**Health-Seeking Behaviour of Afghan Women Immigrants:**

**An Ethnographic Study**

**Abstract**

**Background:**

**Purpose:** The aim of this study was to investigate the perceptions of Afghan immigrant women’s health-seeking behaviour in order to better understand their health care needs and to examine the views of healthcare professionals with responsibility for the Afghan women’s healthcare to identify areas of focus for healthcare improvement and healthcare management

Methods: An ethnographic design was used to examine the health-seeking behaviour of Afghan women immigrants in Mashhad, Iran.. Participant observation and fieldwork was also included. This study took place in Tollab -Tabarsi area of Mashhad, Iran in March 2013 to July 2014.Data were analyzed using thematic analysis.

Results: Fourteen Afghan women immigrants and five healthcare professionals, with responsibility for healthcare of Afghan women immigrants, were interviewed. The overarching category derived from the data was gender inequity. The emergent three themes were: cultural taboos, women position and information gap.

Discussion: Major disparities were common amongst the Afghan women, which impacted on both their physical and mental health. The displaced Afghan women were found to be at significant risk of adverse health events.

Key words: 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 1584,000 people, 95% of all immigrants living in Iran, are of Afghan origin (UN 2017). According to a recent census of immigrants in Iran, 219,442 Afghan immigrants live in Mashhad (Statistical Centre of Iran, 2017). Divkolaye and Burkle (2017) indicate that the prevalence of disease among Afghan immigrants is significantly higher compared to the Iranian population. Indeed, there are reports of higher incidence and prevalence of Tuberculosis, Hepatitis B, and HIV amongst Afghan immigrants in Iran (Behzadi, Ziyaeyan and Asaei, 2014; Jabari, 2011; Moradi, Hassanshahi and Arababadi, 2008). Furthermore, Afghan immigrants displaced and marginalised 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). Furthermore Afghan Immigrant women and girls are even more marginalised compared to 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 (UNAMA, 2017). Sibermann et al (2016) also contend that they are a most vulnerable group in receipt of substandard healthcare.

Gender inequality in women is not new and has impacted on both the physical and mental health of millions of women and girls across the world (WHO, 2009; Alferdo, et. al., 2018). 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 and Cummings, 2016). Additional barriers mentioned in previous studies related to women also include social, cultural, and patriarchal norms (Sen, Ostlin, 2011; Sen, Ostlin, 2010; Sen and Ostlin, 2007) resulting in further subordination and discrimination. Although the environment has changed for Afghan immigrant women in Iran, they remain displaced, subjected to historic cultural discrimination which significantly negates their access to education, employment and healthcare services (Warren and Hopkins, 2015; Otoukesh et al., 2012; Kaur and Ayubi, 2009; Okonofua, 2007; Turner, 2006) and which subsequently impact on their health-seeking behaviour (WH0, 2016).

Additional barriers to health care reported in earlier ethnographic studies include communication difficulties, lack of information, lack of social support (isolation), cultural beliefs, inadequate healthcare services, concerns about being inconspicuous of their cultural traditions, religious and traditional preferences and physical, symbolic and cosmological threats (Higginbottom et. al., 2016; Higginbottom et al, 2015; Higginbottom et. al., 2014; Quereshi and Pacquiao 2013; Lipson, et. al., 1995a; Lipson et al., 1995b).

 There has been some progress in dealing with healthcare 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 and Mostafavi, 2015). Moreover, the healthcare system of Iran does not have a comprehensive policy to address either the health risks or health needs of Afghan women immigrants (Divkolaye and Burkle, 2017). Consequently there is an urgent need to reduce health inequalities and their determinants and protect and promote the health and wellbeing of Afghan women immigrants in Iran.

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

**Method**s **Design**

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

**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. The respondents were recruited from two healthcare clinics in the Tollab Tabarsi area in Mashhad (Table 1).

