	0	12	1	2	10
Legal services	2	6	8	2	3	9
Centrelink	15	0	1	13	1	0

Traditional practices

Nearly all of the women and half of the men identified particular cultural practices that they wished to practice shortly following birth and in the extended postnatal period. There was a range of customs. These included: reciting verses of Azaan (Muslim call to prayer) as first sound; sweetened water as first taste but after first wash; performing the first wash before the first breastfeed; allowing for an attendant to be with the women for the first few nights after birth; maternal diet and showering following birth; application of Soorma (cosmetic kohl) on the infant's eyes; tightly wrapping infants; circumcision of male infants.

Only two of the Afghan women were asked by a health professional if there were particular practices or customs they wished to follow.

I was being asked by the midwife after of birth that if I wanted to perform any religious practice I had their permission to do so. I was very pleased for this opportunity. They respectfully stood aside while we were performing all the acts. (Female participant)

Overall women weren't concerned about not being asked, noting that they could perform most of the cultural practices anyway. Several said their maternal and child health nurses questioned them about why they follow particular customs - these women noted their appreciation of the nurse's interest in them and their culture.

The questions about traditional practices prompted a number of women to reflect on encounters with health professionals that caused distress.

In the first night after birth of my baby a nurse had asked me to have a shower but I refused and told her that culturally we don't do that because our elder had told us that after birth the body is very warm or rather hot that leaves the joints apart, therefore, pouring on warm water may keep it apart forever and that may result in joint pain or back-pain later in life. The nurse listen to my argument with gentle smile but forced me to have a shower due to hygiene reasons and to avoid infections. (Female participant)

Yes, the midwife who visited my house once and I had wrapped my baby in a piece of cloth and tied with a thin fabric on top to stabilize her in a position. It is traditional practices that I have learnt from my mother and aunties. The midwife who visited me in my

house after birth of my baby didn't appreciate it and acted abruptly by un-wrapping the infant and throwing away the piece of cloth to the far end of the room. I felt really embarrassed and had the growing feeling that she disrespected my culture. She could have explained the side effects of practising that tradition but never did. (Female participant)

The role of Afghan men as fathers in Australia

As described previously, men played a key role in providing interpreting support for their wives, both at pregnancy and postnatal appointments. For women who required language support in labour, overwhelmingly this was provided by their husbands.

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

In reflecting on their role as fathers in Australia, many men talked of changed responsibilities without extended family support. Being involved in pregnancy care was noted as necessary given the absence of female relatives. Many welcomed this.

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)

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 throughout pregnancy, childbirth and in infant care.

... there is a big difference in Afghanistan, the father doesn't normally have a role during the pregnancy, doesn't look after the baby ... everything is done by the mother and grandmother. 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)

Men talked of additional home duties, their role in providing transport, caring for a new baby and other children, coupled with their concern about managing this without extended family.

... in Australia there is a lot of support and help during pregnancy. A lot of information about how to take care of a baby. Here, all the time, I was with my wife but in Afghanistan, my father, mother and other relatives would take care of my wife and child. But here I play a hundred roles during pregnancy and at appointments, I accompany her, but in Afghanistan the culture is different. Sometimes it is difficult. (Male participant)

Half of the men (men who completed interviews or the husbands of the female participants) were unemployed (15/29). Of those employed, half (7/15) were employed full-time. Several men noted the critical importance of employment in having financial security but on the other hand, how full-time employment made supporting their partner during and after pregnancy difficult, particularly in the absence of extended family or few friends.

I don't have a job. If I had a job I couldn't help my wife. (Male participant)

Several men commented that they were pleased to have the opportunities that came with a different role as fathers in Australia including understanding more about the health system and health issues, supporting their wife during pregnancy and after the baby was born, and in caring for their new baby.

Well the difference for me here compared to Afghanistan is that I feel a lot safer here. Also in Afghanistan I wouldn't go to appointments with my wife... but here I can spend the time with my wife... (Male participant)

Some men whose wives could speak English and drive a car reflected that their wife was able to attend appointments independently. In this case, men reported a more traditional role particularly in relation to pregnancy and postnatal health care with less need for them to attend antenatal and maternal and child health visits. This often resulted in the husband not engaging in his wife's or infant's care and missing out on health and local service information.

The interview study with local stakeholders is a complementary component to the primary study *Having a baby in a new country: The experience of Afghan families* to explore the views and experiences of Afghan families' use of services in the antenatal period and first few months after childbirth. The study involved interviews and focus groups with health care professionals and other local key stakeholders working with the Afghan community in the south east region of Melbourne.

A total of 21 interviews and focus groups were conducted with 34 participants. The participants included midwives, general practitioners (GPs), refugee health nurses, universal and enhanced maternal and child health nurses, obstetricians, bicultural workers, Healthy Mothers Healthy Babies team members and several other care providers. The majority were female participants, three were male.

Quotes from the discussions are used to illustrate and illuminate key points. In order to maintain the anonymity of the participants, quotes are identified as midwife, medical practitioner, maternal and child health nurse or community-based care provider (this includes bicultural workers, Healthy Mothers Healthy Babies staff, refugee health nurses, enhanced maternal and child health service staff and others), unless otherwise stated.

Identifying families with a refugee-background

Being aware of patients' migration experience, particularly if they have refugee experience, can assist care providers to tailor the care provided to meet specific needs. There is currently no agreed defined way of identifying people with a refugee-background, and asking about this is not necessarily straightforward. This adds to the complexity of providing care to families with a refugee-background.

All service providers taking part in the study were currently providing care to Afghan clients/patients. This ranged from seeing one Afghan family per week to seeing up to five families a day. Much variety was used to describe the local Afghan community with diversity observed across ethnic groups, education levels, length of time in Australia, English language proficiency, adherence to religious and traditional practices, ascribed gender roles and degree of acculturation. Generally, most providers could identify on a one to one basis that their clients were Afghan, or of Afghan descent as their 'country of birth' or 'language spoken' was recorded on client records.

Apart from refugee-specific services, it was difficult for all service providers, from an organisational perspective, to identify whether people were of refugee-background based on their service client records.

It was not standard practice for service providers to record whether clients had a refugee-background in medical records. Interviewees suggested that as their clients' country of birth is recorded and the need for an interpreter is ascertained, this information could be used to identify the refugee population attending the service. For most care providers an informal note on clients' records would be the only record of someone's refugee-background.

In our database we have no formal way of finding that out...It would only be if somebody added a note on the front of the history to say asylum seeker, refugee, with a date that they arrived. (Maternal and child health nurse)

When a referral was made from a refugee-specific agency to a health care provider, the background of a client was obvious and therefore refugee-background assumed. Some health service providers, mostly community-based care providers, reported that it was important to identify whether their client had a refugee-background, in order to identify their potential needs. This information also helped those community-based providers to determine which issues and tasks to prioritise and what supports to put in place, such as linking them to services or community-based programs

to address specific needs. Care providers would often determine this by asking several informal questions about their client's life, which also helped to establish a rapport with new clients, rather than asking directly about refugee-background.

