

Understanding the mental health and wellbeing of Afghan women in South East Melbourne

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Foundation House Placement Report
January 2010



Foundation House
The Victorian Foundation for Survivors of Torture

ACKNOWLEDGEMENTS

There were a number of people and organizations who made this study possible. I would like to thank Victorian Foundation for Survivors of Torture (Foundation House) for providing the opportunity to explore this important issue, and for hosting me during this placement. My placement supervisor Josef Szwarc and academic supervisor Associate Professor Ben Smith for their encouragement, guidance and advice throughout the development of the research. Donna Chesters, particularly in facilitating recruitment of the Afghan Advisory Committee and knowledge of the Afghan community in Melbourne. Sue Casey, Sue Willey and Andrew Block also provided valuable information, guidance and advice.

The resilience of the Afghan participants in this study is remarkable, their willingness to share their knowledge, attitudes and experiences has been invaluable. Health and community worker participants were generous with their time, when playing important and demanding roles in supporting their clients. This study would not have been possible without the support of the following organizations: Centacare, The Dandenong-Casey GP Association, Greater Dandenong City Council, Southern Health, Queen Elizabeth Centre.

This study stemmed from initial research conducted with Iraqi community by Consultant Psychiatrist Rosemary Schwarz. The rationale from an unfunded proposal to beyondblue is reproduced here as part of the introduction.

The research costs were provided by Foundation House made possible through funding from the Sidney Myer Fund and William Buckland Foundation. Angela Rintoul is a Fellow of the Victorian Public Health Training Scheme (VPHTS), funded by the Victorian Department of Health.

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ACRONYMS

| | |
|-------|--------------------------------------------|
| ANC | Antenatal care |
| DIAC | Department of Immigration and Citizenship |
| FFGD | Female participant, Focus Group Discussion |
| FGD | Focus Group Discussion |
| FSS | Family Strengthening Strategy |
| GP | General Practitioner/Practice |
| HMHB | Healthy Mothers, Healthy Babies |
| MCH | Maternal and Child Health |
| MFGD | Male participant, Focus Group Discussion |
| PND | Post- natal depression |
| SE | South East |
| TPV | Temporary Protection Visa |
| VPHTS | Victorian Public Health Training Scheme |

EXECUTIVE SUMMARY

The impetus for this investigation stemmed from reports that the prevalence of depression and anxiety amongst the Afghan population in South East (SE) Melbourne is particularly high. These reports came from both Afghan community members and health and community workers. This qualitative study identified and explored a range of topics to provide information that aims to ultimately increase the capacity of health and community workers to promote the mental health and wellbeing of Afghan women in South East Melbourne, with a particular focus on pregnancy and childbirth.

In-depth interviews were conducted with health and community workers in contact with the Afghan community and focus group discussions were held with Afghan community representatives in October and November 2009 to identify and explore:

- cultural practices around pregnancy and childbirth in Afghanistan to understand usual roles and responsibilities of family members and the health system in Afghanistan;
- acceptable ways of dealing with distress in Afghan cultures in order to understand appropriate community based responses to promoting mental health;
- factors that contribute to poor mental health and wellbeing for Afghan women in this area in order to better understand the source of poor mental health for this population; and,
- barriers to appropriate antenatal care.

The findings revealed complex transitions and social change required by Afghan refugees upon arrival in Australia. Practices around pregnancy and childbirth in Afghan cultures usually involve relatively intensive support of the extended family. This means that in Australia the husband plays a greater role due to the absence of the family network, and the role of maternal and child health support is crucial. Some cultural practices relating to pregnancy could potentially compound feelings of isolation for some Afghan women - such as restrictions upon movement during pregnancy and for 40 days after the birth. The trauma of conflict and the refugee flight were noted as contributing factors to poor mental health. Post-migration stressors reported by the majority of participants included feelings of isolation, related to a perceived lack of community in SE Melbourne, compounded by poor access to transport. The impact of strained and sometimes dysfunctional spousal relationships associated with adjusting to life in Australia, often after long periods of separation following the migration process to Australia, were reported by a significant majority of participants.

Strategies to address poor mental health in the Afghan community should provide information about mental health, sexual and reproductive health and support couples to foster positive spousal relationships. An existing unfunded proposal that engages Afghan parents in conjunction with antenatal care may be an appropriate vehicle for delivering this information, and would fill a gap in existing antenatal services for Afghan parents.

BACKGROUND

In early 2009, a consortium of health professionals in the Dandenong area identified a need to address mental health concerns among Afghan families of a refugee background. An early intervention, based around antenatal care of pregnant Afghan women and their husbands was proposed to beyondblue. The proposal was led by the Victorian Foundation for Survivors of Torture (VFST) in collaboration with consultant psychiatrist Dr Rosemary Schwarz, and included representatives from the Dandenong Hospital Refugee Health Clinic, Dandenong General Practice (GP) Association, and the Key Centre for Women's Health at the University of Melbourne. Unfortunately, the application was unsuccessful. Despite this setback, it was agreed it would be important to explore ways to address the continuing needs raised in this proposal. The consortium supported the further exploration and documentation of the issues contributing to poor mental health and wellbeing among women of childbearing age and their families.

Foundation House already works closely with the Afghan refugee community in the Dandenong area, including through its Family Strengthening Strategy Program. Established in 2008 as part of this strategy, the Afghan Advisory Committee has 16 members and meets on a monthly basis. Membership of this group comprises of a balance of men and women and includes representatives of the Pashtun, Tajik and Hazara ethnic groups. The committee was developed as part of a capacity building strategy to support the development of this emerging population. Importantly, the committee informs the development of Foundation House activities and identifies issues raised by the Afghan community. The committee also acts as a key point of information dissemination to the Afghan community in the Dandenong area.

Foundation House provides direct services to clients in the form of counseling, advocacy, family support, group work, psycho-education, information sessions and complementary therapies. Direct services to clients are coupled with referral, training and education roles aimed at developing and strengthening the resources of communities and service providers. Foundation House provides services across Melbourne with offices in Brunswick and Dandenong. Services are also provided in a number of rural and regional centres in Victoria.

INTRODUCTION

MENTAL HEALTH PROMOTION AND A RIGHTS-BASED APPROACH

The WHO defines mental health as *“a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”* (WHO 2005). Depression is the leading cause of disability adjusted life years (DALYs) worldwide, with a 50% higher burden amongst women compared to men (WHO 2001). Documented explanations for why women may experience depression and anxiety at higher rates than men may include hormonal imbalances, i.e. following the birth of a child; that women experience more stressors due to pressures to maintain traditional roles within the family unit and society; and that women experience higher rates of sexual and domestic violence (WHO 2001).

The Victorian Health Promotion Foundation's (VicHealth) Mental Health Promotion Conceptual Framework outlines three key aspects that are fundamental to mental health – social inclusion, freedom from discrimination and violence and access to economic resources. Social inclusion refers to an individual's connectedness with their community, and the networks of support available to them. Discrimination and violence relate to physical safety, the ability to control one's life and valuing of diversity. Economic resources includes an individuals ability to participate in employment, receive an education, appropriate housing and sufficient financial resources (WHO 2005).

State-sanctioned discrimination against women, along with a health infrastructure that has been depleted by decades of conflict, has led to a public health crisis in Afghanistan, indicated through exceptionally poor maternal and child health statistics. Forty-three percent of women are married before they turn 15, and Afghanistan has the second highest fertility rate in the world; an average of 7.1 pregnancies per female. A skilled attendant is present at only 13% of births, and the country has a staggering maternal mortality rate of 1,800 per 100,000 births (up to 8,000 in some districts), with hemorrhage and obstructed labour the most commonly reported causes (UNICEF 2009). One in seven children die before their first birthday and 20% don't make it to their fifth birthday (UNICEF 2007; UNICEF 2009). Table 1 outlines a striking contrast in human development indicators between Australia and Afghanistan.

