Health-Seeking Behavior of Afghan Women Immigrants: An Ethnographic Study

Rana Amiri, PhD1, Kathryn M. King, PhD2, Abbas Heydari, PhD1, Nahid Dehghan-Nayeri, PhD1, and Abu Ali Vedadhir, PhD3,4

Abstract
Background: Nowadays, in light of gender inequity, new concern has been raised for health-seeking behavior of women in clinical setting. The aim of this study was to investigate the perceptions and health-seeking behaviors of Afghan immigrant women residing in Mashhad, Iran. Method: An ethnographic design was used to examine the health-seeking behavior of Afghan women. This study took place in Tollab Tabarsi area of Mashhad, Iran, from March 2013 to July 2014. For gathering of data, participant observations, fieldwork, and formal interviews were included. Data were analyzed using thematic analysis. Results: Fourteen Afghan women immigrants and five health care professionals were interviewed. The overarching category derived from the data was gender inequity. The emergent three themes were cultural taboos, women position, and information gap. Discussions: The displaced Afghan women were found to be at significant risk of adverse health events, which affected both their physical health and mental health.

Keywords
gender, inequality, Afghan women, immigrants, health-seeking behavior

Introduction
Afghans form the largest group of immigrants in Iran, and according to the latest census report, 1,584,000 people, 95% of all immigrants living in Iran, are of Afghan origin (United Nations, 2017). According to a recent census of immigrants in Iran, 219,442 Afghan immigrants live in Mashhad (Statistical Centre of Iran, 2017). Hosseini Divkolyae and Burkle (2017) indicate that the prevalence of disease among Afghan immigrants is significantly higher compared with the Iranian population. Indeed, there are reports of higher incidence and prevalence of tuberculosis, hepatitis B, and HIV among Afghan immigrants in Iran (Behzadi, Ziyaeyan, & Asaie, 2014; Jabbari et al., 2011; Moradi, Hassanshahi, & Arababadi, 2008). Furthermore, Afghan immigrants displaced and marginalized because of violence and insecurity in their home country have to adapt themselves to new situations, new language, new social laws, and new family relationships (Koepke, 2011).

Afghan immigrant women and girls are even more marginalized compared with men (Razia’s Ray of Hope Foundation, 2017). Historically, these women have always been viewed as subordinate to men, abused by culture and gender discrimination. They have been subjected to appalling daily difficulties to survive, which continues to the current day (United Nations Assistance Mission in Afghanistan, 2017). Siervemm, Daher, Nimri, Al-Jadiry, and Baider (2016) also contend that they are the most vulnerable group with regard to receipt of substandard health care.

Gender inequality in women is not new and has affected both the physical health and mental health of millions of women and girls across the world (Alvaredo, Chancel, Piketty, Saez, & Zucman, 2018; World Health Organization, 2009). Unfair distribution of access to care, nutrition, water, sanitation, and education negatively affects women’s health and health care outcomes globally and creates many problems that affect women’s lives (Mills & Cummings, 2016). Additional barriers mentioned in previous studies related to women also include social, cultural, and patriarchal norms (Sen & Östlin, 2010, 2011; Sen, Östlin, & George, 2007), resulting in further subordination and discrimination. Additional barriers to health care reported in earlier ethnographic studies include communication difficulties, lack of information, lack of social support

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(isolation), cultural beliefs, inadequate health care services, concerns about being inconspicuous of their cultural traditions, religious, and traditional preferences, and physical, symbolic, and cosmological threats (Higginbottom, Hadziabic, Yohani, & Paton, 2014; Higginbottom et al., 2015; Higginbottom et al., 2016; Lipson, Hosseini, Kabir, Omidian, & Edmonston, 1995; Lipson, Omidian, & Paul, 1995; Qureshi & Pacquiao, 2013; Varley, 2013).

Although the environment has changed for Afghan immigrant women in Iran, they remain displaced, subjected to historic cultural discrimination that significantly negates their access to education, employment, and health care services (Rostami-Povy, 2007; Kaur & Ayubi, 2009; Okonofua, 2007; Otoukesh et al., 2012; Turner, 2006; Warren & Hopkins, 2015) and which subsequently affect their health-seeking behavior.