I naively thought...it was because they all had the birth date the 1st of the 1st, I thought oh yeah I can tell. But now...I actually ask them, how did you come to Australia, what was your journey and find that out. And they're actually really interested that you ask.
(Maternal and child health nurse)

We ask them about what sort of accommodation they're living in, what they and their partner's employment status is, often then it comes out if they're not working or they're on benefits or whatever the situation is, but we don't specifically ask them if they're refugees. (Midwife)

This girl had three children drown so you don't bring her into the room...and say "is this your first baby". Now we're not ignoring but you've got to be very aware of the background and the trauma they have had.
(Community-based care provider)

In contrast, several health care providers noted that identifying whether their client was of refugee-background was not important as it would not have altered the course of care provided. The view that all women and families are to be treated equally (the same), within the public health system, was more apparent in some services than others. For some providers, there was a limited awareness of the experiences that refugees might have had previously, and currently face, and the subsequent impact on their capacity to voice their concerns or the ability to access services when needed.

I suppose we tend to treat everyone pretty much the same ...it doesn't really make a big difference to what we can offer them.
(Medical practitioner)

Several others could identify the value in knowing the refugee-background of their patients, as they would perhaps approach some issues more sensitively, or inquire more about whether family support was available. However, they were uncertain whether knowing this characteristic about their clients would change any aspects of medical care that they could provide. Further, some providers felt that asking clients about their background could result in disclosure of information that they did not feel they could respond

to and deal with directly. Beyond referring to social workers, care providers felt there was little they could do to assist with refugees requiring support.

I think most of the doctors if they saw that tick (client is a refugee) they'd just sort of glance on it and then turn the page. They'd bear that in mind when they're asking questions and they probably ask the questions a little bit more sensitively than they would otherwise but that's about as much as I think it would change. About the same way that if it was an Aboriginal or Torres Strait Islander and they ticked that. I'd look at it and say "okay, that's good to know, I'll screen them for diabetes earlier" maybe and then that's all I'd do. I think we're a little bit ignorant about what special needs refugees need or have.
(Medical practitioner)

One health professional suggested that not all clients would want to be identified as a 'refugee' per se, so it would be more important for care providers to identify other aspects of their lives that could indicate particular supports that may be required.

It depends on whether that person wants to be identified as being a refugee so that's obviously an important thing too...perhaps newly arrived that's important...and that's all about personal choice.
(Maternal and child health nurse)

Providing care to Afghan families

HEALTH AND SOCIAL ISSUES IN THE AFGHAN COMMUNITY

The Afghan community living in the South East were not considered to have physical health concerns that were different to any other refugee or cultural group that providers would see. This was particularly so in the antenatal sector.

Several social issues were identified that were seen as prominent for Afghan families. Social isolation was the most common concern, alongside mental health issues such as depression, anxiety and post-traumatic stress associated with their migration and settlement experiences. Most community-based care providers acknowledged that it was likely that depression in pregnancy or postnatally were not being identified as it was difficult to differentiate clinical depression from feelings of sadness due to missing family and feeling homesick.

Several other social issues were identified by those providers working in the community setting. These included a lack of extended family presence, limited English, family intergenerational issues, limited access to transport, low health literacy, housing, unemployment for men, lack of childcare and poverty. Providers reported that most of their refugee-background clients from other origins as well were in similar situations.

Providers in community settings also reported that many women struggled with self-care and exhaustion, particularly with multiple children to care for. Family violence was noted as an issue of concern. All of these were compounded by a lack of knowledge about what services were available to help, where they were located and how to access them. Some of the issues experienced by Afghan women were thought to be quite different to the experiences of other groups of women of refugee-background. For example:

Compared to other groups, like the Sudanese women...they come along for their first pregnancy and they didn't speak any English and we'll get an interpreter and they'd all be going to school, and by the time they've come back and having their third baby I don't need the interpreter and they'll sit and chat to you and...whereas the Afghan women they don't...they keep their traditional role going very much when they get here. (Midwife)

For some service providers, Afghan male asylum seekers were their main clientele. A gamut of other health, social and economic issues were raised for this population group.

IDENTIFYING PSYCHOSOCIAL NEEDS AND PROVIDING SUPPORT

Assessing for social and emotional wellbeing and mental health issues was conducted differently in each setting and was often adapted by the providers. In some services, the Edinburgh Postnatal Depression Scale (EPDS),¹² a ten item screening instrument for identifying depression, was the standard tool to assess women's mental health. Some service providers were aware that it was currently being introduced to their service but had not yet applied it. For those who were required to use the tool (e.g. maternal and child health nurses), it was rarely used as prescribed. Challenges were reported in administering the scale with Afghan women, as well as other culturally diverse and non-English speaking women. Care providers felt that particular words used in the scale were difficult to explain to women.

We have to explain things differently to them. Self-harm...they often don't understand...I talk about that in various terms, I talk about do you feel like you want to run away, do you want to hide under the doona, or have you thought or planned about killing yourself and really putting it out there, 'cause it's just too vague for a lot of women. (Maternal and child health nurse)

The Edinburgh postnatal depression scale but I must admit I don't use that ... I ask them things like how are they feeling in their heart, I ask them are they sleeping, are they eating, do they cry a lot, and dad's will say 'oh she cries all the time.'
(Maternal and child health nurse)

It was more common for early childhood workers such as maternal and child health nurses and some general practitioners to ask women and their husbands what was happening in their lives as indicators of emotional wellbeing.

Always ask them how they are, and I've learnt to ask the questions quite differently now because postnatal depression is not a concept Afghan women understand but feeling very sad and missing your family and then asking them about other things. (Maternal and child health nurse)

Recognition of the circumstances of the lives of refugees made it difficult for some care providers to differentiate between the traumas they had previously experienced compared to symptoms of postnatal depression.

When is it postnatal depression and when is it trauma, you can't distinguish...a lot of women are just sad because their family's not here, and often talk about they feel guilty 'cause they're safe and they just...everything that's on the news they just worry, that must be horrible. (Maternal and child health nurse)

For one group of care providers, a different assessment tool was used and found to be helpful.

We have our own tool where it's a rating scale, how have you been feeling over the last week, it's not 0 to 10, it's just a scale. And we do that at the start and we do that at the end (after 3 months) so that we can compare... there's a significant clinical change, and we show that, say look where you were and look where you are, so it's something that's tangible that they can say oh yeah OK, yeah I remember when I first spoke to you this is where I was. (Community-based care provider)

Care providers identified a range of factors that contributed to difficulties in assessing and tracking women's social and emotional wellbeing during pregnancy. These included: lack of continuity of care; and poor systems for documentation and communication between care providers, resulting in fragmented care provision.

