MATERNAL AND REPRODUCTIVE HEALTH CHALLENGES AMONG AFGHAN REFUGEE WOMEN IN URBAN AND RURAL SETTLEMENTS OF BALOCHISTAN

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ABSTRACT

This study examines the maternal and reproductive health challenges faced by Afghan refugee women in both settings of urban and rural regions of Balochistan, Pakistan. Despite extensive research on refugee health, little attention has been paid to the gender-specific challenges that impact Afghan refugee women`s access to healthcare in displacement settings. Within the framework of refugee and public health studies, the study examines how socio-cultural norms, financial restraints, and economic limitations combine to impact healthcare results. However, there are still gaps in our knowledge of the gendered characteristic of refugee, despite the fact that previous studies have shown overall health disparities among them. Using qualitative method, purposive sampling were adopted based on marital status and number of children of Afghan refugee women. Through semi-structure interview, data were collected from 20 Afghan refugee women living in the rural area of Saranan and the urban area of Ghosabad. The results show that health problems among Afghan refugee women are caused by social marginalization, cultural injustice, inadequate institutional support, and limited access to healthcare. According to the study, inclusive, gender-sensitive policies that address systemic discrimination and promote equitable healthcare delivery are essential to improving the health of Afghan refugee women.

Keywords: *Afghan Refugee women, maternal, reproduction, urban and rural, Health challenges, Balochsitan.*

1. INTRODUCTION

As per United Nations High Commissioner for Refugees (UNHCR), a migrant is defined as an individual who has departed from their home for various reasons. These reasons are not solely in pursuit of improved education, employment, and family; whereas refugees are described as "individuals who flee due to war, violence, conflict, or persecution (Hawkins et al., 2021).

The global refugee population continuous to grow each year, with 25% of these individuals being of reproductive age (Erhardt-Ohren & Prata, 2025). Among those displaced by conflict 117 million individuals forcibly displaced. (Chalouhi et al., 2025). Additionally, refugees and migrants frequently encounter inadequate experiences and outcomes in healthcare (Kanga-Parabia et al., 2025). In particularly, refugee women and girls face significant and interconnected health challenges. These health challenges are the result of forced displacement, restricted healthcare access, and gender-based violence, exploitation, and various elements impacting the social determinants of health (Chalouhi et al., 2025). However, health of refugee mothers living in camps, conflict areas, or settled in developed countries is one of issues needing special attention and intervention (Badshah et al., n.d.).

A broader understanding arises regarding the Afghans` historical reliance on mobility. Their mobility are based on means of survival or as a form of social, economic, and political security for enhancing their livelihoods or fleeing from conflict and natural catastrophes (Avis, 2021). The migration patterns of Afghan refugees and the historical context of Pakistan`s regulatory framework for refugee have been extensively studied (Turton & Marsden, 20218). Pakistan is the country in which there are some 1.4 million Afghan refugee who fled their homeland because of the conflict. Nonetheless, the number of registered Afghan refugee in Pakistan is 1.3 million, with, 840,000 having citizenship card which offers some level of protection. (Gluck, 2023).

A significant segment of the refugee population is made up of Afghan refugee women (Kakar et al., 2022). Women and children are vulnerable to sexual violence, early marriages, harassment, isolation, and exploitation as a result of the effects of migration and conflict (Bendavid et al., 2021). There have been many difficulties brought on by the overflow of Afghan refugees in Pakistan, particularly in Balochistan, especially for women. Additionally, while seeking evacuation and medical assistance, both general and conflict-affected populations face immediate and long-term health consequences (Usman, 2020).

However, international studies have shown that refugees frequently have limited access to medical care in both developed European countries and developing Asian countries (Rehman et al., 2025). Research on the health of refugee show that systemic neglect in host countries disproportionality affects women. Healthcare problems like cultural barriers, lack of health insurance, low health literacy, and sporadic racism are all part of this systemic neglect. This is particularly challenging for women, who have particular reproductive health requirements that can significantly limit their access to healthcare (Hawkins et al., 2021).

In spite of the fact that they usually experience discrimination, financial limitations, and cultural barriers, the urban refugee usually have a higher access to maternal health services. (Usman, 2020). Nevertheless, these challenges are debilitating and pose great threats to physical, mental and social welfare in terms of reproductive health and other health complications. Thus, through improving reproductive health, individuals have the knowledge and choice to make their own decisions and be able to enjoy a happy and safe sexual life (Khan et al., 2022).

