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A Qualitative Analysis on the Reproductive Health Needs of Afghan Refugees in South Texas

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Abstract

Objective. To assess the reproductive health perspectives and needs of Afghan refugee men and women living in South Texas to inform the development of community-driven, culturally-sensitive, evidence-based local interventions.

Methods. Two gender-specific focus groups of married, reproductive-aged Afghan refugees (7 female and 5 male participants) in Texas were conducted in 2018. The study team performed a phenomenological qualitative analysis on de-identified transcripts of the discussions to identify themes and patterns as related to family planning and reproductive health in this population.

Results. Four themes were discovered including challenges of resettlement in the United States, gender preferences, navigation of family planning decisions, and barriers to reproductive healthcare.

Conclusions. Participants agreed on the importance of addressing reproductive health needs in their community. They also expressed interest in reproductive health education and improved access to contraception at local community clinics. A comprehensive initiative addressing reproductive healthcare should be specifically designed and allow flexibility as values evolve over time in response to circumstances such as resettlement.

Introduction

Refugee populations face unique challenges in regard to reproductive health and family planning[1]. Displacement poses significant obstacles to reproductive healthcare access largely because their new homes are often religiously, culturally, socially, and economically distinct from their country of origin[2]. With recent maternal mortality rates as high as 400 per 100,000 births, pregnancy can be life-threatening, especially with the majority of women in rural Afghanistan coming from low socioeconomic backgrounds with little to no reproductive health education[3]. Barriers including lack of accessibility and education cause underutilization of existing maternal health resources and contraceptive methods [3, 4]. As a result, families often receive minimal prenatal care, do not practice child spacing, and are unfamiliar with their contraceptive options [3, 4].

Among non-displaced Afghans, there is a preference for larger families, especially in rural populations[4], for reasons such as economic security and happiness. When Afghans are displaced, they often maintain these beliefs and refuse contraception, fearing that it harms women and causes bleeding, weight gain, cancer, and infertility [2, 4, 5]. Similar concerns are shared by men, and additionally, they believe male methods of contraception decrease their strength[6]. Overall, ethnic minorities living in the United States tend to be less likely to use contraception and more likely to use less efficacious methods [7].

However, studies have found a correlation between increased availability of contraception and decreased maternal mortality rates, illustrating the importance of reproductive health education and access[3,8]. While the benefits of contraception and family planning are well documented, determining how to deliver this information to specific populations can be challenging. To understand how to effectively educate Afghan refugees in the United States, we must consider how culture and past experiences have shaped attitudes toward contraception and family planning[2]. This study aims to evaluate the reproductive health beliefs and needs of displaced Afghan refugees in south Texas and to compare these findings between male and female participants.

Methods

Two gender-segregated focus groups were conducted in October and November of 2018. After a chart review at a refugee clinic, inclusion criteria consisted of the following: each participant must be a refugee, married, an adult of reproductive age (18 to 49 years), and have at least one child. The authors developed semi-structured focus group questions aimed to assess perceptions, barriers, experiences, and desires regarding family planning and overall women's reproductive

healthcare. Pashto speaking interpreters reviewed the questions for content, sensitivity, and clarity.

Focus groups were conducted at a refugee social service agency. An interpreter, two facilitators, and two transcribers were present for each group, all of whom were gender-concordant with the participants. Consent was obtained from participants with the assistance of the interpreters to ensure understanding. Groups ran for approximately one and a half to two hours. Participants were offered modest incentives valued at $15 for their participation. Focus groups were audio recorded and transcribed verbatim with quote de-identification to ensure anonymity of the respondents. The group analyses included both individual level and in-person discussion among five researchers with a phenomological qualitiave analysis approach to identify themes related to reproductive health needs of Afghan refugee men and women. A phenomological approach was chosen in order to focus on the lived experiences of the participants and how that influenced family planning decisions.

This study was reviewed by the university institutional review board and was approved as exempt from review.

Results

The study sample consisted of seven women and five men. All of the Afghan women spoke Pashto and two were also fluent in Dari. Of the four men who indicated “good” English proficiency, two also spoke Dari, one spoke Pashto and Persian, and one spoke Pashto. One man indicated that he spoke limited English, but he was fluent in Pashto. None of the women indicated employment, and all the men were employed. Additional social and demographic characteristics are shown in Table 1.

Table 1: Demographics of Afghan male and female refugee participants.

	Women's Group (n=7)	**Men's Group (n=5)**
	Mean ± SD	**Mean ± SD**
Age in Years	29.3 ± 2.7	27 ± 5.3
Number of Children	4.6 ± 1.8	2 ± 1.1

Years in U.S.	1.6 ± 1.0	1.3 ± 0.6
Years of Formal Education		
None	3, 43%	0, 0%
< High School	1, 14%	0, 0%
High School	2, 29%	4, 80%
> High School	1, 14%	1, 20%
English Proficiency		
None	4, 57%	0, 0%
Limited	3, 43%	1, 20%
Good	0, 0%	4, 80%

Four themes were discovered in the analysis and are organized as follows: 1) "Life is harder here": Challenges of resettlement in the United States, 2) "Everyone wants to have a boy": Gender preferences, 3) "We are life partners": Navigation of family planning decisions, and 4) "We don't have access": Barriers to reproductive healthcare. The following section contains interpreted quotations from the respondents, which encapsulate each theme.

