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Family planning and Afghan refugee women and men living in Melbourne, Australia: new opportunities and transcultural tensions

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ABSTRACT

This research aimed to explore the family planning perspectives and experiences of Afghan women and men living in Melbourne. A total of 57 Afghan women and men participated in six focus groups and 20 semi-structured interviews. The majority of participants indicated a preference for two or three children and were open to using modern contraception. However, many women described experiencing negative side effects when using hormone-based contraception and expressed difficulty negotiating condom use with their husbands as an alternative. Some women described how these difficulties resulted in inconsistent contraceptive practices and, at times, unintended pregnancy. Participants recognised that health professionals have an important role in addressing their family planning needs. This study highlights the ways in which Afghan women and men are changing in relation to their family planning beliefs and practices, and the opportunities, challenges and transcultural tensions they experience as they navigate these issues in Australia.

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Introduction

Family planning is an important public health strategy that enables people to make informed choices about family size and birth timing. This is largely achieved through access to fertility regulation and assisted reproduction technologies (World Health Organization (WHO) 2018). While the benefits of family planning have been realised in most developed countries, the issue remains a concern in many less developed nations.

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There is a body of research exploring family planning among refugee and migrant populations that have moved from less developed regions, into more developed, Western contexts. Such studies have found that many cultural groups continue to experience unmet reproductive health needs post-resettlement, including low rates of contraceptive uptake, and increased risk of unintended pregnancy (Metusela et al. 2017; Ngum Chi Watts, Liamputtong, and Carolan 2014). These issues have, in part, been attributed to inadequate contraceptive knowledge (Metusela et al. 2017), concerns about the health risks of hormone-based contraception (Hawkey, Ussher, and Perz 2018; Rogers and Earnest 2014), religious beliefs (Ellawela et al. 2017; Srikanthan and Reid 2008), and cultural norms that impede discussions of sexual and reproductive health (Rogers and Earnest 2014; Ussher et al. 2017). Furthermore, several studies have described how, at times, male partners' decision-making authority overrides women's preferences to use contraception (Dengi, Koivusilta, and Ojanlatva 2006). Paradoxically, however, men's voices are largely absent within this field of enquiry.

While migration is a significant life event that can profoundly impact sexual and reproductive health (Ellawela et al. 2017), there is a paucity of research that has considered the ways that rapid social and cultural change influences family planning in refugee and migrant populations. The limited research in this area has found that some cultural groups, such as Somali and Afghan migrants, have experienced a reduction in family size following resettlement in countries with lower fertility rates (Abbasi-Shavazi et al. 2015; Dengi, Koivusilta, and Ojanlatva 2006). Additionally, several studies have highlighted shifts in knowledge, attitudes and behaviours by undertaking intergenerational comparisons (Dean et al. 2017; Rogers and Earnest 2014). However, there is a need to gain additional insights into the experiences of cultural transition for individuals themselves and explore their perceptions of how family planning needs change and evolve as they navigate new cultural environments.

People from Afghanistan have been well represented in the humanitarian intake of many Western countries over the last 15 years. The social, cultural and political circumstances that many Afghans have experienced suggest that this population group is likely to have unmet family planning needs. Such factors include low levels of contraceptive uptake in Afghanistan (Population Reference Bureau 2013); traditional patriarchal social structures (Povey 2007); widespread religiosity (Tober, Taghdisi, and Jalali 2006); low levels of formal education (Rasooly et al. 2015); extended exposure to political unrest (Huber, Saeedi, and Samadi 2010); and the refugee journey. There is a small body of research investigating the sexual and reproductive health of Afghan migrants and refugees within Afghanistan's neighbouring countries, such as Iran (Abbasi-Shavazi et al. 2015; Tober, Taghdisi, and Jalali 2006). There is, however, a paucity of research exploring how family planning is valued and negotiated by Afghan people in Western contexts.

Sexual health strategies targeting culturally diverse communities can be enhanced by research on specific cultural groups. Currently, there is limited literature available on the family planning experiences of Afghan individuals living in Australia to inform the development of programmes and services. Furthermore, the voices of migrant and refugee men are noticeably under-represented within this field of enquiry. Accordingly, this research aimed to explore the family planning perspectives and experiences of Afghan women and men living in Melbourne, Australia.