Additionally, the displacement of the Afghan women refugees has a significant negative effect on their health, which is why they constitute an exceptionally vulnerable group. Among the issues are maternal and reproductive health problems that are caused by poor healthcare services, cultural restrictions as well as structural barriers. It is however the purpose of this study to explore the maternal and reproductive health problems of the refugee women of Afghanistan and compares them between the rural and urban environments. The paper seeks to present patient feedback to healthcare policy making in an effort to enhance access to health through the analysis of maternal mortality, prenatal care, and access to reproductive health services.

1.1 Problem Statement

Maternal and reproductive health constitute a crucial aspect of women wellbeing, which incorporates safe pregnancy, child birth, post birth care and availability of the needed reproduction services. According to the World Health Organization (WHO), inadequate maternal healthcare is the reason that results in high rate of maternal and newborn death, complications during childbirth, and the long-term health consequences of both mothers and children. To prevent maternal deaths and improve the general reproductive health outcome, family planning, prenatal care, competent delivery care and postnatal services must be available.

However, even though there is a lot of literature on the health of refugees, little of it focuses on the variations in maternal and reproductive health of Afghan refugee women in urban and rural Balochistan. In this study, Ghosabad in Quetta is considered an urban region whereas Saranan in Pishin is said to be a rural region. Also, there is insufficient information regarding the influence of healthcare policies and sociocultural restrictions on the outcomes of maternal and reproductive health among these communities.

1.2 Research Objectives

1 To analyze the socio-cultural norms and barriers to healthcare that restrict the access of the Afghan refugee women in maternal care both in urban and rural settings.
2 To recommend targeted, gender-sensitive, and refugee-inclusive health policy measures aimed at improving maternal and reproductive healthcare access for Afghan refugee women in Balochistan.

1.3 Research Questions

1. What are the socio-cultural and factors that prevent Afghan refugee women from accessing maternal and reproductive healthcare in Urban and Rural settings?
2. What can be possible policy recommendations for targeted, gender-sensitive, and refugee-inclusive aimed at improving maternal and reproductive healthcare access for Afghan refugee in Balochistan.

1.4 Significance of Study

A study`s significance lies in its ability to expand, challenge, or refine existing knowledge. Meaningful research clarifies complexities, uncovers overlooked issues, and provides deeper infights (K. Tracy, 1995). Therefore, this study is significant in addressing an urgent health crises among Afghan refugee women. Furthermore, this research holds significant value as it will address the Healthcare access and barriers for Afghan refugee women in rural (Saranan), Pishin and urban area (Ghousabad) Quetta, Balochistan.

Given the context of Balochistan, a region characterized by massive number of refugees living in both rural and urban refugee population. Particularly, Afghan refugee women face numerous issues mostly related to healthcare that makes them more vulnerable. Despite the importance of Maternal and Reproductive healthcare, there is very limited discussion in existing literature. By differentiating health challenges faced in urban and rural environments, it will provide policymakers and humanitarian organizations with targeted insights to improve maternal healthcare services.

1.5 Ethical Consideration

The study adhered strictly to established ethical guidelines, including obtaining informed consent, maintaining confidentiality, and safeguarding Afghan refugee women as a vulnerable population. Participants received clear information regarding the research

purpose, the voluntary nature of their participation, and their right to withdraw at any stage. Data collection was conducted privately and anonymously, employing culturally sensitive methods and female data enumerators to promote participant comfort and safety. Measures were implemented to prevent psychological or social harm, and referrals were made when urgent health protection needs arose. All data were securely stored and utilized exclusively for academic and humanitarian objectives.

2. LITERATURE REVIEW

Millions of individuals around the globe strive with insufficient access to basic needs and without enough support on the part of a government. (Lister, 2013). In the middle of 2023, an estimate showed that around the globe more than 110 million people had been forcibly displaced by war, violence, or significant violation of human rights. Among this figure were the 26.4 million refugee that were compelled to violate national boundaries and seek refuge (Fakahany & El-Kak, 2024).

The United Nations has come up with the 1951 Refugee Convention which indicates that a refugee is a person who has fled his or her home country based on the fear of being persecuted such as, on his/her identity or beliefs. (Hein, 1993). Almost everywhere on the globe, armed conflicts and wars result in millions of deaths. Since the high number of those displaced is still at a critical humanitarian point today (Myadar & Dempsey, 2022). Immigrants have increased in countries such as the United States, Canada, and Australia but the major proportion is now immigrants of Asian, African and Latin American decent instead of Europeans (Massey et al., 1993).