There has been some progress in dealing with health care issues in Iran for women, and in particular, Afghan women immigrants. Nevertheless, significant inadequacies and disparities exist including failure to protect and promote Afghan immigrant women’s health (Pourhossein, Irani, & Mostafavi, 2015). Moreover, the health care system of Iran does not have a comprehensive policy to address either the health risks or health needs of Afghan women immigrants (Hosseini Divkolaye & Burkle, 2017). Consequently, there is an urgent need to reduce health inequalities and their determinants and protect and promote the health and well-being of Afghan women immigrants in Iran.

The aim of this study was to investigate the perceptions of Afghan immigrant women’s health-seeking behavior in order to better understand their health care needs. We also sought the views of health care professionals with responsibility for the Afghan women’s health care to identify areas of focus for health care improvement and health care management.

Method

Design

A focused ethnographic approach was adopted in order to investigate the perceptions of Afghan women regarding their health-seeking behavior. The best way to explore the cultural experiences of people in a social context is a qualitative study with an ethnographic approach (Wall, 2015). Focused ethnography with its emphasis on groups in communities, organizations, and teams allows researchers to immerse themselves in a social setting in order to develop a rich understanding of the perceptions, behaviors, and social encounters associated with a particular phenomenon (Reeves, Kuper, & Hodges, 2008). It is about telling a credible, rigorous, and authentic story and gives voice to the people in their own local context (Fetterman, 2010). In this study, for gathering of data a purposeful sampling technique was utilized with maximum variation (Miles & Huberman, 1994).

<table>
<thead>
<tr>
<th>Participant</th>
<th>Clinic</th>
<th>Age</th>
<th>Educational experience</th>
<th>Ethnic group</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>30</td>
<td>High school</td>
<td>Turkman</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>38</td>
<td>Primary school</td>
<td>Sadat</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>46</td>
<td>Illiterate</td>
<td>Tajic</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>47</td>
<td>Primary school</td>
<td>Pashtu</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>29</td>
<td>Primary school</td>
<td>Hazare</td>
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<tr>
<td>6</td>
<td>1</td>
<td>34</td>
<td>High school</td>
<td>Hazare</td>
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<td>7</td>
<td>2</td>
<td>38</td>
<td>Illiterate</td>
<td>Turkman</td>
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<tr>
<td>8</td>
<td>1</td>
<td>34</td>
<td>High school</td>
<td>Sadat</td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td>43</td>
<td>Primary school</td>
<td>Hazare</td>
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<tr>
<td>10</td>
<td>1</td>
<td>55</td>
<td>Illiterate</td>
<td>Hazare</td>
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<td>11</td>
<td>1</td>
<td>52</td>
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<td>Sadat</td>
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<td>12</td>
<td>2</td>
<td>33</td>
<td>College</td>
<td>Tajic</td>
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<td>13</td>
<td>2</td>
<td>32</td>
<td>High school</td>
<td>Tajic</td>
</tr>
<tr>
<td>14</td>
<td>2</td>
<td>25</td>
<td>College</td>
<td>Turkman</td>
</tr>
</tbody>
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*Clinic 1 = Sakhteman; Clinic 2 = Golshahr.*

Setting

This study took place in Mashhad, Iran. Mashhad was chosen because most Afghan immigrants reside in Mashhad due to its close proximity to Afghanistan and because the holy shrine of Imam Reza is in this city. The respondents were recruited from two health care clinics in the Tollarab Tabarsi area of Mashhad (Table 1). Tollarab Tabarsi is an area where almost all Afghan immigrants are located. These two health clinics were the most popular clinics in which 60% to 80% of Afghan people went there for their treatment.

Ethical Considerations

The Ethical Board of Mashhad University of Medical Sciences approved this study on March 2, 2013. The objective of the study was explained to each health care professional and each Afghan woman. Formal written consent was obtained prior to commencement of the study. The illiterate participants received verbal information from RA (main researcher) and a local witness. Verbal consent was then obtained together with the participant’s fingerprint.

It was emphasized to each respondent that participation in the study was voluntary and that they had the right to withdraw from the study at any time. Respondents were also informed that confidentiality, which included identity and personal information, would be maintained throughout the study.