It depends on the individual midwife at the moment, when they ask about emotional health and wellbeing. And obviously the most unfortunate thing about the whole service in my opinion is that lack of, continuity of care. If you saw someone regularly then you wouldn't...ask the same questions and I think the documentation for emotional health is virtually very little. So for us to be able to communicate what happened at each visit is almost impossible, we start again, I start again with a woman and if she's telling me she has physical problems sometimes that will lead to the emotional health issues. (Midwife)

Some care providers indicated that if a midwife had already completed the psychosocial assessment with a woman, usually undertaken at the initial hospital booking visit, then there is no need to ask again at later antenatal appointments.

I don't, but the midwives at the booking in visit have asked quite a lot of those social questions...I don't tend to repeat it because I know that it's already happened. (Medical practitioner)

I should, but I don't really screen for things like domestic violence or psychological status. (Medical practitioner)

Working with an interpreter, particularly a male interpreter posed problems for some care providers in obtaining enough information to assess sensitive issues for women.

It depends on the interpreter...some of the interpreters are very au fait with the service and know it very well and understand what we do, where other interpreters are...unsure. The other morning, it was a male interpreter... it limits your conversation with the mother and I wonder how much she didn't say because it was a male interpreter. (Maternal and child health nurse)

It would be more appropriate if we had a female Dari interpreter. I feel the medical staff and the midwives might hear more things if they (Afghan women) felt more comfortable and even though they accept this (male interpreter) who is terrific I know there are reservations because he's male. (Community-based care provider)

Length of appointment time was commonly reported as a barrier for assessing emotional wellbeing. Given that most providers were not satisfied with the EPDS, it was acknowledged that talking to women to gauge and respond to their psychological health took time that was not factored in to rigid appointment structures. A lack of time was reported in both antenatal and postnatal settings, where medical and other physical health assessments took precedence.

Generally half an hour you just can't. There was one woman that comes to mind... and I knew there were...I just felt there was something not quite right but I just never had that time to really sit and talk to her...and I haven't seen her for a while so probably she hasn't come back. (Maternal and child health nurse)

Yes we have to (assess for mental health) we have a sheet that helps guide us through that (mental health assessment). The visits are

quite short; they're only half an hour visit each so obviously the clinical stuff gets done first.

And if you run out of time? (Interviewer)

*Yeah, the other stuff doesn't get done.
(Midwife)*

A medical practitioner, who spoke languages other than English, reported difficulties with the shyness and reservations of Afghan women to disclose personal information.

*Yeah, but no-one tells me anything much. Even though I can understand their language...Dari and Urdu ...and they can speak the language
(Medical practitioner)*

However, this was not a problem for other providers who visited women in their own homes, identifying that women in the home setting were more likely to disclose personal information, even if it was the first time a provider had met them.

You want to get a picture of what's going on for this family...We are quite specific and quite detailed about the questions that we do ask them around mental health, illness, around have they had any thoughts of suicide or self-harm, we're quite direct, and have they had an experience of family violence and that's something that does come up quite a lot.

And families share that with you? (Interviewer)

*Yes. The majority do, for whatever reason they just... they do, they divulge a lot of very personal information on that first visit.
(Community-based care provider)*

For some, there was a sense that women felt safe in their own home, an environment that is familiar to them, which might not be the situation in a hospital or medical clinic. The environment was noted by some as conducive to clients being more likely to open-up to care providers, coupled often with more flexibility in the time providers could spend with women.

Many interviewees raised concerns about the consequences of screening and identifying mental health issues with women of refugee-background. Although care providers knew of services to direct women to, there was apprehension as to whether women had the capacity or desire to access services and concern that this left women in a fragile and vulnerable emotional state.

*But...I found with my experience that you need to be very careful when you are dealing with that sort of issue with these families because if you strip away their holding together mechanism by picking at them and pulling it apart you leave them very vulnerable because a lot of them won't do anything about it, they're not going to talk to their GP about it, they're not gonna go and see mental health services. So if they're holding together and managing then it's cruel to strip away their holding...you say well there are all these services out there but you've got to get them to use them, and that's what I find is very difficult
(Maternal and child health nurse)*

For general practitioners, the multiple appointments required during antenatal care provided them with opportunities to follow-up on mental health issues.

They (Afghan patients) are not big taker uppers on psychology, they're really not.

Because they don't have an understanding of mental health? (Interviewer)

Yeah, they don't. That's right, that's why they somatize. You just have to keep plugging away. I've got one now, she's not a pregnant patient but Afghan patient, she's finally seeing a psychologist.

*It has taken your encouragement to do that, or do you make an appointment for them?
(Interviewer)*

Yeah, I have done that, I just say I really want you to see this person, I think it's important.

And they're okay with that? (Interviewer)

*Sometimes. Sometimes they'd say they don't need it. Sometimes I can be quite concerned enough to offer an antidepressant and they'll come back bright and happy like there wasn't even a problem, and I've been quite convinced that they're in a bad way, that's happened before. As long as you follow up I guess, and that's the beauty of antenatal care is that you do ... you keep seeing them multiple times, so you ask every time.
(Medical practitioner)*

Overall, care providers felt there was limited understanding in the Afghan community of mental health and the assistance from services that is available. A strong social stigma in the community was identified as making individuals reluctant to seek help or follow-up on referrals that are made for them to access a service.

For them (mental) health is not an issue. Maybe they don't understand. When they're sick they will end up in the hospital. Go to emergency. That's how they do it. They don't know the community services available and they can access it. Another thing it's a social stigma for them if they access community services. (Medical practitioner)

The lack of understanding of mental health and its treatment became apparent as bicultural workers reported that it was common for women to share their antidepressants with family members and friends. Interviewees noted that there was frequent sharing of antidepressants with others experiencing similar depressive symptoms as the medication was seen to help with sleeping and feeling positive.

Fear of 'community gossip' was identified as a reason for Afghan women being reserved when asked to share personal information, particularly when on-site interpreters were used. Women were also seen as fearful that they might be perceived as an unfit mother or suffering from 'mental illness', which is stigmatised and not well understood in the Afghan community.

IDENTIFYING AND RESPONDING TO FAMILY VIOLENCE

Several service providers raised family violence as an issue of concern with some of the Afghan families they were seeing. It was uncommon for health professionals to ask routinely about relationship issues and there was little indication that health professionals had guidance on how to inquire about family violence. For some maternal and child health nurses, establishing a trusting relationship with women was an important strategy to foster help seeking behaviours.

This mum had only been in Australia for less than three months and she had been significantly violated by her husband and she knew the maternal and child health nurse would help her and she walked in her state to the centre. (Maternal and child health nurse)

In relation to the introduction of new family violence screening questions in the antenatal setting, most midwives were uncertain about how to find the time, and the adequacy of their skills, to complete this task. Concerns were raised about having the capacity to act

on any concerns and provide support to women who required it.