The 21st century is characterized by migration, which determines demographic processes of the world to a large extent (White, 2016). File displacement reached new postwar records due to the war in Syria, Iraq, Afghanistan, and Ukraine and persecution in Southern Asia and Sub-Saharan Africa, which saw thousands flee (Matlin et al., 2018a). Such regions of settlement as Africa, the Middle East, and Asia show the highest rates of refugees (Ahsan Ullah, 2016). The recent events involving South Sudan, Somalia, and Nigeria wars, Civil war in Syria, and the ethnic persecutions being carried out in Myanmar are some of the most graphic manifestations of violence beyond borders, which make people want to feel safe (Dutta, 2023). By 2020, Syria was considered the leading country of origin of refugees in the world, (UNHCR Refugee Statistics. 2020).

Although Africa comprises only 12 percent of the global population, it is excessively impacted by global displacement, hosting millions of refugees and internally displaced persons. (Crisp, 2000). While the middle East has been extensive and protracted relocation as a result of decades of war, despotism, and internal conflict. Recent events like Arab spring and the Syrian civil war are causing long-term humanitarian catastrophes for millions of people. (Fábos, 2015). As the migration from Asia has great historical significance. Migration in the continent of Asia continued through the movement of labor source between Korea and Japan, One Million Chinese to Manchuria, and Independence of India (Castles et al., 2014). In the present day, 7 of the 8 countries of South Asia, except the Maldives due to population size, operate as source and destination countries of migration and refugees. (Ghosh, 2016).

Afghanistan is seen to be one of the countries where a long history of war has led to a consistent decrease in population (Seekins & Nyrop, 1986). The political instability that has faced Afghans over the past 30 plus years has driven them both internally and externally as refugees. (Alemi et al., 2014). Although Pakistan is not signatory of the 1951 Refugee Convention and the 1967 Protocol (Zieck, 2008), Pakistan accommodates the second-highest number of Afghan refugee in the world (Ali et al., 2019). Afghans since the year 1979, around 5 million Afghans have come to Pakistan in search of refuge (Amina Khan, 2017). The Afghan refugee have immigrated into Pakistan in different waves throughout the history (Khattak, 2003)

In March 2002, UNHCR and Pakistani authorities did a census which estimated the population of Afghanistan living in Pakistan at approximately 3 million people, 42 percent of whom lived in camps and 58 percent in urban areas. Out of this, over 80% of the people belonged to Pashtuns and few of Tajik, Uzbek, and Turkmen among other groups (Pakistan, 2009). With increased number of refugees, six more camps were built in November, 2001 in Pakistan (Kaleem et al., 2024). However, there were 2.1 million registered refugees by the year 2007, of which half a million people continued to live in refugee camps (Tan, 2007). Balochistan, province of Pakistan having population of different ethnic groups. Major ethnic groups are Baloch and Pashtuns (Kundi, 2005). Balochistan is predominantly an underdeveloped and rural region that aggravated the living conditions, and the geographic isolation of the region complicates the provision of healthcare consistently (Shafiq et al., 2025a). Though 54 refugee villages are officially identified all over Pakistan, in these camps, there are 10 recognized camps in just the city of Quetta, Balochistan. Nonetheless, opportunities of having a substantial livelihood are still not full of guarantees even in such camps (Usman, 2020).

Women refugees are most vulnerable of the refugees' population. The culture practices also restrict the mobility of women and they are easily exposed to under-paid employment, exploitative jobs, poor healthcare services, and abuse (Ghosh, 2016). Women refugee experience significant inequality in maternal, newborn, and child health. Health emergencies also increase health inequalities of access to health care particularly in low and middle-income countries. (Shafiq et al., 2025b). The refugee women and children

are normally victims of rape, unwarranted pregnancies, physical and mental torture (Kalipeni & Oppong, 1998). Among these issues, health is a basic right of migrants and refugees, particularly undocumented and asylum seekers with an unclear status. Often they end up between the gaps in national healthcare systems and humanitarian aid services, not getting the stable support or essential services on which one could rely (Matlin et al., 2018b)