Data Collection

Data collection took place from March 2013 to July 2014 and included participant observation, semi-structured in-depth interviews, and informal conversations with an experienced member of the research team (RA). Access to the Afghan women was facilitated by informal contacts with members of the community. The principal researcher was a native from
Afghanistan and understood the language of the participants, and this was influential in establishing initial entry and in gaining trust and developing rapport with the participants (Guest, Namey, & Mitchell, 2013). Further rapport and trust was developed by the researcher with attending and observing the health care clinics over a sustained period of time.

The participant observation was carried out during the morning of all working days. The researcher (RA) observed the health care practice of professionals and communication among them and the Afghan women attending the clinic; observations were recorded as field notes.

In addition to observation, 14 one-to-one interviews involving Afghan women and one-to-one interviews involving 5 health care professionals took place. The Afghan women immigrants had been referred to the clinic for health care and their age range was 18 to 60 years. Their educational level ranged from illiterate to bachelor degree and all had been residents of Mashhad, Iran, for more than 5 years. The criteria for selecting the health care respondents was health care professionals with experience of providing health care to the Afghan women immigrants and at least 3 to 10 years of clinical experience working with them. The health care respondents included a general physician, a nurse, two midwives, and a gynecologist. Three of them were from Iran and two were from Afghanistan (Table 2).

Formal and informal interviews with participants were conducted using Farsi and Pashto languages, which were the language of the participants and RA. Each interview was audio-taped, and during each interview facial expression and nonverbal communication were also noted.

The interviews with the health care professionals took place in the meeting room at the health clinic, and the interviews with women were conducted at a convenient place of their choice. Initially, one by one, women were invited to tell their experiences of being sick and/or of being unwell. The health care professionals were then invited to describe their experience of providing health care for the Afghan women.

Table 2. Health Care Professionals’ Profile.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Professional group</th>
<th>Years of clinical experience</th>
<th>Age</th>
<th>Nationality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>General physician</td>
<td>8</td>
<td>45</td>
<td>Iran</td>
</tr>
<tr>
<td>2</td>
<td>Midwife</td>
<td>10</td>
<td>38</td>
<td>Iran</td>
</tr>
<tr>
<td>3</td>
<td>Midwife</td>
<td>9</td>
<td>32</td>
<td>Afghanistan</td>
</tr>
<tr>
<td>4</td>
<td>Gynecologist</td>
<td>7</td>
<td>48</td>
<td>Iran</td>
</tr>
<tr>
<td>5</td>
<td>Nurse</td>
<td>5</td>
<td>28</td>
<td>Afghanistan</td>
</tr>
</tbody>
</table>

Data Analysis

Data analysis was conducted simultaneously with data collection utilizing Miles and Huberman’s (1994) approach. Max qualitative data analysis software (Godau, 2004) was used to analyze data from the interviews and field notes. Reduction, coding, summarizing, and abstracting the data were performed and initial subthemes were derived from the data. The subthemes were developed and categorized according to their associations and subsequently resulted in themes (Table 3). The themes were further categorized to form an overarching core theme in an attempt to provide a meaningful truth to the findings derived from the data. In an attempt to ensure trustworthiness of the research findings (Guba, 1981), triangulation of the data collection was undertaken, which involved a review of the data codes and confirmation of the findings by an experienced ethnographic researcher.

Results

The results presented here report the views and experiences of Afghan women immigrants attending a multidisciplinary health care clinic together with the views and experiences of the health care professionals responsible for their health care. In addition, field notes collected during observation at the health care centers provided contextual information to the phenomena under study. The findings demonstrated widespread subservience to male dominance, veiled by Confucian traditions, and their inherent need to conform. Additionally, it highlights the constant struggle of the women to live and the constraints they faced on a daily basis. Moreover, the findings indicated that the women remain a marginalized displaced group trapped in a world of inadequate assistance by those who believe they should neither be seen nor heard. Furthermore, they are confined to endure social restraints and increasing impoverishment, which dominates their thinking and their lives.

Our findings derived from the data also suggest that there were barriers regarding the health-seeking behavior of Afghan women, which related directly to their culture. Themes derived from the data included the following: “cultural taboos,” “women’s position,” and “information gap.” The overarching theme was “gender inequity.”