Keep giving us less time to do everything and more stuff to do, something's got to go. There's no point in me asking someone if she's safe at home if she tells me 'no' and I go oh that's nice, next question. I have to be able to do something with the information. (Midwife)

The focus in pregnancy is the mum and the baby and if you're going to start asking about (family violence) it's going to be a big Pandora's box and we're just not given the time to go there. If a woman was to disclose domestic violence now in a 20 minute appointment I'd be saying "I'll ring the social worker and you can discuss it with the social worker." I wouldn't be able to participate in that now, it's just impossible with the time restrictions. (Midwife)

Many care providers, mostly in the antenatal setting, were concerned about how to seek information from Afghan women about their relationship, when often the husband was also present at appointments.

Now that's a whole other can of worms because all the Afghan women, and a lot of the other women too, always come with their partner and obviously you can't ask those questions with the partner sitting there. So I do have some concerns about how that's gonna work out in terms of asking the partners to leave especially when they're some of the ones that, you can tell the ones that won't have an interpreter and all that sort of stuff. (Midwife)

However, there was one reported instance when having the husband present was not a barrier when a woman's own concern for their unborn child was raised. A midwife explained a rare occurrence of an Afghan woman's disclosure at the first appointment with her conducted via a telephone interpreter.

There was one lady, the first time I'd ever seen her, her husband was with her and when we finally did get the female interpreter on the phone straight away she came up to the phone and was telling the interpreter something into the phone and I was like "ooh that's a bit animated for an Afghan lady" and then the interpreter tells me and I'm like "am I hearing that right". So she straight away wanted to say "my husband's hit me" and was

telling the interpreter this whole story and then she's telling me...in front of the husband. That was quite interesting. I guess I thought her worry was for the baby and so that's why she was wanting to communicate it. But that was the first time I'd met her. (Midwife)

For others, the opportunity to interact and observe families was a useful strategy to raise relationship issues with women who were reluctant to disclose this information.

Sometimes it can even be observation, she said 'no' (when asked directly) but you're sensing that there's something in the relationship. So if we get a chance to have the one-on-one we'll just, report back our obs, look this is what I observed, I may be totally wrong but, you know, something, just to give her that chance, and (say to her) 'I know it's hard... it's really difficult to talk about these issues but it does happen to women and there are choices'. (Community-based care provider)

GENDER OF HEALTH CARE PROVIDER

Providing 'female only' care was a significant challenge for health professionals providing care to Afghan families. This was more problematic in the antenatal setting as there were more male health professionals working in hospitals than in community-based services.

We ask them if there's any cultural issues that we need to be aware of, and they always say female only care. (Midwife)

Care providers reported that the preference for female care providers was generally a request from the woman's husband, rather than from the woman herself. However, health providers did feel that this expectation was changing, particularly with the large numbers of Afghan families utilising and becoming familiar with antenatal services and knowing that there aren't enough female medical providers to fulfil this demand. There was concern for the workload of the female medical practitioners given the increasing numbers of Afghan families using the service and to distribute the workload, women had to accept male care providers.

When I first started more or less every Afghan woman who'd come in would say "I'll wait longer to see the female doctor" in the clinic. But then less and less of that is happening I think as time passes. (Medical practitioner)

There were some instances when women did seek female only care, particularly in emergency situations at the time of birth, which could potentially have serious consequences for the health of mother and child.

We had a lady in birth unit last week who just flatly refused to be examined by the male doctor that was on, and we ended up getting a telephone interpreter to talk to her and she said I would rather my baby die than be examined by a male doctor. But that's extreme, you don't get many like that. (Midwife)

Hospital-based staff reported that at the first hospital booking appointment, it is explained to families that paying for private care is the only way to guarantee that you can receive care from a female care provider.

One lady went to the extent, she didn't have any private health insurance, the husband, the poor husband, he works only in a factory, had to pay more than \$5,000 (for private care)...as I said "I can't promise a female doctor will be attending the labour". (Medical Practitioner)

Most providers attempted to accommodate patient requests for a female care provider. Responding in this way helped to build trust between the service and the family as it was respectful of the preferences of the family. On the other hand some care providers felt that Afghan women and families should accept care provided by a skilled health professional rather than a health professional selected on the basis of gender.

I think also respecting, if they prefer female care, I think if we can accommodate we should. And I think that helps because if they see you doing that then they know that, when (a male care provider) is there, it means (the male care provider) has to be there. And I think that builds that trust as well. So I think it works in our benefit to do that as well. (Medical practitioner)

This effort to accommodate Afghan women subsequently raised issues of fairness to women who also preferred to be cared for by a female health professional.

There's a bit of fairness issue with that too because if an Afghan woman asks for, or prefers female care, if we accommodate them but don't accommodate a Caucasian women who asks for female care, then that's not fair. So we do need to be consistent. I think that anyone who asks for female care if we can accommodate we should, if we can't they should be explained why we can't and then they should accept that. And it should be

across the board, doesn't matter what religion or ethnicity you are. (Medical practitioner)

Addressing this issue early in the pregnancy, by explaining the constraints of providing female care was suggested as the best way to enable women and their husbands to understand that it is not always possible for women to have a choice about gender of care provider in the public health system.

Some care providers wanted a better understanding of why it was so important for Afghan families only to be cared for by females and whether this was related to previous birth experiences and poor outcomes in Afghanistan. It was clear that care providers were not aware of traditional birthing practices.

I'm not sure how it works in Afghanistan. I can't imagine that all of the doctors, all of the obstetricians are female, so that also makes me wonder "so why do they expect to come here and then all of a sudden be able to just get a female doctor"?' (Medical practitioner)

Interestingly, the gender of interpreters did not create such difficulties for care providers. There was always the effort made to accommodate women's request for a female interpreter. Some services had on-site interpreters available but often there was only a male Dari interpreter. This was usually accepted by women and the interpreter would sit out of view while

medical examinations were conducted. For some care providers, there were barriers with administrative staff not understanding the significance of booking a female interpreter when this was requested by the care provider. This then caused issues when the client and unexpected male interpreter turned up for the appointment. In most cases hospital systems have adapted to enable women to have a female interpreter. One medical practitioner reported that some women reacted very badly to male staff assigned to them.

Well they discriminate against males caring for them so that has probably been the biggest issue that we face with our Afghan families...their sense of discrimination and how it upsets our staff. We've had staff that have been hit by Afghan women and there's abuse of our staff by them...that's one of the reasons people just find them very difficult to deal with. We just want to treat them equally like everyone else except they won't treat us equally in return which is challenging. (Medical practitioner)

Language services and communication

INTERPRETERS

Utilising interpreters was a critical component of providing care in antenatal and early childhood settings. Several options were available for health providers including on-site hospital interpreters, booking an on-site interpreter through a professional organisation, telephone interpreters or involving women's husbands to interpret.

The process for booking an on-site interpreter was straightforward. Often care providers developed good relationships with interpreting agencies and had a 'pool' of preferred interpreters that they would request from, especially when home-visits were undertaken and interpreters needed to make their own way to the house. In some instances the care provider would travel in a car with the interpreter which had several benefits, such as the care provider being able to ask about any cultural issues to be mindful of or asking for advice on how to explain certain topics. There were occasionally problems with requesting the correct dialect for a particular Afghan ethnic group.