Most importantly, Enhancing women`s reproductive health services is essential for the health and survival of communities (Khan et al., 2022). The experience of being a refugee is complex and involves several difficulties. Among these challenges, obtaining adequate healthcare is a critical need, especially for women (Fakahany & El-Kak, 2024). The barriers to healthcare among refugees are numerous in the world, both structural, social, cultural and personal. (Tappis et al., 2016). Afghan women, in particular, often encounter marginalization, discrimination, restricted access to education and healthcare, and a greater risk of violence and violations of their rights (Bond, 2012). Over the years, reproductive health has become a key component of humanitarian efforts. Many refugee women are now registered individually and receive food assistance along with specialized support programs. For example, in 1995, the Reproductive Health Group was formed by midwives and community advocates to improve services for refugee families. An NGO provided funding to help integrated reproductive health into standard humanitarian aid (Buscher, 2010).

Women reproductive health services should also be improved so as to promote the health and survival of communities (Khan et al., 2022). These challenges include the necessity to have access to proper healthcare, particularly women (Fakahany & El-Kak, 2024). Refugees also have barriers towards healthcare globally, which includes structurally, social, cultural and individual obstacle (Tappis et al., 2016). Especially Afghan women have to face marginalization, discrimination, and limited access to education and medical services and a higher probability of violence occurrence and violation of their rights (Bond, 2012). Reproductive health has been one of the most important points in humanitarian activities over the years. To be able to feed refugees, many refugee women are enrolled as single entities and receive food aid as well as special assistance programs. To cite one example, midwives and community advocates established the Reproductive Health Group in the year 1995 to enhance the services they are offering to the refugee families. One of the NGOs gave money that was used to seek to it that integrated reproductive health was incorporated in the usual humanitarian assistance (Buscher, 2010).

Healthcare services are yet to be offered substantially and it primarily includes maternal and child health services, immunization program, and short-lived medical clinics. Such efforts are not satisfactory addressing the healthcare of the refugee population, particularly the aspect of antenatal and postnatal care (UNHCR et al., 2020). This increasing migrant population is a major challenge to healthcare system all over the world since their health demands are to be met (Brandenberger et al., 2019). Women, especially single or with children are especially susceptible to such difficulties upon arriving in a new country (Chahine et al., 2024). However, the resilient system should be created, and the equalities approach of the health system should be adopted to provide an effective response to the challenges that have been established by the wide-scale displacement (Lamberti-Castronuovo et al., 2022). The case of Afghan refugees living in Pakistan and more particularly in the province of Balochistan in the region of Quetta, shows the necessity of such a change. Afghan families experiences severe obstacles to receiving even simple maternal, newborn, and child health services (Shafiq et al., 2025b).

Concrete barriers, such as poverty, language, discrimination and overloaded state infrastructure all these factors reduce their potential to access quality and on time healthcare. The existence of these long-standing inequalities can not only sabotage health outcomes but worsen social marginalization as well as intergenerational disadvantage. To deal with such gaps, policies have to be coordinated to empower health system to be more inclusive, culturally competent, and ready to respond to the demands of refugees. Conclusively, the need to invest in equitable and resilient health services is not only a moral bet but also a key priority to safeguard the health of refugees and their host countries at the same time.

3. METHODOLOGY

Research design is a process of building a strategy and plan for conducting the research project, there are various approaches to design the research depending on type of research (Creswell, 2014). However, this study is qualitative and phenomenological research design to explore maternal and reproductive health challenges among Afghan refugee women in the urban settings of Ghosabad, Quetta, and rural settings in Saranan, Pishin, Balochistan.

3.1 Research Design

The study has adopted the phenomenological research design because it focuses on exploring the substance of human experiences and understanding the significance individuals assign to them are the main goals of phenomenological study design. (Bliss, 2016). While the research type is qualitative because it focuses on in-depth data to explore the complexities of maternal and reproductive health challenges among Afghan refugee women (Creswell, & Poth, 2016).

3.2 Data Collection

The qualitative data, which are not in the form of numbers, captures personal experiences, opinions, emotions, and knowledge in the form of interviews (Bryman, 2012). The information provided is very useful and in-depth insights into the experience of persons and is essential in understanding complex issues (Patton, 2014).

In this research, semi-structured interviews conducted from Afghan refugee women combining both structured and open-ended components. Over completely structured and unstructured approaches, the study adopted semi-structure interviews because it provide consistency among participants and the freedom to delve deeply into sensitive issues.

