Title

Health and Health Care Access Among Afghan Refugee Women in the United States

Journal

JAMA Network Open, 9(8)

ISSN

2574-3805

Authors

Kandahari, Nazineen
Kayhani, Nilufar N
Zada, Fareha Moulana
et al.

Publication Date

2026-08-03

DOI

10.1001/jamanetworkopen.2026.27727

JAMA Network Open

Original Investigation | Equity, Diversity, and Inclusion

Health and Health Care Access Among Afghan Refugee Women in the United States

Nazineen Kandahari, MD, MS; Nilufar N. Kayhani, MS; Fareha Moulana Zada, BA; Zahra Kayhani; Zarin Noor, MD, MPH; Nicholas Nelson, MBBS; Susan L. Ivey, MD, MHSA

Abstract

IMPORTANCE Afghans are one of the world's largest refugee populations. Afghan women face compounded health risks due to sociocultural restrictions, low literacy, forced displacement, and limited health care access, yet little is known about their experiences with health care after resettlement in the US.

OBJECTIVE To explore health and health care access issues of Afghan refugee women in the US.

DESIGN, SETTING, AND PARTICIPANTS This qualitative study was part of an ongoing community-based participatory research project started in July 2020. Bilingual investigators conducted semistructured interviews with Afghan refugee women in Dari or English. Dari interviews were interpreted to English by a fluent bilingual investigator, validated by a separate bilingual investigator, and then reviewed with an Afghan immigrant community member for accuracy. Transcribed interviews were analyzed using grounded theory from July 2023 to July 2024. Participants who self-identified as Afghan, were born outside of the US, and were 18 years or older were recruited with convenience and purposive sampling from the San Francisco Bay Area of California through refugee-serving community organizations and word of mouth until data saturation was met.

MAIN OUTCOMES AND MEASURES Themes and subthemes about health and health care access.

RESULTS Of 23 Afghan women interviewed (median age, 30 years [range, 19-55 years]), most were married (22 [96%]) and had health insurance (16 [70%]). Their median time of residence in the US was 4 years (range, 1-17 years). Five key themes of health and health care access were identified: (1) health system barriers, such as inadequate interpretation causing miscommunication and mistrust, and insensitive health care including lack of informed consent; (2) sociocultural norms and women's autonomy, with patriarchal gender norms persisting after resettlement and limiting women's decision-making; (3) structural barriers resulting in the use of home remedies, driven by long wait times and negative prior experiences; (4) sociocultural barriers to sexual and reproductive health, with knowledge gaps shaped by intergenerational shame; and (5) mental health challenges, including widespread distress expressed through culturally specific idioms and somatic symptoms.

CONCLUSIONS AND RELEVANCE In this qualitative study, Afghan women described multilayered health care barriers, including displacement-related trauma, sociocultural norms, and structural deficiencies. Study findings suggest that culturally sensitive and linguistically appropriate public health interventions and structural changes are needed to improve health care access for Afghan women in the US.

JAMA Network Open. 2026;9(8):e2627727. doi:10.1001/jamanetworkopen.2026.27727

Key Points

Question What health and health care issues do Afghan refugee women experience in the US?

Findings In this qualitative study of 23 Afghan women residing in the US who shared their experiences accessing health care, key barriers included sociocultural constraints on women's autonomy, inadequate interpretation services, culturally insensitive health care, intergenerational stigma surrounding sexual and reproductive health knowledge and care, and mental health challenges. Structural barriers produced mistrust in and miscommunication with clinicians and led to use of home remedies.

Meaning These findings suggest a need for health care interventions that are sensitive to sociocultural contexts and immigration histories to address the needs of Afghan refugee women in the US.

+ Supplemental content

Author affiliations and article information are listed at the end of this article.

Introduction

Afghans are one of the world's largest forcibly displaced populations, with 11 million Afghans forced from their homes, the majority being women and children.[1-3] Despite growing numbers of Afghan refugees in the US, research on their health status, health determinants, and health care utilization remains scarce.[2,4-7]

Forcibly displaced immigrants face substantial health risks across the displacement continuum.[8] In Afghanistan, health care access is limited: only 10% of the population lives within a 1-hour walk of a health care facility.[9] Displacement itself is associated with war-related trauma, communicable disease, malnutrition, and unsanitary conditions.[2,10-13] After resettlement, new barriers emerge as refugees navigate unfamiliar social services, employment, legal status, and sociocultural adaptation.[8,14-17]

Afghan women face particularly compounded risks for poorer health. In Afghanistan, restrictive sociocultural norms prohibit women from leaving home without a male relative or from seeking care from male clinicians, while a shortage of female clinicians further limits access.[18-23] These constraints exist alongside low workforce participation (5%) and literacy (27%), contributing to higher morbidity among Afghan women compared with men.[18-20,24,25]