Methods

Setting

Between 2017 and 2018, the Australian Government granted 16,250 visas under the Humanitarian Program (Australian Government, Department of Home Affairs 2018). Over the last five years, migrants accepted via this stream have included equal numbers of women and men and approximately 50% have been between the ages of 18 and 49 years (Australian Government, Department of Home Affairs 2018). These migrants have predominantly originated from countries throughout Asia, Africa, and the Middle East – including Afghanistan. Australia's most recent national census data stated that there were 46,800 Afghanistan-born residents, and the local impact of these migrants has been significant in certain regions (ABS (Australian Bureau of Statistics) 2018a). For example, the City of Greater Dandenong and the neighbouring City of Casey, located in the south-eastern region of Melbourne, are home to the largest community of Afghanistan-born people within the state of Victoria. In 2016, it was reported that 14,617 Afghanistan-born people live within these two municipalities alone; over 30% of all Afghanistan-born people within Australia (ABS (Australian Bureau of Statistics) 2018b). The current study was undertaken within these catchments between 2016-2017.

Design

This qualitative investigation involved six focus groups and 20 semi-structured interviews with 57 Afghan women and men. Qualitative methods were considered appropriate for this research given the exploratory, cross-cultural nature of the study and the sensitivity of the subject area (Creswell and Plano Clark 2011; Liamputtong 2013).

This study applied a community-based participatory research approach (Mikler and Wallerstein 2008). As such, community researchers from the priority population were employed, and worked collaboratively with the academic team throughout each stage of the research process. A high level of community involvement, including shared and equal project ownership, was invaluable within the current study. Community researchers optimised cultural competency throughout the research, particularly in the development of research methods and data collection tools. Furthermore, they nurtured trust and rapport between the research team and the participants, and overcame logistical challenges related to community access and language barriers. The involvement of community researchers also improved data quality, as they applied their depth of cultural knowledge and experience to the focus group and interview procedures and enabled a rigorous translation and transcription process.

The theoretical foundations of this study draw on socioecological models of health and contemporary cultural studies. Socioecological models have been widely applied within the field of public health to explore multiple levels of influence on individual behaviour (Wilkinson and Marmot 2003). Cultural studies offers an additional conceptual lens to consider the cultural meanings and influences surrounding health as fluid, dynamic and constantly changing rather than static or fixed within a regional, religious, or ethnic identity (Lewis and Lewis 2015). In this study, these paradigms were

used to critically examine the literature, develop research tools and interpret the findings. As in prior sexual health research (Mengesha et al. 2017), the socioecological model of health was used as an organising framework for analysis and presentation of findings. This study adopted an innovative approach by applying the cultural studies' notion of 'transculturalism' to explore the complex dynamics of culture and social change around family planning. It extends beyond identifying concerns, needs and influences, to consider how people's practices and their meanings may change and evolve in new cultural contexts.

Participants, sampling and recruitment

To be included this study, participants needed to be 18–49 years old, married, born in Afghanistan, of refugee background and currently living in Melbourne. People unable to communicate in either Dari (the most widely spoken language by Afghanistan-born people) or English were excluded due to practicalities related to the bilingual support and translated materials that were available. Women and men who arrived in Australia more than 15 years ago were also excluded.

All participants were recruited using a purposive sampling strategy, guided by a sampling frame (Mays and Pope 1995). For this, community researchers approached existing contacts within the Afghan community and asked them to help identify other individuals meeting the inclusion criteria. Potential participants were given an Explanatory Statement, which was available in Dari and English. This was also offered verbally in both languages to overcome varying literacy proficiencies. All participants provided verbal and written consent, and completed a short socio-demographic questionnaire, prior to data collection.

Data collection

Data collection occurred in two distinct phases; with focus groups being conducted and analysed prior to commencing the interviews. All focus groups were gender-specific and facilitated in Dari by a male or female community researcher accordingly. Focus groups were structured around a suite of participatory activities, including fictional narratives, sorting cards and image boards. Prompting questions were developed in close consideration of the theoretical frameworks and embedded within the activities. This ensured central issues of cultural transition and meaning making within the context of family planning were explored, and that influencing factors at individual, interpersonal, sociocultural and societal levels were thoroughly discussed. All activities were co-designed with community researchers, and further refined between each round of data collection. Focus groups were conducted at a community health centre and lasted up to two and a half hours in duration.