"Life is harder here": Challenges of resettlement in the United States

"We had a family support culture."

In Afghanistan, couples had extended family to help raise and care for children, which they no longer have access to in the United States. A woman said, "It's really hard with everyone living separately and we don't have joint family to take care of things." A male participant said it was

obvious to have more children in Afghanistan because they had support. Now, it is more difficult and dangerous for a couple to provide for children.

"Everyone is struggling."

One man said, "Life is easier there. If you have a good job, you can support a big family." Another man said he could support 15 to 16 people in Afghanistan as the sole breadwinner partly due to government-funded healthcare and education. Multiple participants cited health insurance as one of the most burdensome expenses they now have. Other significant financial costs mentioned were food and rent.

"I wouldn't have wanted to have this many kids."

One woman said, "In Afghanistan, usually a female our age would like to have seven to eight kids. Since we are living here, we would like to have three to four." One man said, "If you raise a child, it means you raise a city. It's that difficult. That's why we prefer less children." Some couples had several children before becoming refugees, and one woman "wouldn't have wanted to have this many kids" if she had known she would be living in the United States. A man said, "We are forced to come here. We are in this new culture and life has new complexities. We need some kind of education."

"Everyone wants to have a boy": Gender preferences

"In our religion, it doesn't matter. They are both human."

The male participants noted that gender preferences were not a result of religious influences. One man said, "It is not a good idea if you prefer one or the other. You are not in line with the guidance." He also stated, "Religiously, it is forbidden" to value male children over female children, and he said the other men were cautious of talking openly about this subject.

"In our culture, it's better if you have a boy."

Even though the participants stated that they believe all children, male or female, are considered a blessing, many had personal preferences. One man said, "Everyone wants to have a boy." There are various reasons why sons are preferred. One man said, "The one making income is the boy," while a woman said, "A boy stays with you and takes care of you when you're old." Another man gave historical context by stating that when the war started "women were told they should stay home" for safety. "Then, the Taliban told women they cannot go to school or work." The men spoke extensively on Miras, an Islamic law on wealth distribution after death, and the value of paternal lineage. One man said, "If I have all girls, my family dies. The whole lineage is cut off."

"They blame the women for having a daughter."

Multiple women had experienced blame for giving birth to daughters over sons. They said that the husbands "consider that it's your fault if you give birth to daughters. They don't know the real biology of what happens." Another woman said, "The woman thinks it's in God's hands that they have a daughter, and the man thinks, 'No, it's you.'" Because of this issue, some women have more children than desired and some men marry multiple times in an attempt to have sons.

"We are life partners": Navigation of family planning decisions

"We compromise, always."

Both groups asserted that partners make family planning decisions together. The men stated that their religion encourages them to space children by at least two years to focus on breastfeeding, recovery for the mother, and raising the older children. When choosing a method of contraception, one man stated, "Mostly, [the women] have the right to make the decision," but some women complained that the men did not understand child spacing or did not want them to use contraception. One woman said, "I was taking [contraceptive pills] without telling my husband" while another called the men "careless" when they pressure their wives to have more children.

"A natural way."

The men saw condom usage as a natural way to prevent pregnancy, while the women felt that no contraception was the most natural. Members of both groups had used multiple contraceptive methods but overall preferred condoms. One man said, "It is healthy, and it's a good way to prevent having a child." Noted advantages included no side effects for the women or risk of infertility, while disadvantages included less sexual enjoyment and inconvenience. The men stated that condoms can take the "joy" out of sex, but it was "still worth it" compared to exposing their wives to adverse effects of hormonal contraception. Some men admitted to inconsistent usage while one man mentioned the withdrawal method.

"We are a little bit suspicious about what it would do to our bodies."

Side effects of hormonal contraceptives were a major concern. One man said, "There will be serious side effects." One woman "had a bad experience with [spermicide lube]" where she got an infection and ultimately got pregnant. One man said his wife used an IUD for two months but then "she felt depression," while another man mentioned bone and joint pain. Other side effects included weight gain, headaches, and allergic reactions. The women were concerned about infertility and questioned, "If we want to have more kids in the future, what if we couldn't?"

"It's in God's hands."

Some women preferred to leave family planning matters "in God's hands" by not using contraception. A male participant stated, "First, it's up to God. God gives everything, and whatever God doesn't want, doesn't come to use." Permanent methods such as sterilization are not accepted by the women because "it would prevent your menstrual cycle completely," and "in some families, it is considered a sin. It would upset God." One woman explained that temporary methods of contraception are not sinful if they are used so that their bodies can heal for future pregnancies.