Afghan refugee women therefore likely arrive in the US with greater unmet health needs and less experience navigating formal health care systems, and resettlement may further compound these vulnerabilities.[8,14,15] Yet the health and health care experiences of Afghan refugee women in the US remain largely unexplored, with smaller studies focused on maternal health or older women.[4,26,27]

Methods

We conducted a qualitative study as part of a community-based participatory research project started in July 2020 to promote health and health care access among Afghan refugee women in the US.[28] The multidisciplinary research team included a female Afghan asylee medical student with graduate training in qualitative methods (N.K.), a female Afghan immigrant public health graduate student with qualitative research experience (N.N.K.), an Afghan immigrant premedical student trained in qualitative research (F.M.Z.), an Afghan asylee community member (Z.K.), Afghan (Z.N.) and non-Afghan (N.N.) clinicians at refugee health clinics, and a non-Afghan qualitative researcher with extensive experience with South Asian populations (S.L.I.). This study was approved by the University of California, Berkeley Committee for Protection of Human Subjects; all participants provided oral informed consent. Reporting followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) reporting guideline.[29]

Participants and Settings

We conducted semistructured interviews with Afghan refugee women in the San Francisco Bay Area of California. Eligible participants self-identified as Afghan women, were born outside of the US, and were 18 years of age or older. Participants were recruited through convenience and purposive sampling via community-based organizations (fliers, emails, and Instagram) and participant word of mouth until thematic saturation was reached. Eligibility was confirmed by investigators in a screening phone call.

Interview Guide

The interview guide (eAppendix in Supplement 1) was informed by a literature review and consultation with community members and key informants (clinicians and caseworkers who regularly served Afghan refugees).[30] Two pilot interviews assessed cultural appropriateness and alignment with study aims.

Data Collection

Interviews were conducted in English or Dari, lasted 30 to 60 minutes, and were audio recorded. Demographic information was collected verbally to accommodate varying literacy levels. Investigators had no prior relationship with participants and documented reflexive memos after each interview. English-language interviews were transcribed verbatim. Dari-language interviews were transcribed and interpreted by bilingual team members, validated by a separate bilingual investigator, and reviewed by a community member for accuracy. Participants received a $20 gift card.

Data Analysis

Sociodemographics were summarized using descriptive statistics. Qualitative data were analyzed from July 2023 to July 2024 using grounded theory. Two investigators (N.N.K. and F.M.Z.) independently performed line by line coding of a random sample of 3 transcripts, using inductive and deductive approaches, and developed an initial codebook through iterative discussion. They then coded a second random sample of 4 transcripts, wrote analytic memos, and refined the codebook through discussion. The same investigators then independently coded an additional random sample of 4 transcripts, reviewed coding, and finalized the codebook through discussion. Both analysts then independently coded all transcripts, including those initially used for codebook development, in MAXQDA, version 22.8.0 (VERBI Software). Discrepancies were resolved through discussion until 100% intercoder agreement was achieved. Themes and subthemes were identified through constant code comparison, examination of code co-occurrence, and team discussion.

Table 1. Sociodemographic Characteristics, Insurance Coverage, and Religiosity of Afghan Refugee Women Participants

Characteristic	Participants, No. (%)
Total No.	23
Age, mean (SD), y	33 (9.2)
Marital status	
Married	22 (96)
Single	1 (4)
Country of birth	
Afghanistan	21 (91)
Iran	2 (9)
Primary language	
Dari	21 (91)
Pashto	2 (9)
Years of living in the US, mean (SD)	5.7 (4.6)
Grade of school completed	
None	4 (17)
1-6	2 (9)
7-9	3 (13)
10-12	10 (43)
>12	4 (17)
Health insurance	
Yes	16 (70)
No	1 (4)
Unknown	6 (26)
Importance of religion[a]	
10	20 (87)
<10	3 (13)

[a] Scale ranged from 0 (not important) to 10 (very important).

Results

In total, 23 Afghan women participated (**Table 1**). Their median age was 30 years (range, 19-55 years), and most were married (22 [96%]), had health insurance (16 [70%]), and reported religion as being very important (20 [87%]). Educational attainment varied: 4 participants (17%) did not complete any school, 10 participants (43%) completed between 10th and 12th grades, and 4 participants (17%) completed beyond 12th grade. Participants were born in Afghanistan (21 [91%]) or Iran (2 [9%]). Their median time of residence in the US was 4 years (range, 1-17 years).

Five major health and health care themes emerged from our research (**Table 2**). These were (1) sociocultural norms and women's autonomy, (2) health system barriers, (3) structural barriers resulting in use of home remedies, (4) sociocultural barriers to sexual and reproductive health, and (5) mental health challenges.

Sociocultural Norms and Women's Autonomy

Participants described various relationships with the concept of autonomy. Navigating health and independence in the US was shaped by familial dynamics, past and present sociocultural gender norms, and immigration-related stressors. Although migration to the US expanded women's opportunities—for example, attending school and making independent appointments—many participants still faced restrictions from partners, family members, or internalized norms that limited their health care access. Autonomy, particularly in health decision-making, was often negotiated rather than assumed and influenced by power relations, unfamiliar systems, and family obligations.