Following the focus groups, 20 semi-structured interviews were undertaken. The interview guide used for these was developed through extensive consultations with community researchers and a piloting period, and was reviewed regularly throughout data collection.

Participants had the option of having their interview conducted in Dari or English. This resulted in seven interviews being conducted in English, and 13 interviews being conducted in Dari. Most women opted to have their interview undertaken within their home, while all men elected to complete the interview at a community venue. Interviews were an average of one and a half hours in duration. All participants received a A$40 gift voucher to recognise their time contribution and cover any travel expenses incurred.

Focus groups and interviews were digitally recorded. Interviews conducted in English were transcribed verbatim. For data collected in Dari, translation and transcription was a time-intensive, rigorous process. This began with community researchers listening to recordings several times to become familiar with their structure and content. Then, community researchers sat with another member of the research team to work through the recording, which was interpreted by the community researcher, and transcribed directly into English. Community researchers then carefully reviewed each transcript while listening to the recording, and corrected errors and missed details. A second party also transcribed a proportion of data to enable crosschecking and determine consistency. The original and re-transcribed documents were examined and the variation between them was considered minimal; therefore, this process was deemed to be valid and appropriate.

All data were de-identified by replacing participants' names with unique numerical codes and pseudonyms. All forms, recordings and transcripts were managed according to ethical guidelines.

Data analysis

Data analysis was a cyclical and inductive process, with preliminary analysis occurring concurrently with data collection (Patton 2002). Initial explorations of the data included reviewing field and debriefing notes, re-reading transcripts, and reflective memoing (Rubin and Rubin 2005). This was followed by a series of coding cycles. Initial codes were concept driven; derived from the research objectives, the theoretical frameworks and the themes underpinning the data collection tools. Data-driven codes were then added throughout the preliminary coding cycles (Gibbs 2007). Codes were discussed, debated and defined by the authors, before being organised into a nested framework, which aligned with the socioecological model of health. This allowed codes to be grouped under 'individual', 'interpersonal/social', 'community/sociocultural', and 'settings and society' categories, and arranged according to their relationship to other codes. A proportion of transcripts were independently coded by members of the research team to assess inter-rater reliability (Mays and Pope 1995). There was a high rate of agreement between the coders, at approximately 85%. Preliminary themes were confirmed through team discussions involving community researchers. Data were then arranged into thematic groups, and findings were compared and contrasted with existing literature. Computer-assisted qualitative data analysis software NVivo QSR International was used to code, organise and retrieve data.

A subgroup of participants was directly contacted by phone and invited to attend an interactive session to hear about the findings and reflect on whether these were

considered representative of the community's opinions and experiences. This respondent validation process enhanced rigour and established confirmability (Mays and Pope 1995).

The study was approved by Monash University Human Research Ethics Committee, Project Number CF16/1777-2016000917.

Findings

Participants

This research included a total of 57 participants. Each participant could only take part in one data collection activity. Eighteen women took part in one of three female-only focus groups, and 10 women participated in interviews. Nineteen men took part in one of three male-only focus groups, and 10 men participated in interviews.

Women were between 23 and 43 years old with a mean age of 33.6 years. Men were between 22 and 49 years old with a mean age of 35.5 years. Both women and men had between zero and six children, with a mean of 2.75 and 2.5 children respectively. Women reported lower levels of formal education than men, with only 22% of women having completed any schooling beyond primary level, compared with 66% of men.

Eighty-six per cent of participants identified as Hazara ethnicity, with the remaining 14% comprised of Pashtu, Tajik, Sadath and Afghan participants. Further, 76% of participants reported speaking Hazaragi (a language closely related to and mutually intelligible with Dari) within their homes. While all participants were born in Afghanistan, only eight were living there directly prior to arriving in Australia. Before arriving in Australia, 29 participants were living in Pakistan, 15 were living in Iran, four were living in Indonesia, and one was living in the United Arab Emirates. At the time of data collection, participants had been in Australia for between 4 months and 14 years, with a mean length of time in Australia of 5.5 years.

Family size

The majority of participants indicated small family size ideals, most frequently stating a preference for two or three children. Participants described how living in Australia had influenced their decisions of how many children to have. A key factor included contraception being available and acceptable within Australia, which was frequently discussed in contrast to Afghanistan.