The majority of health providers preferred using on-site interpreters.

I mean if you have to use it (a telephone interpreter) you've got nothing else, but it's very much specific question and answer when you use the phone interpreter, you get no variation, no shades of grey, nothing leads onto other things. Whereas if you've got an onsite interpreter then you've got that more free flow of information, you're looking at mum you can see how she's responding, the interpreter can see what's going on. (Maternal and child health nurse)

When hospital-based interpreters were unavailable, particularly out of business hours, telephone interpreters were used. General practitioners tended to use telephone interpreters and felt this worked well as it provided security and confidentiality to the patient. However, some GPs felt that complete anonymity should

be an option for patients and that the interpreter should not request the patient's name.

I have one patient, Afghan patient who had a problem with an actual hospital interpreter, felt that she ... I'm not quite sure what happened but she believes that the interpreter... she didn't feel that that interpreter was safe, she felt that her information had been spread around the community.

And I guess telephone interpreter can provide that confidentiality? (Interviewer)

Yeah, but they (telephone interpreter) always ask for the (patient's) name, and I've tried to tell them you don't need to know the patient's name, because it should be confidential. (Medical practitioner)

Some problems with telephone interpreters were identified, particularly when having to wait to be connected. This reduced the length of the appointment, meaning that only essential or required tasks could be covered.

We are using phone interpreters at the moment, which I don't like. I just think it's impersonal and it takes up time, when you're first trying to get the lady into the room and you're waiting for an interpreter to ring back and some ladies can speak a little bit of English, some ladies can't speak a thing so you're trying to do some kind of sign language of "can I check your blood pressure" and "baby moving" so otherwise you're stuck there waiting 10 minutes or so for the interpreting service to ring back and then you've got 10 minutes left of your appointment...where you would have had time to actually chat with them and actually say "how are you doing" and make that eye contact and actually give them time, you're really cut down in doing that. It's a little bit more task orientated now, which is a bit of a shame. (Midwife)

Another midwife reiterated this explaining that the constraints of booking and waiting for a telephone interpreter to come on line, impacted on critical aspects of antenatal care. These included explanations to women about what was happening during the check-up including physical examinations, to the identification of the needs and concerns of their clients.

The interpreting department's sent us some guidelines for using telephone interpreters. Bring the woman in and guide her to the

examination couch and do your examination of her tummy and everything and her blood pressure and then guide her to the chair and by then you should have your interpreter and then you ask her all the things you have to ask her, and then the very last thing is ask her if she has any questions. I just went (groan) because there's no way I'm gonna bring a woman in, put her on the couch, pull up her top and start examining her tummy and feeling for her pubic bone without any sort of explanation, I'm just not gonna do it. And also when I do an antenatal visit the very first thing I do is ask her if she's got any questions 'cause I don't want to spend twenty five minutes rabbiting on about stuff that I think's important and then ask her if she's got any questions and she drops some bombshell on me and I go oh God I've got five minutes left to deal with this now. I'm gonna ask her what's important to her at the start and deal with that and then if I've got time left I'll do the other stuff that I have to tick off on my piece of paper. (Midwife)

Husbands attended most of the pregnancy care appointments. Husbands would accompany their wives by driving women to their appointments and provide interpreting support. While this was convenient as it meant appointments would begin on time, rather than wait to be connected to a telephone interpreter, it did concern some health providers when men insisted on being the interpreter and refused an accredited interpreter. There were concerns that men were not proficient in English, that they may withhold information from women that the health care provider was communicating.

They come in for all the appointments. So there's a couple of things with that, some of them...we don't like using the partners to interpret but some of them insist and refuse an interpreter, say I don't want to have an interpreter, I can speak English, I will interpret. Usually we get around that by saying oh well your English is really good, I can tell that but you possibly don't know very much about medical things and when we need to talk to her about medical things you might not be able to interpret what we want to say. And sometimes you get a few that just flatly refuse and then you just do the best you can. (Midwife)

In some instances, the husband was happy for an interpreter to be involved in the appointment, but interjected when he did not wish for some information to be passed to his wife.

I've had a face to face interpreter where I was talking to the lady. She was ...in the last month or so with her pregnancy and I was talking to her about labour and birth and I had my little picture book and I was explaining everything, the changes that happen to the cervix in preparation for labour and what to expect in labour and what she should be doing in preparation, and her husband said ... and he spoke English like I do, and he said "interpreter I don't want you to tell her that", and the interpreter said "I'm sorry I have to tell her that", He said she doesn't need to hear that, and I went "yes she does..." I suppose he thought he was protecting her. (Midwife)

Some participants felt that it would be helpful to have the same regular interpreters as they would learn the content, the types of questions being asked, as well as getting an understanding of the service. However, for some it was considered problematic as the interpreter could assume too much and ask questions in a different manner to the way the health provider intended. A maternal and child health nurse found this impacted on the way she preferred to facilitate appointments.

I follow the guidelines and I ask all women about violence, and the interpreter will... sometimes the interpreters need a lot of prompting 'cause they say "she'll just say everything's good". Ask them the questions please; I want to give them the opportunity to tell me. (The interpreter says) "why do you ask? They'll just tell you everything's good." I might just start off gently by saying how does your husband treat you, how's your relationship, and then they've actually said when they translate back to me "she says there's no violence". So I might want to do it in a different way to actually get the context of how things are, especially if I'm in their home an interpreter may know the questions and just do it in a more direct way. So that's frustrating sometimes. Because I'd like to see the woman's response to the first question, think about how I'm gonna phrase the next question. Sometimes that gets a bit taken away from me. (Maternal and child health nurse)

Many health providers, who had contact with women after the birth of their baby, were surprised to hear that no interpreting support was provided during labour and birth. Women told them that nothing was explained to them, that it was frightening and they only had their husbands with them who themselves had poor English skills. A midwife noted that she thought it would contravene the women's confidentiality and privacy if they had interpreters present at the time of birth. When situations arise, for example an emergency caesarean, a telephone interpreter would be used. Midwives realised that husbands did not traditionally have a role to play in the birth of the child but felt it was good for them to have that opportunity to be directly involved.

Never in the birth unit, not usually, no. 'Cause the interpreters; it's a breach of privacy for them to be in the rooms with the women. So if we need an interpreter we'll use a telephone interpreter for a birth unit. But I have to say it's not ... it kind of works alright with family I suppose, with the partner. And I think that's a huge thing for the men 'cause they wouldn't normally be part of the birth process and, you know, they step up to the mark pretty well here and most of them realise that, you know, he's all she's got basically, but most of them are...they're good. (Midwife)

Furthermore, it was considered too costly and unrealistic for an interpreter to be provided to families during labour and birth. Women are expected to organise someone to accompany them to hospital and provide interpreting support. It was acknowledged that their husband, family members and friends would also have limited English and more than likely have other children to care for, and therefore be unable to stay for the duration of the labour and birth. None of the stakeholders referred to guidelines for use of interpreting services in health care settings.