One participant explained, "There are a lot of Afghan men who do not like when their wife goes to see a doctor…people who say things like, 'My wife shouldn't go out in public, my wife shouldn't go to a doctor…because then she'll learn everything.'" Another participant described how relying on her husband as an interpreter compromised informed consent, privacy, and autonomy. "My doctor didn't teach me [about the IUD]….My husband had gone with me, so I asked him, but Afghan men really don't explain things to you. I told him, 'I won't use you as an interpreter again, I'll get my own.' He responded, 'Then you won't tell me what the doctor said.' My husband just told me, 'There's this option and it's the better one,' and I said, 'yes,' and never got to see it."

Health System Barriers

Inadequate Medical Interpretation

Access to medical interpretation was inconsistent; visits were often conducted in English by default. When interpretation was provided, participants frequently described being assigned Iranian Farsi interpreters rather than Afghan Dari speakers, leading to misunderstanding, distress, and mistrust of clinicians. Dari is the official and most widely spoken language in Afghanistan, yet most institutions lacked Dari interpretation.[31]

One participant recounted how a miscommunication led her to believe her child had a serious condition. "The doctor was saying, 'The image doesn't show anything, there's just a place with a streak of blood.'…But the interpreter kept saying my son has a 'tumor.'…We were so worried….We made multiple appointments with our doctor and eventually realized [that] the interpreter made a mistake with the interpretation. Some interpreters don't really know the truth in their interpretation. The doctor says one thing; they interpret something else." Another participant preferred no interpreter at all because of past negative experiences, saying, "I don't understand Iranian Farsi. Whenever they'd call for an interpreter, they were mostly Iranian Farsi-speaking….Some of their attitudes—sometimes you'd get one who was rude. If you asked them to repeat what they said, they'd say, 'Lady! Our languages are not that different for you to ask this many questions of me!'"

Insensitive Health Care

Participants reported receiving care that was inadequately communicated, insufficiently explained, and inattentive to patient preferences. Many participants thought that their concerns were not taken