> In Afghanistan people have 10 or 12 children, because there was no contraception. But now, we are here … people have different types of contraception. They can decide if they want baby, or not. (Nazia, woman, 43 years, 3 children, 10 years in Australia)

Participants recognised a broad range of advantages to having less children, including increased time to foster intimacy within their marital relationships, and having a greater amount of resources to direct towards each child. Additionally, a proportion of women described that increased opportunities to study and work within Australia strongly influenced their decisions to have fewer children.

> … [Afghan women] are actually starting to make more choices … People like myself, working women who have been to universities … all their ideas are actually not more than three kids; you want a career. (Aquila, woman, 30 years, no children, 12 years in Australia)

However, some participants reflected on how living in Australia presented new challenges for parents, and the ways in which these factors were driving decisions towards smaller family sizes. Several participants explained that the lack of social and family support available to assist with child rearing made having more children seem unachievable. However, financial issues within Australia were more commonly identified as a reason for preferring to have fewer children.

> The important issue is economic issue … [In Australia] we have good income, [but] expenses are also more … and all Afghan people have someone overseas to send money; one person earns, and ten people eat! (Ali, man, 39 years, 2 children, 10 years in Australia)

Participants also described a range of transcultural tensions contributing to their decisions for smaller families. Some participants discussed wanting less children so that they could more intently focus on transmitting traditional cultural values that were of utmost importance to them. In addition, several men talked openly about choosing to have fewer children due to a perceived reduction in their position of authority within the family.

> If you have less children you have less issues related to their discipline … The parent wants to discipline their child the way they want to, but they can't because parents are powerless in this country (Australia). (Musa, man, 34 years, 2 children, 6 years in Australia)

Furthermore, some participants described that the standards of care within Australia, enforced through laws, were a key factor in deciding to have fewer children.

> In Afghanistan you didn't even worry [about how many kids you had]. My aunty had 14 kids and at night, when she used to put the plates, then she would know someone's missing … Even if they die no one cares! But I think here, the laws, the child protection, those things are making a huge difference … If kids are not treated well or if they can't look after them, then [parents] will be in trouble with law. (Saera, woman, 31 years, 2 children, 9 years in Australia)

In contrast to the majority of participants, several women and men indicated strong desires to have large families. For some, this linked to religious ideas. For others, the social security system in Australia was believed to help alleviate the economic burden associated with raising children, making it easier to provide for a large family.

> … I already have two [children], and if I can I would make another ten. [When] you have children everywhere you feel happiness … As many as God gives is a good thing. (Reza, man, 33 years, 2 children, 5 years in Australia)

> In Afghanistan, to have more children is difficult. But, in Australia, it's not … If there are any needs, the government will fulfil; government will help with the children. That's why I like a lot of children. (Fatima, woman, 43 years, 5 children, 11 years in Australia)

Pregnancy prevention and termination: beliefs

The overwhelming majority of women and men seemed extremely open to contraception use. Many participants associated the acceptance of contraception with desirable

traits, such as being open-minded, 'modern', and educated. Participants described that, as individuals and as a community, they had built a sense of progressiveness across their migration journeys.

> They came out from Afghanistan, they went to Iran, Pakistan – more civilised countries than Afghanistan – and many other countries like Australia, Europe. When [Afghan people] went and they look at the world, they realise that they were living in a very, very backwards way. So, after that all the people were using contraception; they become more modern. (Sheema, woman, 34 years, 3 children, 12 years in Australia)

A large number of participants indicated that they were deconstructing the traditional belief that contraception is forbidden within Islam. Separating contraception use from religion emerged as an essential step in their move towards the acceptability of birth control.

> [In Afghanistan] the [religious] scholars were saying [contraception] is made of Satan (evil) … They were preaching about these things, saying that if you are using condoms it means you are doing something against God. That sort of rumour was back there … [But when people] come to Australia, they realise that whatever they were thinking, it was all wrong. (Mustafa, man, 28 years, 1 child, 10 years in Australia)

While male participants acknowledged that it was common for men in Afghanistan to forcibly prohibit the use of contraception, no participants explicitly expressed this as being as their personal view.