Table 1: Human Development Indicators comparison (UNICEF 2007; UNICEF 2007)

| | Australia | Afghanistan |
|-------------------------------------------------------------------|-----------|-------------|
| GNI per capita (US\$), 2007 | 35,960 | 250 |
| Child marriage; 1998–2007, total | - | 43 |
| Life expectancy | 81 | 44 |
| Infant mortality rate (under 1), 2007 (per 1,000) | 5 | 165 |
| Total fertility rate, 2007 | 1.8 | 7.1 |
| Antenatal care at least one visit (%) | 100 | 16 |
| Maternal mortality ratio, 2005, adjusted (per 100,000) | 4 | 1800 |
| Delivery care coverage (%), Skilled attendant at birth, 2000–2007 | 100 | 14 |

Women in Afghanistan have experienced extraordinary curtailments on their rights. While abuse of women's rights under the Taliban are now reasonably well documented (Rakesh, Bauer et al. 1998; Wali 1999; Amowitz, Heisler et al. 2003; Scholte 2004) many continue today, despite the Taliban no longer forming government. In August 2009, English-language news reports claimed that Afghanistan's Ministry of Justice passed a law (Official Gazette No. 988, 27 July 2009), affecting the Shi'ite population, that permits a husband to withhold food from his wife if she refuses his sexual demands, grants guardianship of children to fathers and grandfathers and requires a woman to get permission from her husband to work.

Over the last several decades of conflict Afghan refugees have experienced extreme violence, systemic persecution, deprivation and loss. These circumstances indicate that the Afghan population, particularly women, are at high risk of developing anxiety disorders, posttraumatic stress disorder (PTSD) and depression (Fazel, Wheeler et al. 2005; Porter and Haslam 2005). A national population-based mental health survey conducted in Afghanistan in 2002 found high prevalence rates of symptoms of depression (67.7%), anxiety (72.2%) and PTSD (42%). Women had significantly poorer mental health than men (Cardozo, Bilukha et al. 2004). There is no longitudinal information about mental health in refugee populations in Australia. Therefore, limited evidence is available about the prevalence or effective responses to this issue. Foundation House collects direct services data that documents the torture and trauma experienced by clients, as well as basic mental health information such as psychological functioning, and presence of disorders such as depression, anxiety and PTSD. In the financial year 2008-2009 data exists for 536 Afghan clients. However, this data was not explored for the purposes of this study.

It is not possible to address mental health unless fundamental human rights are protected. International instruments ratified by the Afghan and Australian governments, and instructive in the context of this study, include the United Nations Convention on the Elimination of Discrimination Against Women (CEDAW, 1979) and Declaration on the Elimination of Violence Against Women (1993). These instruments outline how enabling environments for improved mental health of women can be achieved, including challenging power relations and gender roles in order to create positive change.

AFGHAN REFUGEES IN AUSTRALIA

Afghan refugees make up the largest refugee group in the world, with around 2.8 million refugees spread over 69 asylum countries (UNHCR 2009). The Australia Government has an allocation of up to 13,750 refugees each year as part of its Humanitarian Program. In 2008, refugees from Afghanistan were the third largest group of humanitarian entrants to Australia under this Program, behind Iraqi and Burmese. The City of Greater Dandenong is the most multicultural local government area in Australia and along with the neighbouring municipality, the City of Casey, is now home to Victoria's largest population of Afghan born people, with 3,390 Afghan born residents at the 2006 census (VMC 2007).

Many Afghans who left the country endure harsh and lengthy periods of displacement before being accepted for resettlement in a safe country, for example refugee camps; unauthorised and dangerous journeys arranged by people smugglers; immigration detention; and the insecurity of temporary visas. Mental health problems are not resolved as a matter of course by re-settlement, which can itself be a highly stressful process (Gerritsen, Bramsen et al. 2006; Omeri, Lennings et al. 2006). Grief is ongoing and associated not only with the loss of family through death and dispersal, but the loss of country and way of life. Refugees have encountered challenges learning a very different language, adjusting to a very different society, such as expectations of gender roles and finding employment. The experience of detention and separation of families on arrival in Australia also compounds the experience of trauma (Silove, Steel et al. 2000; McDonald-Wilmsen 2009). Social isolation may be exacerbated by discrimination and hostility towards Muslims and the Islamic faith, the main religion of Afghanistan-born refugees (Omeri, Lennings et al. 2006; VicHealth 2007). Media coverage of violence in Afghanistan can cause re-traumatisation and direct communication with family and friends still in Afghanistan causes extreme distress about their safety. Reports from service providers such as the Victorian Foundation for Survivors of Torture (VFST) and Dandenong Hospital show that somatisation is common, so that emotional distress manifests as non specific somatic complaints such as headache, pain, weakness or fatigue and collapse. Mental health literacy, which is required to communicate psychological difficulties, is generally low (Schwarz, Dunsis et al. 2008).

A disproportionately high number of people from Afghan origin living in the Greater Dandenong Area presented to the three Southern Health Emergency Departments in the period July 2007 to February 2009. Of the 1,934 presentations during this period, forty eight per cent were aged 19– 40 years, with 27.3% female and 20.7% male. The most common primary diagnostic categories were unspecified abdominal pain, unspecified chest pain, syncope and collapse, gastrointestinal symptoms and dizziness and giddiness. Only nine of the presentations triaged to a mental health clinician. Despite the expected incidence of mental health disorders in refugee populations, use of mainstream mental health services or presentation of mental health problems in other settings is low (Committee 2006). The barriers to use of mental health care in people of refugee backgrounds include different understanding of psychiatric illness and the stigma associated with diagnosis of psychiatric illnesses and other mental health problems (Stolk, Ziguras et al. 1998; Andary, Stolk et al. 2003).

MENTAL HEALTH AND ANTENATAL CARE

Promoting maternal mental health has a number of now well documented benefits not only for the mother, but also her baby and the rest of her family. Current data shows in the eleven months from January to November 2009, there were 252 births to mothers born in Afghanistan at Southern Health facilities in SE Melbourne, an increase from 242 for the 2008 calendar year. Only two births were unbooked, indicating that most Afghan women in SE Melbourne already receive some antenatal care (ANC).

Most of these births occurred at the Dandenong Hospital (n=160), followed by Casey (n=51) and Clayton Hospitals (n=39). Antenatal care may represent a unique opportunity for sustainable intervention to address poor mental health and well being (beyondblue 2006). There are a range of antenatal and postnatal programs available in SE Melbourne, yet gaps exist for women of Afghan background, some of which are described here and below. *Healthy Mothers, Health Babies* (HMHB) is an initiative that commenced in the south east of Melbourne in August 2009. This outreach oriented program is designed to work specifically with hard to reach women, such as drug users and women with a non-English speaking background. The program engages with women during their pregnancy and connects them with existing services, providing support until the baby is six weeks old. At this point HMHB hands over to council maternal and child health nurses. The Dandenong City Council also funds parenting sessions that then lead to programs with NGOs such as Wellsprings for Women and Centacare.

Southern Health also has a maternity program for mothers of non-English speaking background. However, a key element of this program is referral of mothers to a GP that speaks their language in the community. While this reportedly works well for more established communities such as Hindi speakers, there are currently no Dari-speaking GPs accredited with Southern Health as part of this shared-care program. Therefore, outside of midwives in partnership (MIP) program, and the high risk category at Clayton, few public antenatal options exist for Afghan parents.