You can't pay an interpreter for 12 hours, so we would encourage them to think during their pregnancy "you might want to have a support person with you who speaks English" and get them to start thinking about doing that because we can't afford to have an interpreter there for 12 hours, it's just not reasonable.

And who is it likely that they're going to bring with them? (Interviewer)

Well it depends who they've got, a lot of them don't have a lot of support, so a lot of them won't bring anyone but at least we sow the seed that this might help you. (Medical practitioner)

TRANSLATED INFORMATION

Health providers reported that they had access to some translated information related to pregnancy, birth and child rearing. However, they felt that the available resources were minimal and more resources were needed for communicating and providing useful and necessary information to women and their families. There were requests from all health professionals that the resources that are available in English be made available in required community languages. Preference was for all information to be available electronically, in one central location, where it could be easily found and printed.

Obviously there's websites but most of those websites are PANDA and beyondblue, but I haven't found any information in different languages on there of great use...and the access point is pretty difficult. (Midwife)

Most, but not all care providers, recognised that some Afghan women are not very literate in their own language and felt that translated information wasn't helpful and could possibly be dangerous if it meant women were given no other information.

It's quite a dangerous assumption by giving them written material. If it's "how to care for your baby when you go home" or "how to breastfeed" and they accept it, they don't admit they can't read, they act shy. (Community-based care provider)

To help explain tests, test results, procedures, operations and more general topics related to pregnancy, childbirth and parenting, care providers often drew pictures or used picture books to assist and found this helpful.

That can break down beliefs. Things like that and that really helps communication and understanding. Because some people are visual learners aren't they? (Community-based care provider)

On occasions the internet was utilised during appointments, where providers used Google images or Google maps to help explain issues or directions to services.

They're a practical people, so I basically just try to just keep things simple but the Google Images, just some simple printouts off that. (Medical practitioner)

Rarely were DVDs, CDs or videos used to help explain relevant topics. Care providers explained that they didn't have access to such resources and if they did, there were not the facilities available to use them.

Health literacy and community education

Most care providers felt that Afghan families had very little knowledge about pregnancy and childbirth. All health care providers reported that childbirth education classes would be beneficial for Afghan families, yet Afghan women rarely attended these classes. Many reasons were given for their non-attendance at childbirth education programs. This included transport difficulties as their husbands tended to have the car if they were employed. Language barriers were a commonly cited reason for not attending as interpreters were not usually provided in multicultural classes and classes were difficult to facilitate with several interpreters; others noted that it was too expensive to book interpreters in the evening and on weekends when classes were often held. Other reasons given included that the classes were not cost-free and that women often had other children to care for. More broadly, it was reported that the relevance of the classes was not understood.

It must be really scary having a baby in a country where you've got no idea of what's going on. Even if they've had babies before, they've just about all had them at home, not even in hospital and I suppose we come from a background where at least knowledge and education and knowing what decisions you have is quite useful, whereas they have no idea so things start to go wrong, it's very hard to explain a lot of it to them because they haven't had that background education, be it in general or during the classes. (Medical practitioner)

It was so rare for Afghan women to attend classes that those who had were described as being unique in being able to overcome the obstacles.

Yeah, they're brave, they're very brave women who tend to do that, I think they're not the everyday Afghan woman, I think they're quite unusual. (Midwife)

Many providers felt Afghan women and their husbands would benefit from childbirth education programs similar to those successfully provided to Vietnamese and Cambodian parents in the area. A health care provider felt that the Afghan women were a particular group requiring education and missing out on it, resulting in many women not being informed about seeking help and the options and choices during labour and birth.

They're the sort of women that need it the most and they're the ones that we're not giving that education to. (Medical Practitioner)

In response to Afghan women not accessing childbirth education classes, many midwives would try to include what was usually covered in classes in each appointment, noting that it was difficult for them to cover all topics when other clinical tasks had to be prioritised. Care providers felt Afghan women needed more education about a range of issues including: sexual and reproductive health; mental health; contraception; medication use; family violence; self-care during and after pregnancy; nutrition during pregnancy and for infants/children; and preventative health e.g. pap smears, baby care and child development. Care providers noted that Afghan women would benefit in having access to information in classes about navigating the Australian health system for their health and that of their family. There was some concern from general practitioners that women didn't understand the implications of fasting while pregnant. Tailoring of 'education' was seen as important. All providers said that Afghan women were great breast-feeders and while this topic was covered a lot in the mainstream childbirth education programs, this may not need to be prioritised for these women. Most providers noted an overall need to improve women's basic English skills.

Care providers were confused by Afghan families' reluctance to accept second hand goods such as prams, cots, and infant clothing, given that they could not afford to purchase them. A non-Afghan bicultural worker shared that in her culture, people had never heard of 'second-hand' before arriving in Australia, there are no 'opp-shops' in home countries and community members were unsure of where these items had come from, and assumed that they must have been from infants who had passed away.

Wider community education was suggested to dispel myths about pregnancy care and the importance of attending medical appointments both pre and post childbirth.

I recently had a case of a young girl who went back home, got married, got pregnant, came back to Australia, the husband's still overseas and she went to a doctor, a female doctor which was great, and she said "you should have an ultrasound" and then she went home and said to her mother "I've got to go and get this ultrasound" and the mother said "no that will kill your baby - we didn't do that in Afghanistan when I had you." So it's just that concept of health education. (Community-based care provider)

Explaining the role of services, what they can provide and the importance of attending appointments was critical for promoting service utilisation. One strategy to do this involved an investment of maternal and child health nurse time in community engagement activities. An agency that did so reported an increase in the number of culturally diverse families using the service.

They had no idea about the Maternal and Child Health (Service) and a few of them became a bit suspicious because they're going "oh you're from the government and it's about you're going to take my children away." So it was about educating them about what Maternal and Child Health is and how our services work here in Australia. It's a very different model that we have here because it's preventative health. So we had to make Maternal and Child Health Service relevant. (Maternal and child health nurse)

Organisational support

Organisations supported staff to work with Afghan communities in different ways across sectors and settings.

BICULTURAL WORKERS

Employing bicultural workers was one of the most effective strategies for both supporting staff to work confidently with their Afghan and other diverse clients, as well as making the service welcoming and relevant for new and existing clients.

Having bicultural workers, having people that can help support, and being that bit of an intermediate between the service and the community I think is a really...can help to bridge some of those gaps.

(Maternal and child health nurse)

Agencies that employed bicultural workers were seen as equipped to provide much more than language services and were critical for delivering appropriate care to culturally diverse clients. For example, a care provider reported that when she is having difficulties explaining issues to patients, she will ask the on-site bicultural worker to assist.

And sometimes I say "oh this is just not making sense" and I will go in and get (the bicultural worker) and say "how can I...?" and she might go in and try and explain it in her culture. (Community-based care provider)

Some service providers felt that it was not possible to meet all the specific needs in the community using bicultural workers because of the huge diversity in language and cultures. However, an interviewee from one agency who had an Afghan worker reflected that many found that the presence of bicultural worker demonstrated diversity within the health service and the likelihood that this made people from other cultures feel welcome.