Given the sensitivity of the topic, Female out-reach volunteers (OVs) have been hired for data collection as a data enumerators in both regions. These females was trained and local of their community and they have been engaged in several NGOs and institutions working for the refugee.

3.3 Sampling Method

A sampling plan is a structured approach to selecting participants for research (S. j. Tracy, 2012). Because the study focused on the maternal and reproductive healthcare of Afghan refugee women, purposive sampling was adopted for data collection. Additionally, the participants were chosen based on their marital status and number of children. The targeted population was Afghan refugee women in Ghosabad and Saranan and the data was collected till its saturation. In qualitative research, there is no fixed sample size for data collection; rather, it depends on the research deign and data saturation (Creswell, 2014). However, 20 interviews were collected from the participants of both areas and these Afghan refugee women were married and POR card older. By ethnicity most of them were Tajik in Ghosabad and Pashtuns in Saranan camp.

3.4 Data Analysis

Data analysis is the process of organizing, interpreting, and making meaning from the collected data (Merriam, 2009). However, this study has applied thematic analysis manually to analyze interview data, allowing for the identification of recurring themes. Thematic analysis includes the process organizing data, familiarization of data, coding, categorizing themes, and interpreting findings (Creswell, & Poth, 2016).

4. THEORETICAL FRAMEWORK

This study grounded in two explanations from two major theories of Structural Violence (Johan Galtung, 1969) and Intersectionality (Kimberlé Crenshaw, 1989). The combined effect of these theories offers a multidimensional approach to the study of the relationship between systemic inequalities, institutional failures, cultural limitations, and overlapping identities of gender, class, ethnicity, and refugee status that influence the lived experiences of the Afghan refugee women. The framework aids in understanding data by placing the problem of reproductive health of women into larger frames of social injustice, marginalization, and cultural restrictions instead of perceiving them as isolated or personal problems.

4.1 Johan Galtung Structural Violence Theory

The Structural Violence as conceived by Johan Galtung is a type of violence in social, political and economic systems that are constructed. Structural violence in contrast to direct violence is entrenched in institutions of society and leads to the lack of equal access to resources, opportunities and power. It is expressed through the denial of the basic needs of people; health, education, and dignity by unfair social structures (Galtung, 1969).

The concept of structural violence can be used in this context of the study to explain why the poor maternal and reproductive health of the Afghan refugee women are not the failure of individuals but as a result of an institutional neglect, economic deprivation, and systemic discrimination. In this perspective, maternal health problems are not the medical problems but effects of institutionalized violence which acts silently through poverty, displacement, bureaucratic marginalization and absence of political determination. This research is therefore able to view the suffering of the women as a systemic effect of inaccessibility rather than as personal health issues, as proposed by the theory.

4.2 Intersectionality Theory (Kimberle Williams Crenshaw)

Intersectionality Theory indicates the interaction of various types of identity-based oppression to create distinct feelings of marginalization. Initially, intersectionality as a concept was formulated by Kimberle Crenshaw as a part of Black feminist studies

to explore the intersection of power relations and social exclusion between gender, race, class, ethnicity, migration status, and culture (Crenshaw, 1991).

In this study, intersectionality provides an opportunity to conceptualize the gendered experiences of health inequality of the Afghan refugee women with regard to the fact that the experience is further amplified by their refugee status, ethnicity, poverty, and place (urban or rural). Thus, intersectionality offers the depth of analysis that is required to comprehend the complexity and multiphase of their suffering and highlights the fact that the issue of health outcomes is not dictated by one thing, but rather by many and mutually reinforcing systems of oppression.

5. FINDINGS AND ANALYSIS

The results of the study on Afghan refugee women`s access to maternal and reproductive healthcare in Balochistan`s rural area of Saranan, Pishin and urban area of Ghosabad, Quetta are presented in this chapter. The purpose of this chapter is to present a descriptive analysis of the participant`s experiences in accordance with the study`s objectives, which are to investigative systemic and sociocultural barriers to healthcare access, and establish the foundation for policy recommendations.

5.1 Financial and Structural Barriers to Healthcare

The distance from hospitals, and the high cost of medications were constantly noted as significant obstacles in both urban and rural areas. Women in poverty frequently has to put food or rent ahead of medical care, which led to unfinished prescriptions and recurrent medical emergencies. This was stated by the urban participant saying that: *"Our home is too far from hospital and clinics which costs 500 one way and 600 on the way back. It's very difficult for us to pay for this all."* Some refugee women further shared that their health problems were made worse by their unemployment which left them without financial support and forced them and their children to suffer. Another participant stated that *"We cannot afford anything and there is no source of income. We suffer a lot. I and my children are deprived from healthcare and medicines etc. because of financial crises".* Unemployment and less daily wages were also one of the factor that prevented them to have their healthcare for both pregnant women and the newly birth children.