Cultural Taboo

This theme related to the manner in which the Afghan women expressed their experiences of their subordination and male domination and the daily struggles they were forced to endure. The subthemes derived from the analytical process were as follows: “cultural shamefulness” and “women behind the door.” The women spoke of their difficulties,
inequality, future aspirations, traumatic experiences, and limitations that prevented them from accessing health care treatment. Many identified Afghan culture as the reason for being denying basic human rights, and they spoke of their fear, isolation, and need to obtain their husband’s permission to attend health care clinics.

Often, cultural beliefs caused the women to remain passive and adopt submissive roles; those seeking independence were said to bring disgrace and dishonor to their family. The women’s daily lives were challenged by domination, persecution, and oppression. Indeed, many were imprisoned within their family home and lived with oppression and insecurity. Access to health care was equally challenging and restrictive, particularly when associated with genital, urethral, or anal problems.

I don’t know where the local clinic is; when I want to go out even for treatment I must get permission from my father in law. (Women Respondent 5)

When I was a new bride I had disturbing and irritating dysuria. When I told my husband and my mother in law they didn’t pay attention. Finally after 9 months I was able to go to the doctor, the doctor said I have a severe infection. (Women Respondent 1)

The women not only worried about day-to-day problems but also about their husband’s accusations. They were often forced to have medical examinations for chastity and were well aware of the punitive stance by their abusive husbands if infidelity was suspected. They spoke openly about invasive examinations to check whether their hymen was intact and to confirm virginity. The findings indicate that in Afghan culture, the only criterion of virginity for young women is vaginal bleeding after their initial sexual encounter. Findings also highlight that if vaginal bleeding does not occur on the night of Zafaf (the wedding night), infidelity would be suspected, resulting in severe, and in some cases, fatal consequences.

When there was no bleeding on my weeding night it caused a big argument. I immediately went to the doctor for examination, and the doctor told me my hymen was elastic, but my husband refused to accept the doctor’s diagnosis. (Women Respondent 12)

A 28-year-old girl referred to me for a hymen examination. As it was intact I gave her a confirmation letter. Six months later I found that her husband had killed her on their wedding night because she did not bleed. (Health Care Respondent 2)

In the clinic an Afghan women was referred for a hymen examination. The husband was an engineer and his wife was a nurse. After examination I informed the husband that his wife had an elastic hymen. He accepted and did not say anything that time, but the following morning he attended again without his wife and asked: do you think her hymen is intact really, because she works in the hospital and I am afraid she has had sexual relationships with her colleagues. (Health Care Respondent 5)

Many of the women were unable to access health care services and spoke of concerns and associated stigma related to gynecological problems. If a girl was referred to a gynecologist, unfaithfulness was suspected within the family. Consequently, gynecological referral is often delayed resulting in chronic infection and infertility.

Many of the women had significant medical problems. However, they were often too embarrassed to seek medical opinion. Vaginal examination was equally highlighted as embarrassing. Many of the health care professionals spoke about how women and especially their husbands preferred to be examined by a female physician. In fact, some husbands only permitted their wives to be examined if a female physician was available, and consequently an examination often did not take place, resulting in severe negative consequences.

An elderly woman was referred to me with a chief complaint of dysuria. When I asked her for permission for a cervical examination, she did not accept and said, it is impossible, I’ve...
had nine pregnancies and deliveries, but nobody has examined and observed me. Finally she accepted with assistance from her family. When I examined her, I found that she had a complete prolapsed uterus. Half of her uterus was completely outside of her vagina. I asked her, “Do you not feel something coming out of your vagina? She answered I did, but I was too embarrassed to tell anyone.” (Health Care Respondent 4)

The following field note reflects this issue:

After a long engagement, I found that a woman who was suffering from a health problem had hidden her disease for several years. She had timea and hemorrhoids, but she was too embarrassed to visit and speak to a doctor. When I spoke to her GP, she said I am visiting her every month over 8 years and as yet she has not talked to me about her health problems.

The women spoke about many hardships they suffered. Many indicated that they were repressed, prohibited from working, and were only responsible for maintaining the house. Furthermore, many of the women stated that Afghan men believed that a working wife would bring dishonor to them. This belief caused the women to remain apart from society and stay at home, confined to domestic roles. Many of these women spoke about being isolated and their difficulties in terms of their ability to access health care services in response to their health care need.