The mother's mental health is central to the wellbeing of the family and the intergenerational effects of mentally ill mothers are well established. Previous research has shown these potential benefits to Iraqi women and their families (Schwarz 2006). Antenatal care as a point of entry has several advantages. Women are generally at heightened emotional vulnerability during pregnancy, childbirth and the postpartum year. Afghan women would be at additional risk of developing depression and anxiety during this period. They are often isolated from family members, such as their mothers and mothers-in-law. In Afghanistan, pregnancy normally elicits support from a large group of women and there are culturally specific rituals associated with childbirth. Such support is usually not available in Australia. Furthermore, Afghan women are expected to resettle in SE Melbourne in high numbers over the next few years as they are reunited with their husbands under Department of Immigration and Citizenship (DIAC) split family visa provisions.

The aim of this study was to explore specific aspects of Afghan cultures, including attitudes towards mental illness and support during pregnancy, as well as patterns of service use, that would assist in identifying strategies to improve the mental health and wellbeing of Afghan women in SE Melbourne.

Objectives

1. To identify antenatal and postnatal support usually available to parents in Afghanistan
2. To document factors that may contribute to poor mental health and wellbeing of Afghan refugees who have settled in SE Melbourne
3. To identify acceptable ways of dealing with stress and distress in the Afghan cultures, in a community setting
4. To identify barriers and opportunities for ensuring effective access to appropriate ante-natal and post natal support for Afghan women in SE Melbourne

METHOD

Qualitative methods were used to explore the cultural norms in Afghanistan and document factors that contribute to poor mental health for the Afghan community in SE Melbourne. Objectives 1, 2 and 4 were explored with Afghan participants. Objective 3 was explored in-depth at the secondary level only with health and community workers in order to avoid exploration of distressing experiences for Afghan participants. Inevitably, however, Afghan participants did offer personal experiences in order to illustrate their knowledge and opinions.

FOCUS GROUPS

Two focus group discussions (FGD) with Afghan community representatives who had migrated to the SE Melbourne area were conducted, one with women (n=8) and one with men (n=6). The Hazara, Tajik and Pashtun ethnicities were represented in both the male and female FGDs. Data collection took place late October 2009. An experienced counseling staff member from Foundation House was available to provide support to any participant who requested counselling or became distressed during the course of the discussion. Participants were purposively recruited from a pre-existing committee of the Family Strengthening Strategy Program, overseen by Foundation House. During the FGD participants were asked to describe the “usual” journey of pregnancy and childbirth for Afghan parents, including important people, events and facilities where support may be provided. In the second part of the FGD participants were presented with a brief scenario of Fatima, an Afghani woman, who was displaying symptoms of post-natal depression (PND) and asked about appropriate ways in Afghan cultures to manage this condition (see Annex 2: Question guides).

INTERVIEWS

Thirteen semi-structured in-depth interviews (Bernard 2002) were conducted with health and community workers in the SE Melbourne area. A pre-designed set of questions was used to guide discussion and included factors they believed contribute to poor mental health for Afghan clients, and ways in which the service or program was competent in working with Afghan clients (see Annex 2: Question guides). All participants were purposively recruited for their sectoral expertise and known contact with Afghan clients through the course of their work. A range of perspectives were sought, including refugee health, mental health and maternal and child health. Data collection took place over October-November 2009.

Both interviews and FGDs were digitally recorded and transcribed. Interviews ranged in duration from 35-73 minutes and the FGDs lasted 2.5 hours. Data were managed and analysed using Nvivo8®.

Most participants were in the 40-55 year old age bracket. All the Afghan community participants had been engaged with Foundation House for over a year, through their involvement as members of the Community Advisory Committee for the Family Strengthening Strategy Program. There were three health and community workers who were also born in Afghanistan.

Table 2: Participant Demographics (n=27)

| | FGD | In-depth Interview (health and community workers) | Total |
|------------------------------------------------|-----|---------------------------------------------------|-------|
| Country of Birth | | | |
| Afghan born | 14 | 3 | 17 |
| Australian/other country born | 0 | 10 | 10 |
| Age Group | | | |
| 22-29 | 1 | 1 | 2 |
| 30-40 | 6 | 3 | 9 |
| 40-55 | 6 | 7 | 13 |
| 55+ | 1 | 2 | 3 |
| Gender | | | |
| Female | 8 | 11 | 19 |
| Male | 6 | 2 | 8 |
| Health and Community Worker Occupation* | | | |
| Refugee Health | N/A | 2 | 2 |

| | | | |
|---------------------------|-----|---|---|
| General Practitioner | N/A | 1 | 1 |
| Mental health | N/A | 1 | 1 |
| Maternal and child health | N/A | 5 | 5 |
| Midwife | N/A | 1 | 1 |
| Community Development | N/A | 4 | 4 |

* a number of health and community workers had a range of roles for which they engaged with Afghan community in South East Melbourne. For instance, some people working in MCH also worked part time in community development. The primary role that informed their responses is listed here.

ETHICAL CONSIDERATIONS

Institutional ethical approval was granted by the Monash University Human Research Ethics Committee. The sample of Afghan participants in the FGD were selected for their usual role in reporting community perspectives. In order to avoid revisiting traumatic memories the question guide was designed to deliberately avoid asking personal questions, particularly in relation to mental health. The line of questioning was directed at the community level cultural norms and practices. Inevitably, some Afghan participants used personal examples to explain their comments, however this was not encouraged. Factors contributing to poor mental health were explored at the secondary level through health and community workers in regular contact with Afghan clients, rather than Afghan people themselves.

RESULTS AND DISCUSSION

Selected findings from both health and community workers and Afghan participants are presented here. These address the following themes: antenatal and postnatal support in Afghanistan; spousal relationships; pre-migration events; loss and family separation, and barriers to accessing services in SE Melbourne .

ANTENATAL AND POSTNATAL SUPPORT IN AFGHANISTAN

This topic was explored with Afghan participants during FGD, as well as in some interviews with Afghan health and community workers.

Afghan women described a combination of pride and pressure in Afghan cultures for a woman to deliver her baby alone. In Afghanistan a wife will move into her husband’s parents home, this is known as a joint family. Women reported that in the joint family hierarchy, the mother-in-law (described by one female participant as “The General”) can wield much control over her son’s wife. The consequences of this power dynamic in the joint family situation varied according to whether she was a “good” mother-in-law or not. Conflict was reportedly not uncommon in joint families. Female participants reported that access to support during the birth is often mediated by the mother-in-law and other joint family members (including the husband). While in part this may have developed out of necessity given the dearth of health facilities available in Afghanistan, poor transport links or danger in traveling at night during conflict, there were also beliefs that the mother should not be seen by others during pregnancy and birth:

‘[if] they live in joint families where there are a lot of restrictions on women they have probably been told you know, “This is your first child, you can’t have somebody else in the room with you because you are bringing shame into the family. Nobody is allowed to see your body, you have to do it all by yourself.’ [FFGD]

One female FGD participant described her experience of an extremely difficult labour in a refugee camp in Pakistan, where medical intervention was refused by her mother-in-law. After two days she was finally taken by a cousin to a clinic where she underwent a cesarean:

'...because my mother-in-law give birth to seven boys and she want me to repeat the same procedure [give birth alone]. There was no medical obstacle [to seeking help], but maybe she got something in heart, to give punishment...Some mother-in-law is very good. Some mother-in-law is no good. My mother-in-law ...did not have a good heart.' [FFGD]

This was contrasted with descriptions of pride by older women, who were likely to be the source of pressure for the younger women to deliver alone:

'every woman in Afghanistan is a hero, because she give birth to baby in the home and then she have to fight all the stuff [injustice] in Afghanistan' – [FFGD]