 **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 healthcare professional respondent and each Afghan woman respectively. Formal written consent was obtained prior to commencement of the study. The illiterate participants received verbal information from RA 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 included participant observation, semi-structured in-depth interviews and informal conversations by 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 participants and this was influential in establishing initial entry and in gaining trust and developing rapport with the participants (Guest, Namey and Mitchell, 2013). Further rapport and trust was developed by the researcher with attending and observing the healthcare 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, fourteen, one to one interviews involving Afghan women and one to one interviews involving five healthcare professionals took place. The Afghan women immigrants had been referred to the clinic for healthcare and their age range was 18-60 years. Their educational level ranged from illiterate to Bachelor (B.S) and had all been resident in Mashhad, Iran more than five years. The criteria for selecting the healthcare respondents was healthcare professionals with responsibility for providing healthcare to the Afghan women immigrants and at least 3-10 years of clinical experience working with them. The healthcare respondents included a general physician, a nurse, two midwives and a gynaecologist physician. Three of them were from Iran and two were from Afghanistan (Table 2). Formal and informal interviews with participants were conducted using the Farsi and Pashto language; which was the language of the participants and RA1. Each interview was audiotaped and during each interview facial expression and nonverbal communication was also noted.

The interviews with the healthcare professionals took place in the meeting room at the health clinic and the interviews with women were conducted in 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 healthcare professionals were then invited to describe their experience of providing healthcare for the Afghan women.

**Data analysis**

Data analysis was conducted simultaneously with data collection utilising Miles and Huberman’s (1994) approach. Max qualitative data analyse software (Godau, 2004) was used to analyse data from the interviews and field-notes. Reduction, coding, summarizing and abstracting the data was performed and initial sub-themes were derived from the data. The sub-themes were developed and categorized according to their associations and became themes (Table 3). The themes were further categorised 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 healthcare clinic together with the views and experiences of healthcare professionals with responsibility for their healthcare. In addition field-notes collected during observation at the healthcare centers provided contextual information to the phenomena understudy. The findings demonstrate 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 illuminate 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 behaviour of Afghan women, which related directly to their culture. Themes derived from the data include: ‘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 experience to their subordination and male domination and the daily struggles they were forced to endure. Subthemes derived from the analytical process were: ‘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 healthcare treatment. Many identified Afghan culture as the culprit for denying them basic human rights and they spoke of their fear, isolation and need to obtain their husband’s permission to attend healthcare 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 healthcare was equally challenging and restrictive, particularly when associated with genital, urethral or anal problems.

As women respondent 5 said, “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”.

As women respondent 1 said, “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”.

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 amongst the 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.

As women respondent 12 said, “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 ”.

As healthcare respondent 2 said, “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.

As healthcare respondent 5 said, “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 reallybecause she works in the hospital and I am afraid she has had sexual relationships with her colleagues”.

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

As healthcare respondent 1 said, “An Afghan girl referred me for treatment. She had dysuria and pain. I asked her for permission for a vaginal examination, but she didn’t accept. When I spoke with her, she told me I came here without permission of my mother. If my mum knows that I came, she would treat me badly, so I was afraid. When I asked the reason she told that in our culture a girl does not have the right to visit a gynecologist or midwife prior to their wedding”.

As Afghan women respondent 12 said, “my daughter had an ovarian cyst and for her treatment was referred to a gynecologist. When I took her to the doctor, I heard that our neighbours has gossiped that my daughter might be pregnant”.

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 healthcare professionals spoke about how women and especially their husbands preferred to be examined by a female physician. Indeed 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.

As healthcare respondent 4 said, “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”.

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 tinea and haemorrhoids, 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 dishonour 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 healthcare services in response to their healthcare need.

As healthcare respondent 4 said, “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.

As women respondent 2 said, “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 but they didn’t pay attention. Finally when I was divorced, after 5 years, I brought my son to the doctor and the doctor told me my son had colitis and it was now chronic because of the late referral”.

**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 healthcare. 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. As healthcare respondent 5 said, “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”.

As women respondent 10 said, “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”.

 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 healthcare.

As women respondent 1 said: “My husband works in Afghanistan, so when the children become sick all the responsibly 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”.

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.

As healthcare respondent 5 said “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”.

**Information gap**

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

As women respondent 13 said, “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”

As women respondent 5 said, “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”.

As healthcare respondent 3 said, ”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”.

The healthcare professionals spoke about their experiences of healthcare management for the Afghan women. Many spoke about the challenges they faced in providing healthcare. They said that the women would seek advice from neighbours 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, they reluctance to change and accept healthcare treatment.