I finished my study as a nurse. When I got married, after a while I was looking for a job, but my husband told me “everything has been finished, no study, no work and no going out without me, you must be at home as a house-wife.” You can’t imagine what happened to me at that time, the world was shattered for me, there was no way out, except divorce. (Health Care Respondent 4)

I had no right going out without permission from my mother-in-law or my ex-husband, even when I was sick. That time I found that my son who was 3 year old, could not eat anything and was vomiting. I told my husband and my mother-in-law that my son who was 3 year old, could not eat anything and was vomiting. I told my husband and my mother-in-law that my son had colitis and it was now chronic because of the late referral. (Women Respondent 2)

Women’s Position

The subthemes for this category were “men with the main role on decision making,” “self-neglect,” and low support of partner.” The findings from the data demonstrate that the women suffered from low self-esteem and were dependent on men for access to health care. They spoke of their highly patriarchal society, submissive role, and need to obey not only their husband but also all males within their family. They talked about the problems they experienced, particularly in relation to illness, and some resigned themselves to tolerate disease.

I have had some patients whose husband did not allow them to have an operation. One of my clients had cervical polyps, I gave her some drugs, but she continued to bleed. I told her she must go hospital for surgery. After two days she came back and told me, “My husband will not allow me to go for surgery, please if it is possible, give me more drugs.” I told her there wasn’t any drug that could work for you, you need to go for surgery and she answered sadly, “I have no choice.” (Health Care Respondent 5)

When a member of the family was sick, often my husband makes the decision. It is probably because he has money, I mean he works and earns the money so he has authority for spending it. (Women Respondent 10)

Self-image relating to how the women saw themselves was also very important. Generally, they saw themselves as inferior to men and often neglected their health in preference to their children and husbands. Women spoke about being overburdened with responsibilities within the home, which prevented them from accessing health care.

My husband works in Afghanistan, so when the children become sick all the responsibility of taking them to doctor and to the hospital is mine. I take care of all of them, but do not have time for myself. I don’t have time to go to see the doctor even when I am very sick. (Women Respondent 1)

The findings also indicated that Afghan women lacked the confidence to speak about their health problems with their husbands. They often lacked support from their husbands, tolerated poor health and illness, and failed to seek medical opinion. Some stated that the women were reluctant to inform their husband when infection was diagnosed and the treatment of both partners was required.

Herpes is common in this area and treatment must be two-sided involving both partners. When I say to women you and your husband must use this drug, they often don’t have the courage to speak to their husband. (Health Care Respondent 5)

Information Gap

This final category relates to the women’s limited knowledge base and how this affects their daily living. The subthemes developed from these data were “influence of others” and “stubborn.” The results demonstrate the intensity of many of the problems and challenges faced by the women. Many spoke of their limited access to formal education.

I had a great opportunity to go to university but my parents would not let me. While my brother did not want to continue with education, my parents forced him to go to university. My father thinks that high school is enough education for girls and any further education is useless. (Women Respondent 13)
My big brother did not let me go to school because he believes that school would destroy my character. So I am unable to find a boyfriend and gain independence. Because of his ridiculous attitude I cannot continue education after primary school. (Women Respondent 5)

Although there is more opportunity now for Afghan girls to access education in Iran compared to Afghanistan, some families still do not let their girls access continuing education, especially for tertiary education. (Health Care Respondent 3)

The health care professionals spoke about their experiences of health care management for the Afghan women. Many spoke about the challenges they faced in providing health care. They said that women would seek advice from neighbors and their families rather than the medical professionals, preferring to remain subsumed in a world of prejudice and ignorance and resisting conventional evidence-based medicine. Often, they felt frustrated by the women’s reliance on superstition, their reluctance to change and accept health care treatment.

They accept more from their families and neighbors who are not educated than us. Sometimes they say some ridiculous reasons for their disease. I wonder how they made them. (Health Care Respondent 4)

It is so frustrating for me, I explain to someone more than 10 minutes and finally again they repeat their own idea. I think some of them do not accept change and prefer to base their belief on their superstition. (Health Care Respondent 1)

Discussion

Our findings highlight that Afghan women refrain from accessing health care and therefore do not engage in health-seeking behavior. Our findings also indicate that they experience many challenges related to patriarchy and culture. Similar findings have been found elsewhere. Lipson and Omidian (1997) in their study of Afghan women health in California highlighted the superiority of men over women and patriarchy in Afghan culture and found that Afghan women do not have the right to go outside the home without permission from their husbands. Other ethnographic studies related to immigrant women also highlighted isolation, patriarchal norms, and cultural misconception (Manzoor, 2017; Matthews, 2015). An earlier study by Khattab, Yunis, and Zurayk (1999) suggests that when immigrant women reach reproductive age, institutional and cultural inequalities restrict access to health services. Findings from our study also indicate that the health care professional respondents also experienced challenges in providing health care for the Afghan women immigrants. Furthermore, multiple cultural factors including cultural and religious issues and traditional patriarchal structures were reported as significantly affecting Afghan women’s health-seeking behavior.