'I know my grandmother, she had 12 kids and none of them were born with any support, with any help. She had all her kids all by herself, in a room... as she got in labour, she started preparing things for herself and you know, put the scissors next to her to cut the cord and put lots of clothing and you know, water and paper and cotton and everything. And my mum said that she used to go into the room and come back all clean and the baby all clean and all dressed and you know... It's a lot to do with pride and you know, "I can manage" and ... "I am such a good mother that I gave birth, I cut the cord," you know ... so it's a lot to do with pride and how strong you are. I really admire them and I think they must be really strong if they can do all of that all by themselves.' [F2]

'...a lot of curfew is imposed at night-time. And if the mother, she want to go to the hospital, after 9 o' clock you are not allowed to go to the hospital. If you go you will be shoot, you know, because there was a curfew... We are a very big hero in Afghanistan.' – [FFGD]

Male Afghan participants reported a commonly held belief in Afghan cultures that women should restrict their movement during pregnancy and for 40 days after giving birth, and should not visit the home of anyone who has recently given birth:

'Like my wife is for example pregnant. She doesn't visit her family [who have a new baby] because [they] say that might destroy my baby and they [pregnant Afghan women] stay home and they're not going visit, they're not going to attend a wedding party and also they have lots of restrictions... Lots of families you know still just follow the same tradition [in Australia].' [MFGD]

During the first 40 days, the extended family would typically care for the baby to allow the mother time to rest. Significantly, it is culturally taboo for fathers to show affection or touch their baby, reportedly out of respect for their own parents. Therefore, Afghan men described the important and very different role that husbands are required to play for their wives in Australia, particularly following the birth of a child:

'The husbands, they play a very vital role here [in Australia] because women I believe are more depressed here than Afghanistan because in Afghanistan the women have lots of relatives that are helping them and the husbands are free there, but here you know despite working you know, it's just husbands are put under lots of pressure you know to help their wives here [following birth of their child].' – MFDG

Women in Afghanistan were reported to have little, if any, engagement with health care providers. Variation was said to be based largely on the availability of services with fewer facilities in rural areas as compared with urban. However even in urban settings where facilities were available, the degree to which women were able to access health care was sometimes dependent on whether their joint family would permit it. Conversely, those from rural areas reported that clinics may be available yet may not be accessed due to pressure from joint-family members, most often the mother-in-law.

Both male and female participants discussed the preference for sons, and low value of female babies, highlighting the cyclical nature of discrimination against women in Afghan society. One female participant explained that some women did not want a daughter as they were concerned that she would experience the same injustices they had endured:

'this generation keep coming now as asylum seekers, are refugees and other generations who are born in the last 30 years, which means they were born in the war time which was even worse because girls were raped, girls were taken as prostitutes, so they have even more fear of not having girls because they think of what is going to happen, you know. A lot of men in Afghanistan, a lot of fathers actually slaughtered their daughters to save them from being raped and I know it happened when I was still in Afghanistan on our street and to save their daughters from being raped and taken into prostitution... a lot of men actually sold their daughters. They said, "Just take them away, marry them," at the ages of eight and nine because they didn't want them to be raped or taken for prostitution. So there is another theory behind why people want to have boys now.' – F2

'...a lot of women that I work with they say their cousins or their sisters have been raped in front of them. They have been killed, they have been raped and then killed or they have been raped, got pregnant and then committed suicide. "I don't want to have a girl because I have seen what has happened to my sisters..." - F2

The male Afghan participants described the possible reaction that a husband may have to a wife who gave birth to daughters:

'with our culture, boys very important to have boys than girl and especially if a lady has got two or three girls, a husband knows the fourth or fifth one is girl, he wouldn't pay attention too much to the wife' – MFGD

While women reported concern for the safety of daughters being raised during conflict in Afghanistan, there was also stress associated with raising a daughter in Australia:

'I have seen a lot of women who go through a lot of mental pressure throughout their pregnancy, especially having their first child in Australia because they live so far from their country, and they live so far from their families, and because there is a lot of expectation on them, you are in Australia and "How are you going to raise a daughter in ... such a western society as Australia?" So it's easier to have a boy.' – F2

DEALING WITH STRESS AND DISTRESS IN AFGHAN CULTURES

Participants spoke openly about their own experiences of depression in the female group, one man also spoke openly about his own depression in the male FGD. Despite this confidence in speaking openly about depression, there were some references to stigma associated with mental illness in Afghan cultures; some participants reported that mental illness was “shameful” in Afghanistan. Men stated they were typically more guarded about mental illness than women:

'In my culture men are embarrassed to disclose the things, the problems with the strange men. They go first to their very best friend, the closest relative and women normally are embarrassed to disclose things to stranger they go first to their mother.' - MFGD

'In our culture, normally, women are not hiding any problems they have. So first of all they just disclose it to their husbands and secondly they disclose it and just discuss it with the families, so it rarely happen in our culture that they are hiding things.' - MFGD

A few health and community workers compared Afghan's to other refugee groups in terms of their willingness to raise their own mental health problems:

'the Burmese I feel are more open to talk about their mental health issues and are more likely to sit and talk to you about how they're feeling where the Afghanis don't tend to do that.' – F6

The reported prevalence of mental distress among Afghan women is concerning. All female Afghan participants agreed that all Afghan women experience some sort of depression reporting that "every Afghani suffers from mental disease, have mental anxiety or depression, every Afghani", with another stating that "every Afghan woman has some sort of depression or worry." This was also supported by a worker who noted that:

'the level of grief and loss that most of them would present, are very symptomatic for depression... a lot of dissociation and you know highly symptomatic... it probably isn't an understatement to say that they [Afghan clients] all suffer from depression.' – F10

In response to questions about how Fatima, the character from the scenario, may manage post-natal depression, Afghan participants reported that she might talk to friends, talk to her husband, visit her GP or counsellor or take medication. These were all responses that might be expected to be reported from a well informed mainstream population which may indicate in this instance that this sample of Afghan participants may not be representative of the broader newly arrived refugee community, due to the nature and length of their relationship with Foundation House, a specialized refugee service known for its expertise in individual and group trauma counseling.

RELIGION

Cordozo *et al* (2004) found that in Afghanistan reading the Koran or praying was the most commonly reported coping mechanism for Afghan people managing a mental health problem. Other studies with survivors of trauma have also found that religion is reported as a useful coping mechanism (Schweitzer, Melville *et al.* 2006). However, there were mixed responses to the role of religion as a coping mechanism in the present study. It became apparent that religion was not an appropriate topic for a group discussion with these Afghan community members. During FGD, women stated that religion was not an important part of dealing with distress in Afghan cultures, and Afghan men avoided providing a direct response to probing around the role of religion in dealing with distress:

'We are not religious in Afghanistan and we have not got the support of the mosque.' FFGD

An Afghan community worker who initially stated that she was 'not a very religious person' went on to explain that Afghans 'were a religious people but not in the way it is expected now' she stated:

P: I think after the Taliban people have been forced to do that sort of thing [display visible religious signs such as wearing the burka]

I: Sure and now people want to move...

P: Some of them are sick of it.

I: Yes, okay.

P: Some people are sick of it....' – F7

When asked about praying, as distinct from religion, she went on to say:

"I pray three times a day... I want to be a good Muslim... One thing that is really good and has been helping us that we all believe this, we all believe in God. We all believe that if something is to happen, it will happen and so we accept it...That's how we survive. Like myself I lost my home, I lost my job, I lost my money, I lost everything, but I regained it with full power." – F7

It is likely that conflict has produced divisions around religion. More sensitive questioning about specific aspects of religion, such as the five pillars of Islam (profession of faith, prayer, giving alms, fasting and

pilgrimage to Mecca), rather than religion itself, may yield more useful insights into the role of Islam as a means for Afghan people coping with distress. This may also be more appropriate to explore in an interview rather than FGD.