> Afghan men in Afghanistan will slap his wife, [and say] 'Don't go after these things, God is great, God is good!' And always Afghan men say these things. They do not give any right of decision to women in Afghanistan. (Jaah, man, 49 years, 3 children, 12 years in Australia)

Religious beliefs related to abortion were approached with greater caution. While several women and men indicated shifting views towards abortion becoming an acceptable option in Australia, most participants remained firmly against terminating pregnancies.

> If someone gets pregnant in Afghanistan, whether she wants it or not, she needs to keep it … But here it is different. If we do not want, it is not crime … [Women can] benefit from abortion if they want. (Yalda, woman, 24 years, 2 children, 2 years in Australia)

> According to our religion, abortion is forbidden. It is killing. I will not do this thing. (Musa, man, 34 years, 2 children, 6 years in Australia)

Experience using contraception

Despite limited exposure to, or experience with, contraception prior to living in Australia, many women reported that they had consulted with general practitioners and used a form of hormone-based contraception since their arrival. While some women explained that they had found a method that was suitable for them, many described experiencing adverse side effects. This deterred participants from further pursuing hormone-based methods and led them to try condoms as more suitable alternative.

> I used the pill and I was always impatient; I would give answers so quickly. Now I put the capsule (Implanon) in my arm … I'm feeling good, but my period is less and I'm gaining weight. (Jamila, woman, 31 years, 2 children, 2 years in Australia)

> When I came to Melbourne, I used Implanon. But it had side effects on me; I had a lot of bleeding issues. And then my husband said, 'No, take [it] out, condom is much better' … ' (Fawzia, woman, 32 years, 2 children, 1 year in Australia)

Some women and men found condoms to be effective, accessible and easy to negotiate within their relationships. Several men indicated that they were comfortable with the trade-off of reduced sexual pleasure for themselves, for fewer side effects for their wives.

> Honestly, first of all, I never liked condoms, and I prefer tablets. But, when I became aware of the side effects of tablets, I thought [the] condom is much better. (Sayed, man, 25 years, 1 child, 4 years in Australia)

However, a proportion of women described experiencing challenges in negotiating condom use with their husbands. Men's preference not to use condoms often led couples to rely on the withdrawal method to avoid pregnancy. While some participants deemed this to be a suitable option, for others it was a source of contention within their relationships.

> At the start, I was going with condoms, and after that, I thought 'nah', I went just with the withdrawal method, and that's it … I didn't like condoms, so I'm going with the withdrawal method and it's working. (Mustafa, man, 28 years, 1 child, 10 years in Australia)

> I like condoms. Women usually like things which have no side effects on them … Men do not like condoms, and they use withdrawal method … We start fighting, and men usually asks us to go and use pill, and put capsule in our arm, and women say 'This has side effects, this is not good' … We ask them to use condoms, but usually men do not agree with us. (Safia, woman, 33 years, 2 children, 6 months in Australia)

Partner communication and decision-making

The majority of participants indicated strong ideals of shared decision-making between wives and husbands in relation to all aspects of family planning. Religion emerged as fundamentally sanctioning and supporting close and open communication in this area.

> Your wife is your partner. I don't think when we talk with our wife there will be [a barrier] between us, because it's like two bodies, one soul. (Ahmad, man, 43 years, 5 children, 4 years in Australia)

However, women in particular described experiencing challenges achieving this in reality, due to traditional cultural systems that reinforced patriarchy, shame and silence.

> When my husband is talking about all these things, I'm feeling shy and I am saying 'Don't say all these things to me! I don't like to say these things!' I'm awkward; I am not comfortable. In our religion, husband and wife should be very close, they should not have any secrets between each other … But I don't know, I can't discuss anything. (Sheema, woman, 34 years, 3 children, 12 years in Australia)

While both women and men reflected that they were open to contraception use, women indicated feeling that the responsibility of preventing pregnancy disproportionately sat with them. The contending contraceptive priorities of women and men,

that is, side effects versus satisfaction respectively, frequently underpinned couples' inability to establish effective contraceptive practices.

> Always the man is more demanding. And they usually do not use condom and they say, 'Whatever happens, if you get pregnant, it's not my problem, it's not my responsibility. If you do not want to get pregnant, contraception is your responsibility, your problem!' (Fariba, woman, 38 years, 6 children, 10 years in Australia)

A number of women openly shared their experiences of men wanting more children without adequately considering the complexities of women's lives, or the demands of a new child. In such instances, some participants believed in their right to use contraception without their husband's knowledge or permission.