"We don't have access": Barriers to reproductive healthcare

"Back in our country, healthcare is free."

Both groups felt they had better access to reproductive healthcare in Afghanistan with one woman stating, "We had a small clinic where we would go and be seen by a female provider. We would share our concerns about our body and birth control" for free. Another woman stated, "We use condoms because we don't have access to doctors" in the United States. The women appreciated having the refugee clinic nearby "so we can walk, and we don't need our husbands to go with us." A male participant asked for more contraception options to be available at the clinic, and the women preferred female providers.

"In our community, there are people who have no idea about family planning."

The men learned how to use condoms from television and heard about contraception from advertisements. One man said, "It's not hard to learn. Mostly school friends, the job, coworkers, and if the brother or father is friendly, they will teach you how to make babies." Similarly, a female participant said, "We are informed by girls in the family. The one that experiences it first will tell the younger ones." The women recognized that their sources may not be reliable and expressed an interest in a class on menstruation and contraception. The men also desired a class, and they had many questions that reflected previous miseducation.

Discussion

A concerted effort to address the reproductive health needs of refugee populations can be dated to the mid-1990's when the International Conference on Population and Development recognized

reproductive health as a basic human right [9]. While substantial progress has been made, refugees may experience significant challenges in obtaining reproductive healthcare as 43% of pregnancies in 2017 in developing regions were unintended, with 84% accounted for by an unmet need for modern contraception [10]. Upon resettlement, refugees are exposed to new barriers, such as competing social priorities[1], limited health literacy[1, 11], communication difficulties[12, 13], and lack of cultural sensitivity among healthcare workers[12, 13, 14], that further complicate achieving family planning goals. With the majority of these studies being conducted in Europe and Australia, there is a gap in the literature on sexual and reproductive health (SRH) concerning displaced refugees living in the United States. Therefore, the purpose of this study was to assess the SRH perspectives and needs of Afghan refugee men and women living in south Texas to inform the development of community-driven, culturally-sensitive, evidence-based local interventions.

Both groups unanimously concluded that life is more challenging in the United States due to a lack of larger family support and higher costs of living. They now desire fewer children with some expressing regret about the number they already have. A study conducted on families in Afghanistan found that the majority of participants preferred larger families to secure economic wellbeing, act as caregivers for the elderly, and compensate for war-related deaths[6]. Meanwhile, other studies demonstrate that Afghans desire more family planning resources and less children if they are impoverished[6] or live in urban areas with fewer resources[15].

While the women explicitly stated that their husbands preferred sons, the men stated that it is up to God but implied that sons were ultimately preferred[4]. As a result, many women are blamed for not bearing sons[6]. This preference seems to be culturally and historically, rather than religiously, influenced. The literature suggests that immigrants may anchor to traditional expectations of family, sexuality, and fertility when faced with the challenges of acclimating to a new society[2]. Therefore, families may ultimately bear more children than planned in order to have a son, which can result in burdensome financial implications.

In Islam, family is the basic unit of society[16]. Both groups stated that family planning decisions are made as a couple which is also observed in outside literature[17]. However, while the men said it is mainly a woman's choice, the women criticized "careless" husbands. In a study on Muslim women living in the United States, contraception under the direct control of the woman was preferred to maintain personal control or privacy[7]. The male participants stated that two years of child spacing is ideal, which is supported by a study in Afghanistan that found both men and women believe child spacing is important for healthier mothers and children[4]. Ultimately, both groups preferred "natural" methods of contraception and displayed hesitancy toward hormonal methods due to fear of side effects, a sentiment found throughout the literature[4, 5].

Lack of access to reproductive healthcare is a significant obstacle to living out desired family planning goals. The participants usually receive SRH information from family, friends, and media and recognize a need for more reputable sources such as health classes. They also expressed an appreciation for the local refugee clinic with requests for more female providers and contraception options.

Opportunities to address the needs of this community include increasing availability of interpreters and female providers[18] as well as supporting clinics that serve refugees, specifically through implementing culturally sensitive educational resources for contraception, preventative health, and reproductive health[19]. A continued commitment to understanding the value systems and perspectives of refugees is imperative to effectively address the variety of physical, economic, and social barriers they face and to improve reproductive health outcomes.

Limitations

The language barrier between facilitators and participants proved to be the most challenging limitation. No team member was in the same demographic category as the participants. As a result, the facilitators had the difficult task of generating conversation to understand beliefs with limited understanding of the language and an inability to fully interpret non-verbal and verbal cues throughout the discussions. The facilitators were also unable to fully discern the completeness of interpretation.

Another limitation was related to trust between the research team and the participants since topics within reproductive health have associated stigma. Among refugee communities, talking about sex is often forbidden, possibly due to the religious and cultural prohibition of coitus before marriage[14, 20]. Lastly, the sample size was small and limited to the experiences of Afghan immigrants resettled in South Texas. Therefore, the conclusions in this study cannot fully account for these differences and may be less generalizable to the beliefs of all Afghan immigrants.

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