FACTORS INFLUENCING MENTAL HEALTH AND WELLBEING

There are many layers to the refugee experience, however these can be broadly categorized in to two areas – pre-migration and post-migration. Themes that emerged largely related to the socially determined framework for understanding mental health described by VicHealth: social inclusion, freedom from discrimination and violence and access to economic resources. Afghan women are particularly vulnerable to poor mental health for a plethora of socially determined reasons, outlined below.

PRE-MIGRATION TRAUMA, FAMILY CONFLICT AND SEPARATION

Afghan participants mentioned trauma, family conflict and separation from family members as major concerns that continue to affect the mental health of the Afghan community in Melbourne. They also offered information about the high prevalence of poor mental health amongst the Afghan community:

'P: To be honest with you we are coming from war zone. Anybody who sees people being killed, poverty, hunger, sad neighbours and all that, it adds to the sickness, isn't it?

I: Absolutely.

P: So I think this is the main reason, because... half of [the reason]...

I: Okay.

P: ... and most of the women are suffering from body pain and joint pain and all that. And the other day I asked one of them, "What happened, why everybody is suffering from back pain and body pain and this and that?" And she told me that for a number of days in winter, we have been hiding in the basement because the rockets were coming and we couldn't come out. Mostly we were hiding and if we were brave enough, one of us would sneak up and get some food or something. Otherwise, we had to hide in there and by the time we got out of it, we couldn't walk anymore, our backs were so painful and it's remained there.' – F7

'...in Afghanistan, nearly 40 years, we have a war. And women, they come here, everyone have a post-traumatic disorder or something like that because they remember the trauma. Because mother-in-law traumas, like in-laws traumas, that's why they make her more upset, or the war traumas...' - FFGD

'The woman is coming from Afghanistan... they are suffering from lots of problems back there and here they are also suffering from depression and anxiety and lots of problems [here].' - FFGD

'The presence of a woman is very, very important in our culture. If Fatima [character from scenario during FGD] has her mother with her, she is less depressed. If Fatima does not have her mother with her she is more depressed. The presence of mother is very vitally important in our culture.' – MFGD

However the causes of mental health problems were largely explored with health service providers rather than in-depth with Afghan advisory committee members to avoid revisiting potentially traumatic memories. A health worker noted:

'obviously all of the torture and trauma, the family you know the loss of family members, the trauma and difficulties with travel and uncertainty they would have experience no doubt in [Afghanistan]. The trauma and certainly of brutality and torture and regime, there's no question about that being unfortunately a component. But there's lots of others you know I think we do

tend to sort of just lift up the torture/trauma because it's immediately identified but I don't think it's – by no means is it all – does it completely encompass that they mental health issues that they experience. So there's also significant illness that the loss of security that comes from seeing family members severely ill just as a result of malnutrition and moving around and lack of access to housing and lack of access to clean water and all these other things.' - M12

THE LEGACY OF TEMPORARY PROTECTION VISAS (TPV)

Health service providers also commented that on top of these pre-migration issues, the post-migration problems are also far reaching. The Australian Governments' asylum seeker deterrence strategy involved the use of Temporary Protection Visas (TPVs) for almost a decade from October 1999. TPV holders had restricted access to basic services such as Centrelink, education, and had no family reunion rights. A TPV granted refugee status for only three years, after which time the claim could be reviewed. While TPVs were abolished in August 2008, the damage to relationships and the mental health problems associated with holding this type of visa endures. The psychological distress caused by the fear of being deported at the end of this period has been documented elsewhere (Johnston, Allotey et al. 2009). Lengthy periods of separation from family members has been found to exacerbate trauma, and the toll this separation on individuals and families has also been documented elsewhere (McDonald-Wilmsen 2009). At the time of this study, many Afghan community members had been recently reunited with immediate family members after years of separation. Afghan men had invariably spent lengthy periods in detention centres.

Questions about the impact of TPVs were deliberately not explored with Afghan participants. Instead, service providers were to be asked to describe factors that contribute to poor mental health for their clients. Distress associated with TPV was mentioned by some health and community workers in this study, but not the majority. This may be because at the time of this study it had already been over one year since the visa was abolished and was therefore not in the forefront of participants' minds. Those who did mention the problems associated with TPVs worked solely with refugee clients, as distinct from "mainstream" services:

'..the TPV situation, the separation that families had for many years, I think that is going to take a long time for people to recover. I think that's impacting a lot and that's why we ran the fathers and children's group to help with the connection of the men with the kids because they have been separated for such a long time... women also said "we need this [group] for us", like "we don't know how to connect with our husbands, you know, they are like strangers to us." Because they have been separated for six or seven years...' - F10

'Obviously a lot of the more recent arrivals in this decade have been Hazaras and a lot of them came on the boats from the Tampa onwards and were in detention for periods of time, were then given TPVs so it's only been in the last couple of years that they've all started to get permanency and so reunification with wives and children having had long periods of separation some up to seven years. I mean they [the Afghan FSS Committee] quite clearly identified that there are many challenges reuniting families and kids not knowing their fathers, wives having maybe only been married very briefly before their husbands fled and so that whole thing of one reuniting with family that they don't really know but also within a cross-cultural context which gives all these added issues.' - F3

SPOUSAL RELATIONSHIPS

Acculturation difficulties for Afghan men were reported by a significant majority of Afghan participants and community and health workers in contact with Afghan clients:

"Afghanistan ... is a ... man dominated country and here it's a woman dominated country, so ... it might contribute to depression in families here...women have more power, women understand

their rights, but Afghanistan it's totally different. A man is, a man dominated area, where a man can have a position in an office and with the government, so he's higher than a woman" – MFGD

"the difference between Afghan culture and Australian culture is so wide, so it's hard to bring them together..." - MFGD

Afghan male participants also reported that expectations placed upon Afghan women in Australia could lead to "confusion" for Afghan women. For instance Afghan women may be expected to make decisions and sign forms independent of their husband, and may typically be the recipients of Centrelink payments for their children.

This complexity of the acculturation process was reported to cause tension in many spousal relationships which some cases led to domestic violence. While there was a recognition that the underlying dysfunction in spousal relationships was associated with damage done to the family unit through lengthy periods of separation, a huge change in and gender roles, expectations and an elevation of women's rights in Australia was also reported as a major source of tension in relationships:

"I think in many families struggling with traditional roles or ways of living and you know, some are more, you know, able to adapt or are adapting and you know the women are, ... there are amazing Afghan men who are very supportive of their wives. But then there are some very traditional and you know, just how do they negotiate that? – F10

Both Afghan participants and health and community workers reported that domestic violence was not uncommon in Afghan families:

"I believe the husband plays the best role in avoiding that [PND] for a woman. But unfortunately in our culture, in Afghan culture violence is the common way so lots of women not getting help from their husbands." - MFGD

"In my community there's a lot of unhappy relationships. A lot. It's, maybe, 80% of my community women are not happy. But because of the culture they should be still with the husband. If happy or not happy, they have to survive. Because it's a part of culture... women should know their rights and that not everything is compulsory for them." – F1

Injury was also reported to be a significant issue for men:

"I think there is a lot of family relationship, family conflict kind of issues but that's not our core business you know, that's not to do with trauma. That's a lot to do with settlement ...particularly with adolescents around managing the kids acculturation and the parents wanting to be more traditional... the number of Afghan men that we work with injuries who are trying to get Work Cover is huge, well a lot.. because many of the men, when they got work rights they went straight to work, they didn't go to English classes, to try and get money to sponsor their families." – F10

Many health and community workers felt that an intervention to address poor mental health of women should engage and support men through this cultural transition:

But you know, while we're down on the men, we need to help the men and start where they're at so that they can accommodate this new way of being.' – F9