Table 2. Major Themes and Subthemes, With Additional Representative Quotes

Themes and subthemes	Exemplar quotes
Sociocultural norms and women's autonomy	
Persistence of past restrictions on present autonomy	"The problem is that Afghan women experience more *qyudat* (restrictions) in Afghanistan than other places, in terms of getting an education and those sorts of things. These restrictions continue here [in the US] too. *Becharaha* (Those poor women), a lot of them have difficulties with learning English. A lot of those who have newly come have issues with driving." (participant No. 16)
Transitional experiences of autonomy in the US	"In America…I go to school, I come back, and I get to take a fresh breath, I go alone, I really go with courage. In Afghanistan, we couldn't go—either our dad or a brother or someone accompanied us, because we couldn't leave the house alone. Here, alone, I can take my kids. This…it…it's made my self-esteem high. Now I'm not scared of anything. And I have found strength in myself—found belief that, God willing, whatever difficulties may come up in life, I can surpass it. At first, I was really scared." (participant No. 14)
Ongoing challenges to autonomy in the US	"One of the women I know, her husband is very *sakhtgeer* (strict). They are here in America; it's been years that they have been living here. She is not allowed to go outside, for example, to go someplace alone for shopping or work. She has high cholesterol; she is not allowed to go shopping or go for a walk in the park….For example, [her husband] says, 'If you went, who saw you? Did someone see you?' Or for example, 'You have become American now.' I know that in her own living room, for 2 hours or an hour and a half she walks and paces. Just in the living room. Imagine how hard that is. They don't even have a backyard." (participant No. 9) "My schedule—whenever I do something or go somewhere—I must coordinate it with my husband's work schedule. If he says no, then I will have to cancel that plan. For most Afghan women, this is their problem in America." (participant No. 22)
Aspirations for future generations	"More than a mother, I want to be like a friend to my daughters. I want to help them in whatever way I can. I want to help them to go to school in the future *bakhair* (in peace and safety) and get a quality education. I want them to have a good job so they can be independent. Most girls in Afghanistan, not all of them but the ones who don't have a good financial situation, always dream of getting married so their life gets better in terms of financial stability and all. I say that my daughters shouldn't be dependent on a man, and they should be independent. They should work on their own and help someone else." (participant No. 24)
Health system barriers	
Inadequate patient guidance and support	"When you go in a bad condition, coughing, sneezing, drainage coming from your eyes, and you ask them, 'Make an appointment for me.' They say, 'The doctor is busy, we will see you in 2 months.' When you say 'I am sick and have a fever. What should I do then?' They say, 'Go to the emergency/urgent care.' When you say, 'Then make an appointment for me for the emergency room and tell them, this is our patient and the doctor doesn't have time. Give this patient an appointment.' They say, 'No, go ahead and call on your own.' I am illiterate and I cannot call. My husband is illiterate. They don't say anything else at all. They give you a paper in the hospital and say, 'Go.'" (participant No. 2)
Poor attitudes from clinicians	"That doctor did not behave well. He would complain about my way of speaking English and everything else. The doctor would say 'Why don't you speak well? Why don't you understand what I say?' When he would speak, I would understand half of what he said. The doctor would say, 'Why don't you understand?' I mean everyone has a struggle with the language. The doctor behaved very badly. When my second son was born here…the nurse was a very good lady but the doctor that delivered my baby was very impatient. I didn't agree to let them inject epidurals in my lower back….I said, 'I want everything to go naturally, and I don't want an injection.' The contractions were very intense, and I was screaming, too. In my opinion, I was doing everything right, and when the doctor would tell me to push, I would push well. But the doctor was saying, 'You're not pushing well.' Towards the end the doctor got mad and left." (participant No. 23)
Short appointment times and long wait times	"The time [spent with your doctor] is short….My own doctor comes and checks in a hurry and then leaves. She doesn't take a lot of time with you to talk….She doesn't even really talk about things like 'What's your problem? How are you?'…When the nurse comes and you have a wait time, it's meaningless. We've gone and we just sit in a room. Then when the doctor comes and quickly checks and then leaves." (participant No. 21)
Delay to receive care	"Just getting an appointment is very difficult. Anytime you call them—and you can be in a very bad state—no matter what you say, describing or explaining how bad you feel, they will not consider it. You have to go to the appointment at the time that they have available for an appointment, whether that is 1 month away, 2 months, 1 week, or 3 weeks away." (participant No. 22)
Structural barriers resulting in use of home remedies	
Self-reliance and initial attempts to manage health concerns	"In my opinion, a patient does not go to the doctor unless their condition is serious and getting really bad. Because when you know something can be treated at home, you make the medicine. For example, when your stomach hurts a little and you eat anise seed and your stomach gets better….Or you put something warm on it. Or, for example, when you have cramps during your period you drink tea or something or keep yourself warm and you get better. When it's something that you cannot treat on your own, you go to the doctor. You can't get anywhere just by a doctor's words alone." (participant No. 2)
Sociocultural barriers to sexual and reproductive health	
Embarrassment and shame about menstruation	"When I got my period for the first time, nobody knew about it….Whenever I would leave my room, I would go to the bathroom….Every few minutes I was there. [I would go to] the place where the toilet papers were, take it and hide it under my dress or under my scarf and go to the bathroom. I would clean [myself] with that and cry. I would hide and cry in the bathroom, and then I would wipe my tears and come back. Finally, my sister got suspicious about me and said, 'What is going on? Why do you go to the bathroom so much?'…I couldn't hide anymore. I told her. I cried and told her that I have such a condition." (participant No. 8)
Modesty and shame	"To be honest, I felt embarrassed during the Pap smear. I have delivered babies twice, and still, I feel different in that situation. I didn't know what Pap smears are and what they do. I felt a little embarrassed. Poor doctor was a good doctor too. She was a woman, but I felt a little embarrassed." (participant No. 23)
Learning through experience	"I didn't know anything, I swear, until I went to school. My son was my first pregnancy, and when he was born, that's how I learned how people are born. When people don't know something, honestly, it's so hard. Those times in Afghanistan, there weren't even phones. At least now people see things from their phones and the internet. Those times, there wasn't anything and nobody knew anything." (participant No. 14) "Oh, the first time my menstrual period came…I spent all day worrying about what this thing is. If my mom or my family had told me about it before, I would've known everything. The first time, it was weird. I was crying like I got some disease or had some kind of weird problem. I didn't know about [menstrual periods]." (participant No. 7)
Abortion	"In Afghanistan, if you get pregnant and you absolutely do not want to be pregnant, you do not have the right to abort that fetus because they say that is a sin. And if you found a *qabaleh* (doula), it's very hidden/secretive and for a very high price. Even then they won't do it in a hospital or a clinic; it's usually done in someone's home. Here they told me, 'If you don't want this pregnancy,' and then gave me 2 papers. At the time I knew that my memory was not good, and I used to forget things. I had just immigrated here. Then they asked me, 'Well which one do you want to sign? If you sign this one to keep the pregnancy, we'll see you on a monthly basis. If you want an abortion, you can sign this one.' I thought about it and decided I didn't want the abortion." (participant No. 14)

(continued)

Table 2. Major Themes and Subthemes, With Additional Representative Quotes (continued)