> If men want [a baby], and women do not want, she can [use contraception] without him knowing, if she is clever … Women are always dominated by men, and women do not have to do everything he says! (Safia, woman, 33 years, 2 children, 6 months in Australia)

Unintended pregnancy

At times, the challenges that some women experienced in achieving consistent contraceptive practices had led to unintended pregnancy. The impact of unplanned pregnancy was compounded by the intricate contexts of women's everyday lives, which included migration issues; caretaking and housekeeping responsibilities; compromised mental health; personal goals and aspirations; separation from family and limited social support; and complex and challenging marital dynamics. Religious beliefs were consistently drawn upon to guide decisions related to unintended pregnancy.

> I wanted to have a termination. But I thought a lot about this, and I discussed with my husband [and] we made a decision that we will keep it. If God gives it to me, he knows better … I got very bad stress … It was very difficult for me to take care of my father, my home, already I had two kids … At that time, I was really hating my husband, I was just thinking if he didn't do this, I wouldn't be pregnant. No one was there to support me. My family is not here, and I don't have any very close friend to share it with … (Sheema, woman, 34 years. 3 children, 12 years in Australia)

Although a large proportion of women openly described experiencing, at times multiple, unintended pregnancies, men did not report facing this within their own lives. This provides valuable cultural insights into the gendered ways women and men perceive and create meanings around some pregnancies.

> Nothing like this ever happened to me. We leave it for God. (Hossein, man, 43 years, 4 children, 1 year in Australia)

New ways to build a family

A small proportion of women spoke about their willingness to explore alternative ways to create a family; specifically, through embracing fertility technologies and adopting children. Their openness to these opportunities provided a sense of security as they delayed starting a family to pursue their careers. Their mindsets, particularly with respect to adoption, were in conflict with traditional values tightly held by other

Afghan community members. However, women were firm in their beliefs and indicated confidence in making decisions that contrasted with common community opinion.

> My husband and I have discussed that we might have one child of our own, and we might adopt one. It's not something that everyone can think of. Not even our parents can approve it … [They] say that a biological child is something different to having an adopted child. You don't know about their family, their history, and their bloodline … [But] at the end of the day, a child is the result of what you bring up … If you give the child the happiness of having parents it's going to be so much better than having your own child … (Nafeesa, woman, 28 years, no children, 10 years in Australia)

Health seeking: opportunities and barriers

Both women and men consistently stated that general practitioners should be their first point of contact for family planning needs. Overall, there was a preference to see a health professional of the same sex, but participants frequently stated that this was not a necessity. Doctors were described as *mahram* – approved by God within their profession, exempt from cultural practices of gender segregation, and permitted to engage in discussions of personal nature. The accessibility of health care in Australia, including a culture that is more open to discussing sexual health issues, was often contrasted with experiences from Afghanistan.

> In Australia, if I want to ask something from my doctor, I can, very comfortably. But over there we do not have courage to talk about sexual health – even with a doctor. (Tajj, man, 36 years, 2 children, 9 years in Australia)

However, some participants described barriers that continued to hinder their ability to access health services. While interpreters were reported as being of central importance to effective communication with health professionals, some women indicated experiencing increased feelings of embarrassment and discomfort when disclosing personal information in the presence of an onsite interpreter.

> The doctor needs to book an interpreter. But if the interpreter is there, it is hard to say things, sexual health things. I do not feel comfortable in front of an interpreter, so it's much better to use a phone interpreter. (Alia, woman, 23 years, no children, 1.5 years in Australia)

In addition, several women described that they needed to visit the doctor more than once before they built up the courage to proffer the health topic that needed to be addressed. Other participants spoke about using euphemisms and actions to explain their health problems due to experiencing shame and embarrassment when speaking about their bodies and other sexual health issues.