In addition to supporting findings in earlier studies, our findings importantly highlight gender inequalities and male domination including a high dependency on men specifically relating to health care decisions for Afghan women. Husbands often restrict their wives from accessing urgent medical care even when presented with serious life-threatening consequences. Indeed, many Afghan men refused to allow their wives access to medical treatment, and some women were only allowed to seek medical care if they were accompanied by a male escort, which often caused difficulties especially in emergency conditions.

Our ethnographic study indicates that women were often dismissive regarding their ill-health, and when sick, many often tolerated the situation. An earlier study from rural Egypt found that while reproductive health problems were prevalent, women rarely sought care for such problems (Younis et al., 1993). Our results indicated Afghan women were often influenced by superstition and accepted advice and health care recommendations from friends and neighbors rather than seek expert medical opinion. The present study found that the perceptions women held about their own health were the single most important factor governing their utilization of health services and their health-seeking behavior. Many of the Afghan women respondents had gynecological problems, but the majority did not seek health care services. Furthermore, most of these women saw this condition as normal.

Additionally, findings from our study also indicated a lack of access to education and employment restrictions as a contributory factor for accessing health care. A study in Iran pointed out to some barriers for accessing health care services among Afghan immigrants such as high treatment cost, being ignored intentionally, being a stranger, and feeling inferior as a consequence of limited education and limited employment opportunities (Heydari, Amiri, Dehghan Nayeri, & Vedadhir, 2016). McKinlay’s (1972) health-seeking model pointed out that the impact of others and psychological factors are essential factors related to health-seeking behavior.

Implications for Practice

This study highlights the gaps and barriers to health care and importantly identified that social determinants for women negatively affected their health-seeking behavior. This resulted in harmful consequences for these women. It also posed a major problem for their health care professionals. The health care management for Afghan women immigrants poses many challenges to the realization of optimal health, many of which are inherent in the culture and traditions of Afghan immigrant women. In part, their capability to achieve this goal is reliant not only on their attitudes regarding their health status but also their perceptions of their long-term health outcomes. Inequalities impinge on their daily activities and subsequently affect all aspects of their lives. This study shows that current health care for Afghan women falls below the recommended
standard. Improvement in health care management for this group is required, together with the development of sustainable culturally cognizant and a responsive patient-centered health care workforce. Afghan women may benefit from a health care policy purposefully developed to respond to their specific health care needs. Development of health education training courses for Afghan immigrants may also be of benefit.

Conclusion

The challenge of addressing health-seeking behavior among the Afghan women in Iran is a clinical problem with deep sociocultural roots. The combination of the sociocultural environment together with their health behavior status contributes to the development of poor health outcomes for these women. The current political agenda to address inequality across all social groups is clear. However, only if we acknowledge and approach health-seeking behavior as both clinical and sociocultural problems will we finally comprehend the challenge. The relationship between Afghan culture and Afghan women’s health-seeking behavior was a key finding of our study. Although the relationship was complex, there did appear to be a substantial relationship. Inequalities were profound and significantly affected all aspects of daily living. The limited access to health care treatment for our sample may have implications for other Afghan women living in this country. The findings from this study may be of interest to the wider community and may be used to inform clinical practice and develop health care policy. It is acknowledged that while this study was small and specific to a particular demographic group, findings do demonstrate that adopting health-seeking behavior in this group is a sociocultural phenomenon. The Afghan women experienced significant marginalization, which negatively affects their health and well-being. Findings from this study highlight the difficulties and challenges experienced by the health care professionals who are responsible for the Afghan women’s health care. This study also highlights the imperative need to better understand patients’ needs and develop a culturally sustainable, responsive, patient-centric workforce to enhance health care and improve health care outcomes.

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