Themes and subthemes	Exemplar quotes
Mental health challenges	
Postmigration mental health issues	"Well, here, you know, when something is out of your hands, something that you are unable to help with—like being unable to help your kids—that on its own is a stress, a depression itself that bothers you." (participant No. 4) "Here, you'll hear that a lot of Afghan people have depression. Most Afghan people have that. It comes from stress of being away from family. We don't know if it's from being away from our families or from something else." (participant No. 13)
Economic stress and financial pressures	"Because there is immigration, right? They come here from their country. Their husbands don't have a job. Studying is hard. These things are very hard. Driving is hard. They leave their parents and everyone behind in Afghanistan. Because of this, a lot of us [Afghans] have mental ailments." (participant No. 15)
Worries about safety of children	"Because of my kids, I worry. I worry that they have good schools to go to. There was one school, my elder son told me 'Mom, the environment there is not very good. People fight, they hit each other a lot, they smoke cigarettes, they smoke marijuana.' I would stress a lot because he's young and his classmates do this....I worried a lot about where to enroll him next so there wouldn't be any bad activities since he is young and immature....All around their schools don't have very good safety. I'm scared they are young and they will get injured or involved in bad activities....As they get older, the stress increases too. You wonder what he does, where he goes, if he fights, if he gets hurt or not. These thoughts ruin your mind." (participant No. 13)
Somatic symptoms of mental health issues	"When you newly immigrate, you are like that. When I first came, my stomach wouldn't digest food and *delem tang mishud* (I would feel tightness in my soul; I would feel sad/nostalgic). I would say 'delem tang misha.' I still have this *deltangi* (soul tightness). Every once in a while, delem tang misha, and my food doesn't get digested. When I eat food, I feel like it's stuck on my chest in a row, like this. I say, 'Give me medicine so my stomach gets better.' They say, 'You have depression.'" (participant No. 2) "Sometimes my heart would really start to hurt, it felt like someone was stabbing me with a knife right here, my chest hurt. And all 3 of my kids were little. And this was it, and the doctor said, 'You have undergone a lot of pressure, which is why you have this current condition. As your kids grow up, you will get better.' The doctor told me that this was the truth." (participant No. 14)
Difficulty accessing mental health care	"For people that come from Afghanistan and start a life here, not knowing English, going to the doctor, from inside the home to out in the world, wherever they go, they have challenges. They live here and stress because these problems just come up. If at home there is a problem, they cannot find someone to solve their problems. For example, find counseling, find someone to talk to. I personally experience this. You stress about the problem that you have, but you cannot communicate your problem to society. You cannot explain what you want or need." (participant No. 5)
Coping mechanisms and resilience	"I personally have a big depression right now, and I try for my children to not drown myself in depression. I don't know the way to save/rescue ourselves from this, but because of my 2 children, I will find a solution for it. I don't know whether I can succeed or not. But I try because in human life when it comes to children, all of one's attention must be towards their children [crying]." (participant No. 20) "At home, I am busy. Most of my time is at home. I might become *jigarkhoon* (my heart bleeds; I feel worried). I might become stressed, or I hear some things. In Afghanistan, all of my family, my mother, my brothers are all in Afghanistan. There are suicide bombers. When you see these things, you stress, cry, and worry. Then I'll cry or sit at home, work on my cooking. If I am free, I will get up and go out until 3 pm when I have to pick up the kids. I go for a walk, for a round, and then come back." (participant No. 25)

seriously, particularly regarding reproductive care, and were left with little understanding of diagnoses or treatments. In several cases, participants described having to advocate persistently for themselves; requests, such as for contraception, were at times ignored altogether. Others reported feeling disrespected and dismissed, especially when language barriers or sociocultural differences went unaddressed.

One participant described, "When I came to America, I told the doctor that I didn't want any more kids so I can learn parenthood a little bit and get used to it. The doctor didn't pay attention to me at all. I told them twice...to give me medication so that I do not get pregnant again. It didn't happen, and eventually 2 or 3 months later, I got pregnant with my daughter." She recounted later receiving contraception without adequate consent, stating, "After I had my daughter, I had an IUD installed. I never saw it, and I used to worry, 'What was that thing? What will it do?'...My doctor didn't teach me."

Another participant described the toll of examination by a male physician during labor despite expressing preferences for a female clinician. "I was doing everything all right. When the doctor would tell me to push, I would push well, but the doctor was saying, 'You're not pushing well.'...The doctor got mad and left....They called a male doctor....I felt ashamed because it was hard for a Muslim Afghan woman to be seen by a male doctor during that [sensitive] situation. It [adversely] affected me a lot."

Structural Barriers Resulting in Use of Home Remedies

Participants often attempted to manage health concerns at home before seeking formal medical care. Home remedies, peer advice, and over-the-counter medications were common first steps, driven not by avoidance of health care, but by structural barriers, including long wait times, language and transportation barriers, referral requirements, and prior negative clinical experiences.

One participant explained, "[I go to the doctor] when I have no other option, when I must go, when there's nothing I can do. Like when I had abdominal pain, despite however much home treatments or whatever else I did, it did not improve, so then I had to go to the doctor."

Another participant described how system inefficiencies drove self-management. "Most of the time, when I feel really sick, I try my best to resolve it on my own at home. Because when you need the doctor, the doctor is not going to be available to see you. They will give you an appointment for 1 month later or 1 week later."