> The first time I went [to the doctor] I felt so shy and I couldn't tell them the problem. My husband told me I have to go back. So, I went back a second time, and I spoke to him. (Ghulsom, woman, 31 years, 3 children, 4 years in Australia)

> I can't say (points to condom). I can only say 'plastic, plastic'. And I am not confident to say body parts, like this, what this is (points to breast). I can't say. I feel shy, with my husband, with doctor, everyone. (Latifa, woman, 36 years, 3 children, 9 years in Australia)

> I had infections when I had Mirena [IUD] … I didn't tell the doctor that I have infection in my, ah, there (points to vagina). I told her that I had sore legs, and I'm feeling very uncomfortable … Very bad sore legs and I think I have an infection. (Sheema, woman, 34 years, 3 children, 12 years in Australia)

The Internet emerged as a much used source of family planning information, particularly for men. However, access to information online was contingent on language and literacy proficiencies. Participants elucidated that going online provides a confidential, safe space to learn about sexual health issues, and this level of privacy made it a preferred option over seeking information from peers or family members.

> I will consult with Google and Google will give me the right answer … All information is in Google. You can read and you can check every website and choose which [contraception] is right for you. (Abed, man, 39 years, 4 children, 3 years in Australia)

Overall, participants expressed a willingness to seek information from health professionals and the Internet and suggested an eagerness to learn more about their bodies, family planning and the range of contraceptive options that are available to them in Australia.

Discussion

This research adds to existing knowledge by providing new insights into how interpersonal, sociocultural and societal influences are shaping family planning beliefs and practices, and the ways in which these are shifting and evolving as Afghan people interact with and navigate new cultural contexts.

Afghan women and men have indicated that they are actively embracing new opportunities available within Australia, and making informed, autonomous decisions about family size that contrast with norms of Afghanistan; a finding consistent with prior migrant research in Iran (Abbasi-Shavazi et al. 2015). However, this study has presented new insights into challenges and transcultural tensions that also influence decisions to have fewer children. These factors include changes in power dynamics within families, enforced standards of care obligations and the struggle to genuinely impart traditional cultural values within children. Decisions made on these bases were particularly uncomfortable for participants, as the trade-offs sat in a more culturally and emotionally contentious space.

In contrast to prior studies involving Muslim women in Australia (Hawkey, Ussher, and Perz 2018), religion did not appear to dissuade contraceptive use among this group of participants. Rather, findings highlight the ways that Afghan women and men are deconstructing beliefs that have traditionally tied contraceptive prohibition to Islam, and renegotiating meanings around religion, culture and gender in a fluid and progressive manner. This resonates with research involving Afghans living in Iran, which describes how varying interpretations of Islam can be applied to preclude or accept family planning (Tober, Taghdisi, and Jalali 2006). Furthermore, Tober, Taghdisi, and Jalali (2006) found that participants of Hazara ethnicity (the dominant ethnic group represented in this research) were often open to using contraception. This is consistent with the current study, in which participants indicated a desire

to become 'more modern' by embracing new family planning beliefs and practices throughout migration.

Despite this, participants in this research continued to experience a range of barriers to achieving consistent contraceptive practices, including concerns about the negative side effects of hormone-based contraception (Rogers and Earnest 2014). However, these reservations were largely based on personal experience, rather than pre-conceived ideas or misconceptions. The individual experiential bases of these apprehensions suggests that they are not underpinned by higher-level sociocultural ideas and could, in part, be overcome with increased support to find suitable contraception.

Nevertheless, the provision of education about birth control alone would not sufficiently acknowledge the broader contexts of people's lives that contribute towards inconsistent contraceptive practices, such as interpersonal challenges in partner communication and decision-making (Ellawela et al. 2017; McMichael and Gifford 2010). The current study makes a valuable contribution to existing literature by further illuminating men's perspectives on this issue (Tober, Taghdisi, and Jalali 2006). This has provided valuable insights into the disconnect between the strong ideals presented by men that unequivocally endorse shared decision-making, and the experiences described by some women.

Prior studies have identified that migrant women are at increased risk of unintended pregnancy (Metusela et al. 2017), and the findings of this research suggest that this is indeed likely for Afghan women living in Melbourne. Less disclosures of unintended pregnancy by males, relative to females, is a novel finding which highlights stark differences in the ways that Afghan women and men conceptualise planning for a baby. Men's tendency to overlook the significance of each new pregnancy appears linked to gendered role expectations, in which a disproportionate workload of childrearing sits with women. This finding is not exclusive to Afghan women, as prior research suggests that the unequal workload of caring for children influences fertility decisions among the wider Australian population (Wright 2007). However, interpersonal and cultural factors, such as the patriarchal undercurrent within decision-making and religious prohibition of abortion, place Afghan women in a uniquely vulnerable position. Unintended pregnancy had implications not only for the health and emotional well-being of some women in this study, but also more broadly for their aspirations around work, education and community life as they seek to build 'modern' identities in Australia.