Tension in spousal relationships was also reported to stem from too much or not enough time together:

'...when Afghan men stay home it's big headache for women because they [women] talk all the time and it makes problems for him, and for families. And if men are also working for seven days a week it's a big problem again because most Afghan women haven't got a driver's license to shopping, to pick up kids from school. And this makes problems for them.' - F1

'in Afghanistan women lived in a joint family and she had friends, she had people to chat with. The only time she got with her husband was when they were sleeping or when they were in one room together ... and then suddenly when they come to Australia, the husband is only thing they have got ... and because men, they have never had that role in Afghanistan to speak to their wives and to share things with their wives, suddenly they are under a lot of pressure ... But then women who go outside see these Anglo Australian women who go shopping with their partners, who go to movies with their partners who have dinner and lunch and they sometimes say that my partner is my friend, I talk you know, and these women feel, why don't I have that relationship with my husband...The only time they talked to their husband [in Afghanistan] is if they have to complain about his mother.' - F2

ISOLATION

Many Afghan participants reported they lacked a sense of community compared to their home in Afghanistan:

'You know, in Afghanistan you go out of the house and you are sweeping the front of you house and you can talk to your neighbour and here a lot of women say, "The streets are so clean that we can't even go out and sweep them." Or you know, "we can't even sweep our backyards because there is not dust and if we do, the neighbour next door just drive their car and doesn't even know who we are." So there is a lot of isolation.' – F2

'In Afghanistan we have a really social life, like, in one street there's 50 houses, all neighbour here know each other. My mother jump from my neighbour house for two hours, just have chat and jump to other neighbours how and they have got chat. And also we have got very close relationship between the close family, like, my aunty coming two nights over to sleep with the us, with the kids. And we have got really social life there. But in here everybody busy by themselves and no time to come to see each other.' – FFGD

Health and community workers also commented on the unhealthy design of the areas where Afghan community were settled, commenting in particular on the lack public transport in the outer south east of Melbourne, where housing is relatively more affordable:

'A lot of them are quite young and they're doing it alone, so the isolation and the new surroundings, very often the whole issue of reunification they don't really know their husbands so they feel even more alone, they're thrown into a new country, a new relationship either pregnant or having a new baby, they've got a little toddler running around, no family support, don't know where to turn for that sort of advice about babies and parenting, all those normal things. They're stuck out in the most isolated areas where there is no public transport, they've got no money, they can't speak English, they have nowhere to turn to.' - F3

Men commented that the Afghan community in this area had formed groups, and described difficulties for those who were not a part of these groups:

'One of the problem that Afghan community are facing in Australia is unfortunately all of them become like a group... each group might have a leader ... that every group should follow the leaders instruction, otherwise they cannot get help that others they benefit from. If one of the pregnant ladies not covered with any of these groups, she's not part of any group she might be isolated, nobody would pay her lots of attention or support to her and they will get depression.' – MFGD

Further questioning could be done to better understand how and of whom these groups are comprised, whether they are ethnically based, family based etc. Participants reported in the present study that Afghan women tend not to socialise outside of their family of their own accord. While many were willing

to join social activities organized by non-government organisations such as community kitchens or playgroups, often relationships formed during these groups were reportedly not sustained:

'... the majority of socialising is done within the house with family members and if it's outside the family home it's with family members.' - F4

When asked what they thought would improve the mental health and wellbeing of Afghan women Afghan participants called for more activities that would bring their community together. They suggested simple community based activities such as playgroups, spaces for women to socialize and talk, dance etc. There are successful existing examples of such activities; Queen Elizabeth Centre runs an Afghan playgroup in Noble Park, and Windemere recently held a community kitchen in Hampton Park. Both of these programs have had positive evaluations and are clearly popular with the Afghan women who attended them. Opportunities to sustainably scale-up these programs would go some way to addressing social inclusion for this population.

AWARENESS OF RIGHTS

While not discussed widely by participants, one of the older female participants in the FGD reported that women of her generation had become depressed and frustrated, having seen the respect that women can be afforded in Australia, as compared to Afghanistan:

*'... [in Afghanistan] we have not got time to ourselves to think about ourselves ...yeah, but **when we come here we know we are human, we have got our rights and we see other women have their rights and that's why the depression is starting.***' - FFGD

ACCESS TO SERVICES

Many Afghan participants made a point of reporting how grateful they were for the services available to them in Australia. Barriers to accessing services included expectation by Afghan men and women that husbands accompany their wives to appointments, inadequate access to and funding for interpreters, the cost of some services, problems accessing transport, and the availability of some services.

HUSBAND AS GATEKEEPER

Almost every health and community worker participant commented on the cultural norm of husbands attending appointments with their wives. Similarly, Afghan men acknowledged the significant role that they play in supporting their wives to attend activities or appointments outside the home. There are some practical reasons for this; husbands who have often arrived earlier than the rest of the family are more likely to have their driving license and be able to speak English. However, there was also an implication from women and health and community workers that this related to an aspect of control over their wives. Requiring both husband and wife also reduces the time-opportunity for women to access health care and participate in social activities, as many Afghan men work long hours. Both female Afghan participants and health and community workers reported that this restricted a woman's mobility and freedom. Some service providers found the husband's presence obstructive when trying to address a concern with their wife:

'Afghanis they've got that more patriarchal community so if you try to talk to a woman about some of the issues that she's facing, it can be sometimes very difficult when her husband's in the room and often there's that real difficulty in trying to separate the husband and wife in order to talk to the wife on her own. It can be quite tricky sometimes.' – F6

"Sometimes the husband would drive the consultation and they would be doing all the speaking, so everything had to go through them, even though the wife is the patient... it really varies on a

continuum. Some husbands are so strict that they just address the husbands concerns about the wife and the wife does not have a chance to raise a concern in the consultation through the husband. Some will be in the middle where they will talk about things and then hand over to the wife who talks and some will be sitting in the background but you know that the wife is conscious of his presence and altering, and being very careful with, her wording about things.’- M13

Participants reported that some husbands would eventually retreat from attending regular appointments with their wives when they had gained trust of the service provider and understanding of the purpose of the activity:

‘A lot of the women for example in the first meetings brought their husbands because their husbands had to give approval where we didn’t necessarily have that in the other groups...[the husbands] needed to know who the other men were, obviously, in the group, what the aims and objectives were, whether it was something they basically approved the women attending... In the first few meetings husbands sat at the back of the room and I guess at some point they realized it was fine and they never came back again... it’s a very vertical structure, Afghan families, it’s very patriarchal with men at the head and then it goes down and I’m not quite sure where the women and children fit. Everything has to be approved of by the husband and I think if you look at it in Afghanistan women really weren’t allowed or rarely mixed outside their ... family group...’- F3

AWARENESS OF SERVICES

Afghan workers reported that Afghan women lacked awareness of services available to them:

‘Most of the violence is against women in Afghan families. Because Afghan women don’t go to the police or go for their rights... most of the women [that see me] have got very bad violence at home but they don’t go to a women’s refuge, not because they are scared, but they don’t know the language and don’t know their rights, don’t know the very basic things in Australia.’- F1

‘I have one family down here that the father he was really, not angry, he was frustrated because his wife had done all the hours at AMES that she could and still could hardly speak English. He said to me “She’s from the village. All she’s ever done is sat in the village and fed the baby and whatever” so he was, he had to get his older children to take her out and teach her how to use a pedestrian crossing. And he said “I want her to do these things. I want her to go to the shop on her own”. He was one that was wanting her, and she just found it very, very difficult. So some of my families that the girls are at that level, you know, suddenly they’re out of Afghanistan, they’re in Pakistan. They have a terrible time in Pakistan. The Pakistanis don’t want them. They’re not allowed to work, and it’s a terrible time. And then finally they get out here and it’s just like they’re on another planet.’ – F9

ACCESS TO INTERPRETERS, COST AND AVAILABILITY OF MENTAL HEALTH SERVICES

In Australia, a GP can refer a client to a psychologist to a mental health plan with a psychologist, where 10 sessions covered under the Medicare scheme. One Afghan participant reported that she had found the cost of mental health psychologists prohibitive, as this scheme still requires an upfront payment of around \$150, resulting in a gap payment of around \$40 following Medicare rebate. Moreover, funding for interpreters is not available to private psychologists, further blocking access for refugees who cannot speak English.