Another participant described feeling her symptoms were persistently misunderstood and unaddressed. "I have been to the doctor a lot. Nobody there seems to understand it correctly. Some days I'll have this ailment on one whole side of my body.…I have so much pain, I can't sit down.…I saw a lot of doctors, and I took a lot of medications. Nothing helped at all."

Sociocultural Barriers to Sexual and Reproductive Health

Participants described substantial gaps in sexual and reproductive health knowledge shaped by shame, sociocultural taboos, and lack of evidence-based information. Most participants had never been taught about menstruation, intercourse, pregnancy, or contraception. These gaps affected health knowledge and agency across the life course and shaped aspirations for future generations of women. Many recognized an intergenerational cycle of misinformation and expressed a desire to end it through education for their children.

One participant described how cultural shame and practices valuing virginity prevented her from seeking information before her wedding, leaving her unprepared for intimacy. "During my marriage, I didn't know that there is something called 'hymen.'…My sister-in-law said, 'I have left a cloth on the sheet that's on your bed.' I wasn't sure if she had left it for cleaning my tables or windows. I didn't know about it. My sister would come near me in the days leading to my wedding and say, 'There is something that I want to teach you.' I would say, 'No, I don't want to know something like that.' I would feel embarrassed and ashamed.…I was dumb.…When I got married and I saw my husband wasn't wearing his clothes, it was the first time that I had seen a man like that. I got so scared I couldn't talk anymore."

Another participant shared her experience with menarche. "For almost a year, I was scared to tell anyone this thing was happening to me. Every time that it was happening, I was crying excessively, asking 'God, why is this happening to me? Who should I tell? How do I tell them? What if they hurt me? What if they kill me?'…I was crying internally—screaming, even—but by tongue, by eyes, by face, I couldn't tell anyone anything about my state. I couldn't even walk because between my legs had been worn away. The things I'd used [as menstrual pads] were too big, because I was afraid that from the time I left home to when I returned, I needed to put something big so my clothes wouldn't get soiled. And after washing the cloth clean, I'd reuse it wet.…I think my chronic back pains came about because of this.…Similarly, no one told me about the night of the wedding. I was completely shocked. I was scared. I cried a lot, too. I wouldn't let my husband even get near me. He would laugh, saying, 'Well this is just how it is,' and I was completely terrified."

A younger participant, aged 23, noted, "Afghan women even to this day, some of them don't even talk about the menstruation cycle or about similar stuff at home, like mothers to daughters. We don't really sit together to share our wisdom on what to do and not to do."

Mental Health Challenges

Mental health concerns were widely reported. There are no direct Dari translations for depression or anxiety; women instead spoke of *deltangi* (tightness or longing in the soul), *tanhayee* (loneliness), and *beh kasee* (not having community or people). Distress was often related to isolation, unemployment, financial hardship, and family separation, and compounded by stigma and unfamiliarity with mental health services. Participants described mental distress manifesting somatically.

One participant summarized, "In Afghanistan, if someone feels lonely, they visit their friend, mother, or father…and her depression or sadness gets better.…Here, there is no family, or if there is, everyone is very busy. You don't really get to see your friends or family.…The stress of living in America is much greater than in Afghanistan—in terms of payments, in terms of money, in every aspect."

Another participant reported somatic manifestations. "When I first came, my stomach wouldn't digest food, and I would feel tightness in my soul.…Every once in a while, I feel tightness in my soul and my food doesn't get digested."

Another participant shared how fear of stigma and formal documentation deterred care-seeking, stating, "Some woman said, 'If you go to the doctor, they'll make an official file/record of you saying her mind doesn't work well,' which really scared me, so I didn't go."

Discussion

In this qualitative study of Afghan refugee women in the US, we identified critical health and health care needs shaped by intersecting institutional, interpersonal, and internalized forces. We draw on Camara Jones's framework of racism to contextualize these findings.[32]

Growing on prior research, linguistic and interpersonal communication emerged as primary barriers to care.[26,27] Federal law mandates the use of professional interpreters for patients with limited English proficiency, yet implementation was inconsistent.[33] The routine assignment of Iranian Farsi-speaking interpreters to Dari-speaking Afghan patients produced clinical misinformation, mistrust in health care professionals, and experiences of disrespect, reinforcing broader patterns of discrimination faced by Afghan immigrants in Iran.[34] This institutional indifference to meaningful communication exemplifies what Jones termed institutional racism: differential access to information, resources, and voice.[32] Inadequate clinician communication about treatment risks, benefits, and alternatives compounded these barriers, aligning with evidence that miscommunication among refugees drives mistrust, medical errors, and poor adherence.[26,27,35,36]