The majority of women and men in this study reported that they were comfortable approaching Australian health professionals for family planning issues. However, several female participants described relying on euphemisms and non-verbal cues to counter their embarrassment and address their health needs. Sometimes their culturally-situated communicative strategies were effective and enhanced their interactions with health professionals. However, on other occasions the strategies adopted went unrecognised by medical caregivers, and consequently women missed valuable opportunities to address family planning concerns. This finding highlights the importance of considering health care acceptability, which is influenced by individuals' social and cultural values (Levesque, Harris, and Russell 2013).

Finally, some participants described a high level of engagement with online resources; dependent on language and literacy proficiency. These findings suggest that

Afghan women and men are actively pursuing opportunities to build their sexual and reproductive health knowledge. The ways that women and men are changing and evolving in relation to family planning may challenge health professionals' pre-conceived assumptions about gender and culture within the Afghan community. By gaining a greater understanding of the perspectives and experiences of this community, health professionals may better recognise opportunities to work alongside Afghan individuals and couples to respond to their emerging needs and facilitate improved family planning outcomes.

Practice and research implications

The findings of this research suggest that general practitioners are in a key position to support Afghan women and men in their quest to find a suitable contraceptive method by: providing more information on the range of birth control options available; informing them of the potential side effects; prompting follow-up appointments; and, nurturing longer-term engagement. However, service-level constraints within the health care setting must be addressed in order to achieve this (Mengesha et al. 2017). In addition, health professionals should be encouraged to ask Afghan women and men questions about sexual and reproductive health, in response to new understandings that at times they want to talk, but have difficulty proffering the topic.

Findings also highlight a window of opportunity to work alongside the Afghan community to better facilitate inclusive family planning decision-making processes that are in closer alignment with the ideals of both women and men. While some participants indicated that they would benefit from family planning consultations involving both partners, this choice must be determined on a case-by-case basis to avoid compromising confidentiality of care for women when necessary. The heterogeneity highlighted within Afghan communities and relationships reiterates the importance of participatory approaches. The development of family planning support strategies must consider the changing perspectives and needs of Afghan women and men. While sensitivity to gender differences remains important, there are multiple synergies between genders that provide important footholds for achieving better outcomes.

Some participants identified challenges in disclosing personal information in the presence of an interpreter and proposed that health professionals use telephone interpreters in these instances. This is a valid and cost-effective solution worth considering. Given that many participants accessed sexual health information on the Internet, there are also opportunities to better utilise this platform to disseminate tailored family planning information within Afghan communities.

Exploring possible differences, similarities and patterns associated with the ethnicities, languages and Islamic denominations of participants was beyond the scope of this qualitative paper. However, such should be considered for future research with this population group (Tober, Taghdisi, and Jalali 2006). In addition, quantitative research determining the prevalence of the issues identified, and establishing correlations between social and demographic factors, and family planning practices and outcomes, would be highly valuable.

Strengths and limitations

The community-based participatory approach employed in this project is a primary strength of the research. Collaborative partnership with members of the Afghan community facilitated community ownership and enabled family planning to be explored with sensitivity and in great depth.

Men have been noticeably under-represented in prior family planning research in Australia. The current study has addressed this omission by providing opportunities for Afghan refugee men to voice their opinions, views, concerns and ideas around this complex and important issue in their community.

There are several limitations to this research. First, it is possible that the study attracted participants who were comfortable and open to discussing family planning, while those with the greatest objection to contraception declined to participate.

Additionally, a large portion of the data set required translation from Dari into English. Extensive precautions were taken to ensure rigour throughout the transcription process; however, the translation of data still contributed an additional layer of interpretation between the raw data and the findings.

Conclusion

The Afghan community in Melbourne is in a state of transition and flux. Individuals and couples are making decisions to have less children, re-constructing meanings around religion, embracing new practices and priorities and contemplating alternative ways to create a family. Afghan women and men have demonstrated that they are open to change, and they are changing. By gaining further insights and understandings of where family planning opportunities, challenges and points of tension are, health professionals can start to navigate this territory, alongside them, with greater sensitivity.

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Disclosure statement

The authors declare that they have no competing interests.

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