As healthcare respondent 4 said, “they accept more from their families and neighbours who are not educated than us. Sometimes they say some ridiculous reasons for their disease. I wonder how they made them”.

As healthcare respondent 1 said “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”.

**Discussion**

Our findings highlight that Afghan women refrain from accessing healthcare and therefore do not engage in health-seeking behavior. Our findings also indicate that they experienced 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 healthcare professional respondents also experienced challenges in providing healthcare for the Afghan women immigrants. Furthermore multiple cultural factors including cultural and religious issues and traditional patriarchal structures were reported as significantly impacting on 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 healthcare 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 healthcare recommendations from friends and neighbours 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 behaviour. Many of the Afghan women respondents had gynaecological associated problems, but the majority did not seek healthcare 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 to health care service among Afghan immigrants such as high treatment cost, being ignored intentionally, being a stranger and feeling inferior as a consequence to limited education and limited employment opportunities (Heydari, et al; 2016). McKinley's (1972) health-seeking model pointed out that the impact of others and psychological factors are essential factors related to health-seeking behaviour.

**Implications for practice**

This study highlights the gaps and barriers to healthcare and importantly identified that social determinants for women negatively impacted on their health-seeking behaviour. This resulted in harmful consequences for these women. It also posed a major problem for their healthcare professionals. The healthcare management for Afghan women immigrants poses many challenges to the realisation 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 impact on all aspects of their lives. This study shows that current healthcare for Afghan women falls below the recommended standard. Improvement in healthcare management for this group is required, together with the development of sustainable culturally cognizant and a responsive patient-centred healthcare workforce. Afghan women may benefit from a healthcare policy purposely developed to respond to their specific healthcare needs. Development of health education training courses for Afghan immigrants may also be of benefit.

**Conclusion**

The challenge of addressing health-seeking behaviour amongst the Afghan women in Iran is a clinical problem with deep sociocultural roots. The combination of the sociocultural environment together with their health behaviour 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 until we acknowledge and approach health-seeking behaviour as both a clinical and sociocultural problem will we finally comprehend the challenge. The relationship between Afghan culture and Afghan women’s health-seeking behaviour 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 impacted on all aspects of daily living. The limited access to healthcare 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 healthcare policy. It is acknowledged that whilst this study was small and specific to a particular demographic group, findings do demonstrate that adopting health-seeking behaviour in this group is a sociocultural phenomenon. The Afghan women experienced significant marginalisation, which impacts negatively on health and wellbeing. Findings from this study highlight the difficulties and challenges experienced by the healthcare professionals with responsibility for the Afghan women’s healthcare. This study also highlights the imperative need to better understand patients’ needs and develop a culturally sustainable responsive patient centric workforce to enhance healthcare and improve healthcare outcomes.

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**Table 1: Respondent’s Demographic Profile**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Participant** | **Clinic** | **Age** | **Educational Experience** | **Ethnic group**  |
| 1 | 2 | 30 | High school | Turkman |
| 2 | 1 | 38 | Primary school | Sadat |
| 3 | 2 | 46 | Illiterate | Tajic |
| 4 | 2 | 47 | Primary school | Pashtu**Key**Clinic 1 = SakhtemanClinic 2 = GolshahrClinic 2 = Golshahr |
| 5 | 1 | 29 | Primary school | Hazare |
| 6 | 1 | 34 | High school | Hazare |
| 7 | 2 | 38 | Illiterate | Turkman |
| 8 | 1 | 34 | High school | Sadat |
| 9 | 1 | 43 | Primary school | Hazare |
| 10 | 1 | 55 | Illiterate | Hazare |
| 11 | 1 | 52 | Illiterate | Sadat |
| 12 | 2 | 33 | College | Tajic |
| 13 | 2 | 32 | High school | Tajic |
| 14 | 2 | 25 | College | Turkman |

**Table 2: Healthcare Professional’s Profile**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Participant | Professional Group | Years of Clinical Experience | Age  | Nationality |
| 1 | General Physician | 8 | 45 | Iran |
| 2 | Midwife | 10 | 38 | Iran |
| 3 | Midwife | 9 | 32 | Afghanistan |
| 4 | Gynaecologist | 7 | 48 | Iran |
| 5 | Nurse | 5 | 28 | Afghanistan |