‘there is some Medicare funding for psychology services, although with these private psychologists, you can’t get interpreters for free, so you can’t use an interpreter with a private psychologist generally and there aren’t any that I am aware of that speak Dari or Pashtu and then with Foundation House which provides a great service, there is a bit of waiting time...’ - M12

Accessing psychiatrists through the public health system in the SE region is reportedly difficult, even for mainstream users, due to the limited number of psychiatrists practicing in the region. A GP noted that psychiatrists were also currently unlikely to be of assistance for the Afghan community in SE Melbourne as the up-front costs would range between \$160-200:

'you can get a psychiatrist if you are so sick that you are admitted into hospital and you are admitted into the psychiatric ward and then discharged, then you will have a psychiatrist, but apart from that it's extremely difficult to get one.' – M12

Simply getting an appointment with a counselor or GP can also be difficult for refugees. Foundation House, which provides specialist counseling and a mental health clinic for refugees, has a relatively lengthy waiting list for refugees who have been in Australia more than one year. Furthermore, there are also reports that fewer GPs in the Dandenong area are willing to consult refugee clients. Reasons reported for this are that they typically have more complex health needs and because they often require an interpreter, essentially doubling the length of the consultation. GPs complain that the existing Medicare Benefits Schedule items do not provide sufficient funding to justify such consultations.

EXISTING ANTENATAL AND MATERNITY SERVICES IN SE MELBOURNE

While Southern Health hospital data shows that of the births at their hospitals, almost all Afghan women have had at least one antenatal visit, some workers reported that some Afghan women did not see the value in antenatal screening appointments:

'P: So we are talking about people who have had kids here before but they are still not used to the system. They think, it doesn't matter, they won't find me out this time and I can just keep – and she just kept telling me, "Why do I have to come to these appointments, what's the point, you know, I am a healthy person. I don't have any problems, three of my kids were born naturally," and so it's teaching them the whole idea about why do you have to come to these appointments.' – F2

'Most women had had home births and they couldn't quite work out why they had to come [to antenatal appointments].' – F11

One participant reported that some Afghan women have a preference for birthing at home:

'So you tell them that they have to have these ante natal appointments and they will go because that's their first child there in Australia and you know, but people who have had kids in Afghanistan and then the second or third child is in Australia they are like, "But why do I have to do it, why can't I just have it at home?' – F2

The MIP program run from Dandenong hospital reportedly has a good uptake by Afghan women. This maternity option provides 3-4 antenatal screening visits with a midwife prior to the birth and, where there are no complications, a "natural" birth with midwives. One participant reported how she believed this type of program was particularly well suited to refugee clients:

'I've said all along the women from Afghanistan and the women from Sudan, they are ideal midwifery candidates because they don't have any expectations really about – they don't come in, like the Australian women "I'm sick of being pregnant and I want to be induced", you know we have the other extreme, "look you're 42 weeks and we're really concerned about your baby, we think you should be induced", "no, don't want to be induced".

I: Right.

P: So they don't have any expectations like that. They're coming in labour, they don't come in demanding an epidural as soon as they come in because they just see labour as you've just got to get on do it you know... And they're really keen to go home early because they've got to get

back to their family and they don't want to stay in hospital where nobody can understand them and whatever. So they're really ideal midwifery care candidates in that regard.' – F5

Afghan people typically have a strong preference for female-only carers, particularly during a birth and some Afghan participants and health workers reported limitations in the maternity system:

'Southern Health has a policy that we can't offer... female- only care because once they come into the birth unit, you know, the doctors work a roster... But most women when you explain that to them are accepting of that... "if there's a problem we have to get the person who's most experienced to deal with the problem and it could be a man." And generally speaking they'll go, "that's okay". But sometimes they don't and we have had issues where – and generally it's the husband more than the woman and just say "no, we won't see a man" if it's a man. We've had women who, you know, perhaps needed to be, have the labour induced for whatever reason and they've just flatly refused because they won't have a man examine them.' – F5

Afghan men reported that the possibility of a male being present at the birth caused distress for women:

'during pregnancy most of the ladies they are ... quite stressed and afraid of being, of their [male] doctor being there during the time that they are giving birth. They want female and that itself generate a stress on them. If from the beginning they know that it's going to be ladies, they have got a better and sort of relaxed pregnancy.' – MFGD

A number of health workers noted that some Afghan clients had low levels of awareness of sexual and reproductive health, including contraception and termination options. Health workers also commented on the difficulties raising large families in Melbourne. Given the high fertility rate of Afghan women (in Afghanistan) it may also be useful to incorporate sexual and reproductive health education into community activities, including contraception options.

A potential limitation for Afghan women, some of whom may be more likely to have complex needs, is that the MIP program caters for low-risk pregnancies - women who have had more than five births, or with a mental illness are referred to the high risk unit at Clayton, unless an obstetrician reviews their medical history and approves their admission to the MIP program. The high-risk unit is characterized largely by young mothers and substance users, a group likely to have quite different needs. Furthermore, it was reported by health workers that Southern Health antenatal classes at Dandenong Hospital cannot book interpreters for after hours sessions. Most Afghan parents are unable to attend during business hours due to their husbands work commitments.

Afghan men suggested that it would be useful to run a class for pregnant women to provide information about the range of support services available. Afghan women also said that it would be useful for Afghan men to be present during the birth of children as this may support the development of respect for women. The MIP program reports that this is now the norm for Afghan parents who use this maternity service.

LIMITATIONS

The information reported here is based on the perceptions of a group of purposively sampled participants and may not be representative of the viewpoints of the wider Afghan community in SE Melbourne. This study did have some limitations, due to the bilingual nature of the study and also the sample of participants selected.

Afghan participants had an existing relationship with Foundation House due to their role in the FSS. This was a strength in the study as the familiarity and trust already gained through this relationship provided an ideal platform for an open and honest discussion. However, it also meant that this sample had more knowledge of aspects such as the mental health system than may be expected of the general Afghan community in this region.

Factors contributing to poor mental health and wellbeing would have best been explored with the Afghan community, however it was ethically questionable to explore these questions in depth with Afghan participants in such a time-limited project. However, much of the information reported by health and community workers, who due to the volume of Afghan clients that they see, still had valuable insights into this population.

Future studies should seek to engage an Afghan researcher to conduct FGDs in Dari, rather than use an interpreter. This would enable a more relaxed discussion and would be more efficient in terms of the time available. The preferred interpreters were unavailable for our FGDs and there were subsequently some problems with the interpretation. For example, during the female FGD the interpreter began participating in the discussion, and at some points she provided her own opinion on topics which seemed to temporarily affect the trajectory of discussion with other women in the group.

Despite these limitations, the study still produced valuable information that should assist in the design or adaptation of services and programs to address the needs of this population.

CONCLUSION

There were a number of strategies identified by this study that that could be developed, as well as adaptations to existing services, in order to address the reported high levels of depression and anxiety amongst Afghan women in SE Melbourne.