While participants from rural areas described several challenges compounded by their geographical isolation. Refugees in rural areas said that whenever there was an emergency, they would always fear and be uncertain about where to go since hospitals were not easily accessible, urban participant emphasized by saying that *" We are poor and we can't afford any rental car… if we give money to transport, then from where do we buy medicines"* . Many women were forced to give birth at home in dangerous circumstances due to the stress of travelling vast distances and their inability to pay for transportation, which made them even more vulnerable. One of the rural respondent dramatically emphasized through quoting *"Sometimes the pregnant mothers die on the way to hospitals and sometimes it is too late to get to hospital and the baby dies".* This testimony was a manifestation of the larger predicaments of rural Afghan refugee women who believed that they were in a rut in a cycle of poverty, isolation, and poor access to healthcare services that put their lives and those of their babies at the perpetual risk of death.

Such problems are aggravated by the fact that food insecurity has become among the most pressing issues that Afghan refugee women report about now. Nevertheless, rural respondent said that, *"I lost my strength and was not fed with vitamins and nutrition during delivery. I failed to receive good food post-delivery to ensure my health and that of my baby".* Such paucity of proper food has a direct effect of their well-being. On the other hand, Children are not able to grow and develop properly because of the inability to receive appropriate nourishment. This problem was always advocated as a concern of serious distress in rural and urban refugee environment.

Other rural respondents said that they felt systemic neglect whereby they could not receive emergency care unless they showed their legal documentations or give bribes. This was raise by one of the Afghan refugee women when she said that, *"Sometimes, in emergency, you take pregnant women and when we go to hospital… doctors say we will not help until you bring your documentation then we are forced and they take our money (bribe)".* The issue of documentation exposed refugee women to more risks particularly, pregnant women, who were in dire need to have their babies attended to, a period that is referred to as the hardest and the most vulnerable period of their lives.

5.2 Cultural Norms

In both urban and rural settlements of Afghan refugee women, participants consistently reported that decisions about healthcare were made by husbands, in-laws, or male elders. Most women did not have the right to visit hospitals or clinics on their own. In urban areas, decisions were usually controlled by husbands and saying that, *"The decision taker to go to hospital for the treatment is my husband, he takes decision whether go to hospital or not"* while in rural areas women faced even greater restrictions, as

mothers- and fathers-in-law also dominated the decision-making process for their treatment. This treatment has been said by an afghan refugee women from rural that,

> *In our family, the authorities are my mother and father in law. My husband don't have the authority to do something or take me to hospital. Without the permission of my mother and father in law, I cannot go to hospital or medical center for treatment*

Many women said they could not even ask for medical care out of fear that their family members would ignore them, even in emergencies or during childbirth. In some rural families, husbands themselves lacked authority, as they feared their parents and could not take their wives to the hospital without permission.

The fact that the cultural prohibition against treatment by male doctors also appeared as a common and highly disturbing issue. In rural communities, this challenge was even more severe, as some women described situations where they returned home without receiving any treatment at all because no female doctors were available at the hospital or clinic this was mentioned by rural afghan refugee women saying that, *"Even if the male doctor is present, we wait for a female one, otherwise we return without treatment".* While urban Afghan refugee women face same cultural barrier from male doctors saying that, we are not allowed to go to a male doctor and we are also not comfortable with male, we mostly go to female doctors". Such experiences created highly dangerous and life-threatening situations for pregnant women who could not seek the necessary care.

5.3 Systematic Discrimination and Healthcare Gaps

Language barriers between patients and healthcare providers were identified both in rural and urban areas; Afghan refugee women repeatedly cited this as one of the biggest barriers to receiving healthcare. One of the participants of the rural region expressed worries about language barrier in the treatment process indicating that,

> *We face language barriers during or treatment and don't get good treatment because they cannot understand our issues and when we tell them they just listen us and give us medicines sometime we get medicines that are not for us nor for our health issues*.