Clients just feel so much more at ease; even they don't happen to be Afghan themselves. You know if it's a Tamil person walks in, diversity is the first thing they meet and I think that that can break down some barriers about us all being kind of white middle class. Hopefully we look a bit more broader than that. (Community-based care provider)

The knowledge and insights that bicultural workers bring to a clinical team were considered invaluable and ultimately provided a better experience and outcomes for the client.

Our bicultural worker...if she notices that an interpreter is from perhaps a different tribal cast or something, she'll actually say "how did you go with that interpreter" especially if it's counselling and she'll say "it's just that they're actually waring" and so she's quite good at letting us know. She's anything but a scaremonger. She's actually just really good at saying to us now "you might find there's some edge there, because of that" or "you might find that they're very professional and that's just some background" so she's really a wealth of knowledge to us. Very insightful. Really helps us get a better match for the client. (Community-based care provider)

One drawback of having bicultural workers as part of the team of staff was that all clients of that culture were automatically directed to that worker. This could lead to increased workload as well as not providing other health workers with opportunities to work with that cultural group. Another consideration was that some Afghan women may prefer to see someone of a different background to their own but were not necessarily given that choice. This was reported by several participants in a focus group of care providers:

My observation is that the rest of us didn't really get to work with those Afghan women initially because (the bicultural worker) was here and that's where they all gravitated to. So I don't think I had an Afghan client until after (the bicultural worker) left.

(Community-based care provider)

I had one when she went on holidays. (Community-based care provider)

So as good as that was having her, I don't know about for the women because they weren't exposed then to anybody else. (Community-based care provider)

TRAINING

It was uncommon for health professionals providing public antenatal care to have participated in training to support their work with the local Afghan community or other people with refugee-backgrounds. One midwife had participated in training provided by Foundation House. Most interviewees said there were probably information sessions provided by their organisations but they had not attended any. Midwives and general practitioners reported mostly learning on the job rather than attending any specific training.

Some reported that it would be unlikely for medical practitioners to attend cultural/refugee specific training unless it was compulsory, there were incentives and it was held in the evening. Even then it was thought the learnings from any training would not be sustained.

I think it would make a difference in the short term, straight after the education, for the first maybe couple of weeks or month. But I don't think that it would be something that people would continue to do. (Medical practitioner)

One care provider reported that because they were not employed in a specific 'refugee' role that it was not necessary.

At one stage I contemplated one (training course) but then, I don't consider myself a refugee doctor. (Medical practitioner)

Most care providers in the early childhood sector had been exposed to some form of training, whether it was specific programs, attending seminars or learning from colleagues who had participated in these and shared the learnings. However, for some the training they had attended was not relevant and did not assist them in their practice.

The insult was no one had come here to find out what we really were doing because it was basically telling us "oh you've got to do this" and people were going "well we do that" and then when we had the group work I think (the trainer) was absolutely blown away and he goes "why do you get it" and we go "well nurses have been here for 20 odd years working with refugees and the different cultural families" ...it would have been really nice if we had been a part of the focus group setting it up so therefore it would be professionals sharing their experience in giving better case studies. (Maternal and child health nurse)

Some nurses requested specific training on trauma related to the refugee experience and applying that to their work with this population group.

I think it's an area that, I feel, we need more training in that area, just talking about and identifying trauma. This new family I'm working with from Afghanistan, the whole family, this woman's living with her parents and her brothers and every single one of them is impacted greatly in some way to do with what they've been through...It's this huge ripple effect in this family. And even just transitioning to a very different culture is trauma in itself.

(Community-based care provider)

Some care providers spoke about experiences of judgemental and discriminatory behaviour towards Afghan women, in their organisation, as well as from other agencies that they interacted with. There were reports of inappropriate interactions with clients such as intentionally appointing male providers to women who had requested female care. In addition, administrative staff did not always accommodate requests from care providers to book female interpreters.

I find that a lot here that sometimes people have a particular racist view and that that will halt our service delivery. (Midwife)

A bicultural worker reported that members of her community spoke openly to her about the way they are treated by different services, particularly in large hospitals. Women had told her:

They not treat me as a normal...because they know I don't know English, I come from other country; I do not know anything, treat me differently from others.

(Community-based care provider)

All participants were asked if they were aware of any existing organisational policies for working with culturally diverse, migrant, refugee or non-English speaking clients. Apart from a bicultural worker recalling policies on 'non-discrimination' no one could recall a specific policy that assisted or guided them in this type of work. However, some mentioned guidelines for working with interpreters.

Strategies for providing care to Afghan families

Overall, care providers felt their colleagues and organisations were providing the best care possible, given all the clinical tasks, requirements, demands and constraints they faced each day. Most felt they were meeting the needs and expectations of Afghan families related to having a baby.

I don't think they're any different to any other woman that they want to have a safe birth and a healthy baby basically. I think that's what people want. (Midwife)

However, there were some care providers who felt that current care provision was 'inadequate' and they would like to be doing more to meet the needs of Afghan families. Suggestions for improvements typically included increased appointment time with patients, additional clinical and social work staff and useful and relevant resources to provide families with appropriate information.

Continuity of care provider was named as an important aspect of developing a trusting relationship with Afghan women, as well as other women and their families.

If you are seeing a regular client, more than once or twice then there is automatically a trust built, you see our body language, your respect, and then the other person sees and feels comfortable to talk to you. (Community-based care provider)

Do clients generally always see the same nurse? (Interviewer)

We try. There's some centres it's just they ring up and nurse A is not available so you offer nurse B and C. But yeah probably the majority will see, at least they get familiar with one or two nurses...When there's significant issues, to have that familiar contact that nurse knows your background, that nurse has supported you, I think it does make a difference however I don't think we can dismiss the majority that all they're looking for is the support for their developing child and for their parenting... look we can't be ignorant to think "oh no it doesn't make any difference" it does make a difference and it...if there is a familiarity, that you built up rapport and that connection, that people would come back to ...the centre if they knew they were seeing that nurse. (Maternal and child health nurse)

Following-up vulnerable clients was an important component of the way community-based health professionals provided care. Consistency in care provider enabled this to happen. Follow-up by other providers required good avenues for communication between health professionals yet conversations between the provider and woman are usually recorded as a note on the client's file that might not always be read and acted upon.

And if I've seen a mum and I'm worried about her I might ring her up the next day or the next week or just see, how you're going, what's happening. (Maternal and child health nurse)

Some considered it more important that there was consistency in the care provided and the key messages from the service. It was unlikely that clients would be able to see the same provider throughout their pregnancy or throughout their child's development so it was important for health professionals and services to provide standard approaches to care.

...was more that the continuity of care which was also really important. So it doesn't always have to be the same person but it's about getting the same messages all the time. (Maternal and child health nurse)

In most instances, attempts were made to provide the same carer. Challenges arose when appointments were made through a central location rather than directly with a care provider who then had little control of their own diaries.