Simple, sustainable, community-based interventions that bring women together in order to overcome feelings of isolation, would support improved mental health and wellbeing. Initiatives such as playgroups and community kitchens are examples of successful interventions that already do this. However, when developing a group model consideration should be given from the outset to transport, interpreters and developing the trust of the women's male partners. Group-based interventions that incorporate health education to assist in improving the mental health literacy of the Afghan community and provide information to women about a range of services available to them are also likely to be effective in improving wellbeing.

Future research should seek to better understand the mental health and wellbeing needs of Afghan men as well as appropriate strategies for addressing problems identified. This study found that acculturation difficulties upon arrival in Australia, as well as long periods of separation, often led to tension in spousal relationships. Afghan men, health and community workers were all vocal requesting resources to address the mental health needs of Afghan men. Further exploration of ways to support men through this complex process of social change is needed.

The reportedly high levels of depressive and anxiety symptoms in the Afghan community in SE Melbourne are of concern. This study did not attempt to measure the prevalence of depression and anxiety amongst the Afghan population in SE Melbourne, however this information may be useful both for advocacy and where appropriate, as an indicative baseline for future interventions. Tools that have been used successfully with other South Asian populations that could be considered and adapted for this purpose include the General Health Questionnaire 12 (GHQ 12) and the WHO Quality of Life (WHOQOL BREF) survey.

While the MIP program seems to be a popular maternity program for Afghan parents in this region, antenatal and maternity care choices in SE Melbourne are reportedly limited for this group. There appear to be relatively simple adaptations that could be made to this system to provide appropriate access to these services for Afghan parents. Such modifications include:

- providing more funding for, and allowing more flexible bookings of, interpreters for antenatal and maternity services at Southern Health facilities, allowing Afghan parents to access more convenient evening antenatal classes;

- assessing existing numbers of Dari or Pashtu speaking GPs in the region and encouraging these GPs to apply for accreditation with Southern Health to provide maternity care;
- exploring the possibility of referring expectant Afghan parents to English speaking GPs who have fee-free access to interpreters;
- encouraging Afghan women to undertake general practice or midwifery training and where existing qualifications from Afghanistan exist, support the transfer of these qualifications to the Australian system.

Women have contact with the health service for a period of approximately six months during antenatal and postpartum care. The prolonged period of contact allows for the development of trust and empathic relationships, both of which are significant elements in the engagement and treatment of traumatised refugee groups. Regular visits to the maternity service may offer a very good context to provide a carefully tailored mental health and wellbeing intervention program(s) to supplement routine care. This would promote the health and wellbeing of the women and their babies and have flow on benefits to husbands, children and eventually the community. The HMHB program will also have a key role in providing support to Afghan women.

ANNEX 1: LIST OF ORGANISATIONS WHO PROVIDED ACCESS TO PARTICIPANTS

Organisation

Centacare

City of Greater Dandenong Council

Dandenong Casey GP Association

Healthy Mothers, Healthy Babies Program, Casey-Cardinia, Southern Health

Midwives in Partnership Program, Dandenong Hospital, Southern Health

Queen Elizabeth Centre, Noble Park

Refugee Health Clinic, Dandenong Hospital, Southern Health

Springvale Community Health Centre, Southern Health

Victorian Foundation for Survivors of Torture and Trauma Inc. (Foundation House)

ANNEX 2: QUESTION GUIDES

FOCUS GROUP DISCUSSION

Afghan advisory group (one group male and one group female)

Context specific support during/after pregnancy

Facilitator acknowledges the complexity of the Afghan experience, in terms of conflict and displacement interrupting the traditional/cultural experiences, and the likelihood that many people may have spent time in Pakistan and Iran.

Request is made of participants to draw (on paper provided) the ideal journey a woman and her husband might follow during pregnancy, delivery and one year after birth in Afghanistan. Note the important usual support mechanisms and key events etc. Please be as detailed as you can.

Each group presents drawings to the larger group for discussion:

- Are there practices that are unique or common to Pashtun, Tajik, Hazara?
- What is the role of various family members e.g. husbands, grandmothers, sisters etc?
- What interaction, if any, occurs with health system?
- What are the key cultural events e.g. celebratory, religious etc?
- Which aspects are protective for mental health and wellbeing of the mother?
- Which aspects may hinder mental health and wellbeing of the mother?

Considering the issues discussed above, what ways of doing things do you imagine Afghan refugees have been able to maintain or wanted to maintain at each point in their journey to Australia- in Pakistan/Iran etc and now in Australia? Is it easier to maintain these in a Muslim country? Are there any that you are happy to let go of, or feel that is more helpful, because you are away from “home”?

Which factors in the environment in Australia do you think are conducive to, or helpful in maintaining? Anything that you view as things that support good health, – e.g. medical & family/community activities? And which things are not helpful?

Culturally appropriate ways of dealing with distress

Facilitator: Introduce the concept of mental health and wellbeing. Acknowledge there are many factors that contribute to distress and poor mental health. The transition to parenthood can be a particularly difficult time for any parents irrespective of cultural background or social position. Research on postnatal depression in recent years has shown that many mothers experience difficulties following the birth of a child. This can have impact on the rest of the family and the health of the child.

Participants were presented with a scenario where a mother who is of Afghan background is displaying symptoms of post natal depression:

Fatima has been here three years, she had her first baby two months ago, she doesn't have an appetite, she is not sleeping well and finds it hard to get out of bed in the morning. She had a group of friends that lived locally that she used to talk to, but lately she doesn't have the energy to visit or phone them.

What impact might this person's poor health have on the rest of the family? What things might an Afghan woman do to manage her problems?

Discuss:

- What does each group suggest as potential problems for Fatima
- What strategies could she employ to manage problems (probe: who, what, where, when, why: eg. praying, husband, friends, yoga, walking etc)
- Do these resources exist in the Dandenong area? (If yes, are they accessible for people of Afghan background?)
- What factors might prevent her from seeking help from health professionals like counsellors (probe: stigma, language, time, doesn't know they exist, does not understand role of counsellor, transport, socially unacceptable to go outside group, husband may feel uncomfortable etc)?
- Are there different coping strategies for men and women in Afghan cultures, if so, how do they differ?
- What could be done both from a community & health providers perspective to help this woman and her family in Dandenong?

INTERVIEWS WITH HEALTH SERVICE PROVIDERS (MCH, COMMUNITY, REFUGEE HEALTH, MENTAL HEALTH ETC)

1. Can you tell me about your role in < *insert name* > organisation? How long have you worked in this role?
2. What proportion of your clients would you estimate are of Afghan origin? Approx. how many Afghan clients (male and female) do you have/see in this service?
3. What is your sense of the reach of coverage of the service/program? Are there groups/people/demographics you would expect to see that you are not?
4. For what reasons do you see Afghan clients?
5. Do the needs of these clients typically differ from other clients?
6. What factors do you think might have an impact on the mental health and well-being of Afghan clients (probe: do your clients have any specific complaints, may related to pre-resettlement or post-resettlement i.e. detention, separation from family, trauma/torture, isolation, language difficulties, visa/legal, ongoing conflict in Afghanistan etc) Anything else?
7. Is the pattern of service utilization by Afghan clients different to that of other clients? If so, in what way? (probe: frequency, brief admissions, etc)
8. What expectations do you think your Afghan clients have of your service?
9. Do Afghan clients have expectations of your service that you feel you are currently meeting?

10. Do you perceive there are unmet needs for your Afghan clients?

11. In what ways do you think your organization is competent to work with clients from an Afghan background? (probe: cultural competence of staff, access to interpreters, general awareness of circumstances of Afghan refugees etc)

12. What strategies could be employed / changes could be made that might improve mental health and well-being of Afghan women and their families in your area? (Probe: changes on behalf of service provider (s) and others changes targeted at client, wider community etc)

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