Sociocultural norms in Afghanistan restrict women's autonomy across education, health care, employment, and mobility. Immigration to the US presents a stark shift in sociolegal standing, requiring women to reevaluate beliefs about their own rights. This study found that opportunities to attend school, drive, work, think, and speak independently were not readily embraced; prior norms persisted, with many women navigating husbands' preferences over daily activities and decisions. Jones defines internalized racism as "acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth," including "accepting limitations to one's own full humanity, including one's spectrum of dreams, one's right to self-determination, and one's range of allowable self-expression.[32]" The constraints our participants described are rooted in patriarchal

Table 3. Tenets of Cultural Humility[a]

Tenet	Description
Lifelong learning and self-reflection	Cultural understanding is never complete and requires a lifelong commitment to self-evaluation, self-critique, and self-awareness. Physicians must continually reassess their own cultural identities, biases, and patterns of unintentional racism, classism, homophobia, and discrimination rather than relying on a false sense of mastery from prior training.
Recognizing and redressing power imbalances	Physicians hold an inherent position of power over patients, particularly those who are poor, racial or ethnic minority individuals, or otherwise marginalized. Cultural humility requires repeatedly identifying and remedying the inappropriate exploitation of this power imbalance in treatment priorities and health promotion, especially in the context of race, ethnicity, class, language, and sexual orientation.
Other-oriented interpersonal stance	Physicians should adopt a less controlling, less authoritative communication style that values the patient's agenda and perspectives. The patient is recognized as the expert on their own identity and illness experience, enabling them to communicate how culture intersects with the clinical encounter. This eliminates the need for complete mastery of every group's health beliefs and instead focuses on respect, curiosity, and lack of superiority toward a patient's cultural background.
Community-based care	Physicians should engage in mutually beneficial, nonpaternalistic, and respectful partnerships with communities. This involves recognizing that expertise regarding health can reside outside academic medical centers, building on the assets and adaptive strengths of communities, and participating in community-informed health priorities, research, and advocacy activities.
Institutional accountability	Institutions must mirror the same processes of self-reflection and self-critique expected of individuals. Physicians are responsible for advocating for systemic changes that address health inequities. This includes evaluating faculty diversity, requiring multicultural training for faculty, and maintaining dynamic feedback loops with employees and the surrounding community.

[a] As defined and originally articulated by Melanie Tervalon and Jann Murray-García.[39]

norms rather than racial stigma, but the mechanism is analogous: systematic exclusion led some women to internalize the belief that such limitations were natural. Like the pink flowers in Jones's tale that reject their own pollen in favor of the red, some participants had absorbed messages that their voices were less worthy, making the exercise of newfound autonomy feel transgressive. These findings underscore the need for sensitivity to Afghan refugee women navigating sociocultural and internalized restrictions alongside new opportunities for self-determination. Prior research of refugees has demonstrated how patriarchal power dynamics and coercive control over reproductive autonomy persist after displacement.[37,38] We extend this work by showing how past values and limited health knowledge influence many aspects of present health and health care. Future research should explore how community-based programs and health care systems can address acculturative stress about autonomy and promote health education among refugee women.

While we highlight findings from our sample to inform changes in practice and policy, we recommend approaching the care of Afghan women with cultural humility—the recognition that one will never be "competent" in understanding the culture of any persons, and the lifelong commitment to learning and addressing power imbalances (**Table 3**).[39] The mental health challenges of women in our study highlight the need for cultural understanding of how their specific language translates into their needs, and for ensuring that health care systems are appropriately responsive to those needs. We also emphasize intersectionality: people's lives are shaped by multiple, overlapping identities, and systems of inequality are interconnected, not isolated.[40] Our findings highlight barriers spanning structural, sociocultural, political, legal, and intergenerational domains, underscoring the need for multilevel interventions.

Limitations

This study has limitations. We did not capture the perspectives of Afghan women who primarily spoke neither Dari nor English. All participants resided near the San Francisco Bay Area in California; experiences may differ in regions with smaller immigrant communities or fewer refugee services. Future research should explore how health care experiences and autonomy of Afghan people vary across socioeconomic contexts.

Conclusions

In this qualitative study of Afghan refugee women, health care barriers included displacement-related trauma, sociocultural gender norms, limited health literacy, and structural barriers. Addressing these needs requires linguistically concordant, culturally responsive care that accounts for histories of forced displacement and diverse beliefs. Our findings suggest that investment in interpreter services, community-based health education, and culturally sensitive health care is essential to advancing health equity.

ARTICLE INFORMATION

Accepted for Publication: June 15, 2026.

Published: August 7, 2026. doi:10.1001/jamanetworkopen.2026.27727

Corresponding Author: Nazineen Kandahari, MD, MS, Department of Otolaryngology-Head & Neck Surgery, University of North Carolina-Chapel Hill, 170 Manning Dr, Campus Box 7070, Chapel Hill, NC 27599 (nazineenkandahari@gmail.com).