Most women revealed that they were never sure that the doctors had really understood their health issues despite this being the most important factor in making them get the right treatment. Although they are urban participants as well, they have raised the same issues of having trouble in making understand doctor to treat them and urban respondent stated this as: *"I go to doctor and tell him/her about my health issues in Farsi. After telling him my health issues, I am not sure whether he understood my issues or not and this language produces a lot barriers while having treatment".* This usually led to their going home without any meaningful treatment in either the rural or the urban areas and that both the cash and effort they had sent into it had gone to waste.

At the same time, accessing female doctors posed additional barriers, as clinics with female staff were often located far from refugee communities or charged fees that were too expensive for families already struggling with poverty which was highlighted by rural participant stating that:

> *In our camps there are hospitals but in hospitals there are no nurses and people are very poor and they suffer a lot but they don't go to doctor because they don't have money to get their treatment and they suffer. There must be doctors for afghan women and hospitals must be functional*.

Because of these structural and systemic gaps, such as inability to obtain safe, affordable, and culturally appropriate medical treatment, Afghan refugee women faces several maternal and reproductive health challenges. Women claimed that Afghan refugee women were often treated disrespectfully by doctors, both male and female; harassment and maltreatment by rural doctors' war particularly troublesome. According to the rural participant:

> *With male doctors, we face lot of difficulties and we cannot share our maternal and reproductive health issues. They miss behave during delivery and sometimes they do harassment, frightened us, beat us, and force us which is all are unethical for Afghan refugee women. They don't listen us during treatment and don't give us a proper treatment*.

Many women revealed disturbing accounts of doctors touching them without permission or consent under the pretense of a medical checkup. Due to their inability to complain or take action against such behavior, many women felt powerless, like, a participant shared that: *"Doctors don't check me for treatment because he said you are refugee and government has announced that*

refugee should go back to their home country". Most the Afghan refugee women stressed that when certain doctors insulted them by telling them they didn't belong in Pakistan and should return their own country, they felt intimidated and unwelcome.

The participants of urban and rural areas also expressed a deep disappointment with the NGOs and government serving being able to meet their healthcare requirements. They explained how the representatives of NGOs and government agencies usually addressed their communities, asking questions and doing surveys on their issues but never offer any substantial help or follow-up. As rural interviewee, an Afghan refugee women state that:

> *I request to UNHCR and other NGOs that please listen to our voices. From 2-3 years, no one is listening to us they come and do their surveys in our community and ask us about our issues but then we get nothing. I need help, I urge UNHCR that they must take action and help us*

This trend made women feel exploited, that their suffering was being recorded but not lessened. A number of participants emphasized that the current state of affairs is worse than it has ever been, with poverty, health issues, and resources scarcity reaching alarming levels, necessitating immediate help. While from urban there were participants and wanted to receive adequate treatment and clinics by professional and trained doctors stating that, *"From NGOs and government, we need clinics and hospitals and good doctors that listen us carefully during treatment".* In the urban and rural areas, Afghan refugee women were always frustrated and abandoned saying that they no longer believed what NGOs and government institutions said they supported them yet did not put their fundamental problems into practice.

Overall, the results show that maternal and reproductive health of afghan refugee women in Balochistan is compromised by overlapping poverty, cultural and structural disregard. Women, be it in urban or rural areas, encounter a combination of challenges that inhibit their freedom, constraint their ability to access safe and prompt care, and subject them to extreme health conditions.

5.4 Policy Recommendations

The results prove that Afghan refugee women in Balochistan are exposed to a wide range of barriers, as structural, cultural, and systematic ones limiting their access to safe and reliable maternal and reproductive health. The section thus includes policy recommendation that can not only respond to the immediate need of the women refugee but are also focus on structural reforms in the long term to provide sustainable healthcare.

5.4.1 Administrative and Legal Reforms

Results show that some hospital employees make Afghan refugee women more vulnerable by refusing to treat them or by demanding bribes. Regardless of the condition of documents, policies must guarantee access to emergency maternity care.

5.4.2 Community Engagement Awareness

In order to overcome social norms that restrict women`s access to healthcare, community-level initiatives are crucial. In order to boost maternal health, awareness programs in Pashto and Farsi should focus on Afghan refugee women.

5.4.3 Accessibility to Language and Communication

Afghan refugee women are frequently unable to communicate with medical professionals due to language barriers, which results in untreated cases. To enhance communication, foster confidence, and guarantee inclusive, courteous healthcare.