A well-established maternity program known as MIP (Midwives in Partnership) was recognised by many care providers and they often referred newly pregnant women to this service. Several community-based providers identified benefits of this program such as the antenatal clinic being located outside of the hospital and that women were usually seen by the same midwife for each appointment.

Many service providers had worked in the same organisation for several years and some for up to sixteen years. Over that time they had seen many changes that their organisation had made to the way services were delivered, to meet the needs of the changing community. Care providers reported that recent changes had led to very structured services. Often these changes left little scope for the flexibility required with vulnerable with complex needs.

*I used to bend and flex with the service. You'd have home visits but I used to have enough time in a home visit, I'd go in and I'd say okay, do this home visit, go and have another home visit and I'd think I haven't seen her, her and her so I'm just going to pop in.
(Maternal and child health nurse)*

Some stated that they wanted to provide a holistic, nurturing, community-minded service whereby staff got to know their clientele and their families. While there was recognition of the service mandates and requirements, inflexible ways of operating reduced care providers capacity to follow-up on concerns or provide further intervention when they would have liked to.

*We've got half an hour and we've got to tick this, this and this because this is the requirements and then oh, about your DV (domestic violence)
(Maternal and child health nurse)*

Some care providers did have the flexibility to tailor their appointments. This was considered essential for being able to meet the needs of their clients adequately. Although there were a number of issues that care providers thought were important to cover in appointments, they always attempted to deal with the women's needs first and then move onto other tasks.

*We're there to really meet the needs of the client not our own agenda.
(Community-based care provider)*

Care providers expressed concern about recent organisational changes resulting in reduced appointment times, increased costs to access services and limited access to on-site interpreters. Several noted that changes might constrain them in being able to respond to community needs appropriately.

They're the least able to...look out for themselves in a system like this...and I think that that's only gonna get worse actually 'cause funding's been cut and when that gets cut the people that get cut are the people that need it most. (Midwife)

ENGAGING MEN IN PREGNANCY AND POSTNATAL CARE

Stakeholders noted that Afghan men played a significant role in their wives' attendance at all stages of pregnancy, birth and postnatal care.

Care providers were asked how clients get to their service. Those who knew said that most had husbands who would drive them in the family car, and others got public transport, drove themselves or walked.

Husbands were usually present for all pregnancy appointments. For those who were employed this often meant taking time off work. Men were often the interpreters for women, which was viewed both positively and negatively by the care providers.

Lots of husbands (attend appointments), and that varies from very controlling to wanting to know what's going on and speak for their wives - and being the interpreter, and having refused an interpreter. To just beautiful, gentle, loving dads who want to be there and who just gently encourage their wife to use her English and tell us. So yeah the range is enormous. (Maternal and child health nurse)

As men were usually more confident in speaking English than their wives, it was typical for care providers to speak to them to make appointments. It was important for care providers to have a good relationship with the husband so that they felt their wife was 'safe' attending such services.

I don't utilise the husbands as interpreters. I utilise them because they're the one who have to take these females for the ultrasound appointment... So I interact with them and say "this date you have to take her for ultrasound" because it has to be done at certain time. So I make sure that he knows and he puts it in mobile, he knows where to take them and which place to go. He has to ring and make appointment because she can't speak English. So I don't utilise them because I can tell them in their language what I'm talking, so they don't come for that reason. Mainly they come as transport and moral support. They can't go anywhere by themselves, if I want them to have a 20 week ultrasound then I make her husband to understand she needs to have this ultrasound around this time. You have to take her. You have to first ring and make an appointment, then he understands he has to do that.

¹ Midwives in Partnership (MIP) was a midwife-led clinic at Dandenong Hospital. Women were cared for by a small group of midwives throughout pregnancy, during labour and birth and postnatally. As of mid 2013 the MIP midwives are to work in a larger team of midwives and medical practitioners at Dandenong Hospital as part of the new Monash Women's Maternity Service. The Monash Women's teams will work on principles of continuity and consistency of care.

*It's really important to have the husband here?
(Interviewer)*

Yeah. On some occasions because they can't manage themselves. Even if they come, it's a rare occasion they come by themselves, then I say you have to do this ultrasound and they are immediately telling me "I have to discuss this with my husband" because first of all some of them are costly and I try to help them, to send them to places where they don't have to pay but still the lady has to immediately tell me "yes, I have to discuss that with my husband and he'll be available to take me". So we don't exclude them, they are really important in our consultation because without them we can't do much. That way they are doing a lot. (Medical practitioner)

Interviewees working in community-based and preventative health roles reported that it was much harder to engage men and difficult to find other agencies that had developed strategies for working with men that could act as a guide for implementing change in their own agency.

*Well it really is a learning process and I would really hesitate to think that I've found the right strategies and I know what it's going to take, it really is a matter of trial and error and learning as we go. There just seems to be so few people that we can learn from and get skilled up in this 'cause everyone seems to be feeling their way in this.
(Community-based care provider)*

WORKING WITH OTHER AGENCIES

Care providers knowledge about available services and programs to link women into for support is vital to providing responsive care for Afghan women and families. In some agencies, managers and other designated people attended internal and external forums and network meetings and would then share information with staff at team meetings.

*We know that good relationships are crucial to our clients having good outcomes so there's a lot of network meetings at different levels.
(Community-based care provider)*

It was acknowledged that one service provider could not be expected to meet all the needs that a family might have and referrals were made frequently to internal and co-located services as well as external local services for a variety of health and social issues.

*Our main referral is dental, physio, optometry and counselling.
(Community-based care provider)*

Service providers often called or faxed the particular service to make the referral on behalf of the client or suggested they see their GP for further support. Most felt that their clients would attend the referral appointment if it was concerning a physical health problem which was causing them pain. However, clients were reluctant to attend counselling or psychology appointments.

Hospital-based staff rarely referred people outside of the hospital for mental health or social issues and generally referred to the Social Work Department. However, this was described as a limited service providing acute care only.

We've got social work department but they're quite busy and only want acute things. Depends on obviously if it was a really acute problem then there's the CAT (Critical Assessment Team) services. We've got all the acute problems sorted but I think it's the sort of lower end anxiety, depression that we may not meet as well. (Midwife)

Referrals were made frequently by maternal and child health nurses and Healthy Mothers Healthy Babies, however, some providers had concerns that some services would not be able to provide appropriate care for vulnerable families. A number of issues were identified as barriers limiting the responsiveness of external services. These included location and physical accessibility, a lack of language services and low levels of cultural competence.

*I think there's cultural areas that you need to be aware of, you can't just go in and say well this works for this family, it's going work for this family, it's very different.
(Community-based care provider)*

In summary, care providers identified many challenges in providing maternity and early childhood health care to Afghan families. These ranged from an care provider's understanding of the refugee experience and how best to assess and respond to often complex social circumstances, to organisational structures that are not always conducive to meeting the needs of families of refugee-background.

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