5.4.4 Strengthening Healthcare Infrastructure for Afghan Refugee Women

This study emphasizes the critical necessity for easily accessible and well-equipped medical facilities specifically for refugees by setting up mobile clinics, emergency ambulances, and maternity and reproductive health unites inside or close to refugee camps.

5.4.5 Financial and Protection Mechanism

Families of refugees are forced to pick between rent, food, and medical treatment due to financial difficulties. Reproductive healthcare should be free or heavily subsidized through card or voucher systems that guarantee access to necessary medications and maternal care in order to lessen these trade-offs.

5.4.6 Enhancing the Humanitarian and Government Cooperation

Afghan refugee women are now lacking proper healthcare assistance from NGOs and government institutes. To bridge resource shortfall, different NGOs and institutions relationships must be strengthened.

5.4.7 Protection against discrimination

According to the study, Afghan refugee women are severally harassed and discriminated against in hospitals, which discourages them from obtaining medical attention. To guarantee a secure, courteous, and welcoming atmosphere, a zero-tolerance policy is crucial.

6. DISCUSSION

The findings of the study shows that, despite the fact that they cannot be seen separately, maternal and reproductive health problems are increasingly interconnected among Afghan refugee women living as refugees in both urban and rural settings of Balochistan. When viewed through the lenses of intersectionality and structural violence, these issues are seen as the increasing consequences of the interaction of social, economic, and institutional injustice rather than as personal failures or even cultural habits. The participants` responses highlighted the ways in which cultural restriction, poverty, gender hierarchy, displacement, and systemic neglect interact to produce health vulnerabilities.

The notion of financial crises prevailed, both in the urban and in the rural setting. Women have a tendency to defend it by saying that it is poverty that causes them to make tough decisions such as buying medicine, covering housing and transportation, or healthy nutrition. This burden can be explained by intersectionality: poor Afghan refugee women are not only disadvantaged due to their poverty, but they are also disadvantaged because they live in patriarchal households and are refugees in the host nation, where social and legal marginalization further restricts their access to resources.

Geography intensified these inequalities. The issues affecting the rural Saranan women were qualitatively different to the problems affecting Ghosabad urban. Even though it was mentioned that the two groups were financially constrained, the rural participants observed that the distance to hospitals, poor infrastructure, and high transportation costs contributed to the risks. These scenarios are what is called by intersectionality terms as a number of burdens combined simultaneously: women, refugees, poor, and geographically isolated.

The cultural limitations had a disadvantages as well. Women consistently claimed that husbands, in-laws, or older males could make healthcare decisions on their own, even in emergency situations. However, sometimes male/husbands facilitated clinics visit when complications arose. Additionally, due to the lack of female doctors at both regions, women stated that they were never comfortable with male doctors and would return home untreated.

According to the study, these results also show distinct patterns of structural violence. Afghan refugee women allegedly described how they were being discriminated or verbally assaulted in hospitals, had to pay bribes, or were denied care without proper documentation. This means that doctors in hospitals and their system result in saving no lives are more concerned with paperwork. Silent but brutal, these representations of institutional violence endanger the health and dignity of afghan refugee women.

Additionally, the responses show how prejudice is experienced differently in various contexts. Women in rural region lamented the doctors' blatant harassment, mistreatment, and improper fondling of them during childbirth. In the urban, women were reportedly said to have been insulted and asked to return to Afghanistan. These behaviors show how gender and identity in respect to refugees are linked to create demeaning experiences in the hospital setting. Structural violence in this case is being used both in the form of neglect and in the form of active discrimination and women re made to question their dignity and safety at the time when there is dire need.

When considered collectively, the results demonstrate that cultural and socioeconomic factors cannot be blamed for maternity and reproductive health problems among Afghan women refugees. These disparities cannot be changed because of structural violence, which implies that the evil is ingrained in the institutions and laws that are meant to shield them. Home base births that result in hazardous delivery, often miscarriages, malnourishment, and stillbirths are expected consequences of systematic and intersectional injustices rather than singular tragedies.

Finally, this study shows that rather than being solely personal, the health issues of Afghan refugee women encounter are caused by structural, cultural, and social factors. In order to meet their demands, robust governance, social protection, and humanitarian responsibility are just as important as advances in healthcare infrastructure. Therefore, measure that address the structural violence

influencing their lives and recognize the numerous, overlapping obstacles these women still face must be part of sustainable solutions, which go beyond medical interventions.

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