Author Affiliations: Department of Otolaryngology-Head & Neck Surgery, University of North Carolina at Chapel Hill (Kandahari); Afghan Clinic, San Francisco, California (Kandahari, N. N. Kayhani, Moulana Zada, Z. Kayhani); Harvard T.H. Chan School of Public Health, Boston, Massachusetts (N. N. Kayhani); Department of Surgery,

University of California, San Francisco (Moulana Zada); Department of Pediatrics, University of California, San Francisco (Noor); UCSF Benioff Children's Hospital, Oakland, California (Noor); Highland Hospital, Alameda Health System, Oakland, California (Nelson); School of Public Health, University of California, Berkeley (Ivey).

Author Contributions: Dr Kandahari and Ms N. Kayhani had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis. Dr Kandahari and Ms N. Kayhani contributed equally to this work and are considered co-first authors.

Concept and design: Kandahari, N. Kayhani, Z. Kayhani, Noor, Nelson.

Acquisition, analysis, or interpretation of data: Kandahari, N. Kayhani, Moulana Zada, Z. Kayhani, Ivey.

Drafting of the manuscript: Kandahari, N. Kayhani, Moulana Zada.

Critical review of the manuscript for important intellectual content: All authors.

Statistical analysis: Kandahari, N. Kayhani, Moulana Zada.

Obtained funding: Kandahari.

Administrative, technical, or material support: Kandahari, N. Kayhani, Moulana Zada, Z. Kayhani, Ivey.

Supervision: Kandahari, Noor, Ivey.

Conflict of Interest Disclosures: None reported.

Funding/Support: This work was supported by an Albert Schweitzer Fellowship and a Human Rights Center Fellowship of the University of California, Berkeley School of Law, both to Dr Kandahari.

Role of the Funder/Sponsor: The funders had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

Data Sharing Statement: See Supplement 2.

Additional Contributions: We are grateful for the Afghan refugee women and community-based organizations who participated in and contributed to the project.

REFERENCES

1. Afghanistan humanitarian crisis. USA for UNHCR: The UN Refugee Agency. Accessed May 14, 2026. https://www.unrefugees.org/emergencies/afghanistan/

2. Kumar GS, Pezzi C, Wien S, et al. Health of special immigrant visa holders from Iraq and Afghanistan after arrival into the United States using domestic medical examination data, 2014-2016: a cross-sectional analysis. *PLoS Med*. 2020;17(3):e1003083.

3. Refugee data finder. UNHCR: The UN Refugee Agency. Accessed December 22, 2024. https://www.unhcr.org/refugee-statistics/data-summaries

4. Siddiq H, Alemi Q, Lee E. A qualitative inquiry of older Afghan refugee women's individual and sociocultural factors of health and health care experiences in the United States. *J Transcult Nurs*. 2023;34(2):143-150.

5. Alemi Q, Stempel C. Discrimination and distress among Afghan refugees in northern California: the moderating role of pre- and post-migration factors. *PLoS One*. 2018;13(5):e0196822.

6. Alemi Q, James S, Montgomery S. Contextualizing Afghan refugee views of depression through narratives of trauma, resettlement stress, and coping. *Transcult Psychiatry*. 2016;53(5):630-653.

7. Lipson JG, Omidian PA, Paul SM. Afghan Health Education Project: a community survey. *Public Health Nurs*. 1995;12(3):143-150.

8. Matlin SA, Depoux A, Schütte S, et al. Migrants' and refugees' health: towards an agenda of solutions |. *Public Health Rev (Minneap)*. 2018;39(27). doi:10.1186/s40985-018-0104-9

9. From trauma to recovery: addressing emergency care in Afghanistan. World Health Organization. Accessed December 22, 2024. https://www.who.int/news-room/feature-stories/detail/from-trauma-to-recovery-addressing-emergency-care-in-afghanistan

10. Cookson ST, Abaza H, Clarke KR, et al. "Impact of and response to increased tuberculosis prevalence among Syrian refugees compared with Jordanian tuberculosis prevalence: case study of a tuberculosis public health strategy". *Confl Health*. 2015;9(1):18.

11. Stone-Brown K. Syria: a healthcare system on the brink of collapse. *BMJ*. 2013;347:f7375. doi:10.1136/bmj.f7375

12. Nasir K, Hyder AA, Shahbaz CM. Injuries among Afghan refugees: review of evidence. *Prehosp Disaster Med*. 2004;19(2):169-173. doi:10.1017/S1049023X00001692

13. Kirsch J, Maleku A, Kim YK, Aziz T, Dada S. Understanding the role of collective trauma on Afghan refugee mental health: a transformative mixed methods study. *J Immigr Minor Health*. 2026;28(1):49-60. doi:10.1007/s10903-025-01769-9

14. Castañeda H, Holmes SM, Madrigal DS, Young MED, Beyeler N, Quesada J. Immigration as a social determinant of health. *Annu Rev Public Health*. 2015;36:375-392. doi:10.1146/annurev-publhealth-032013-182419

15. Braveman P, Gottlieb L. The social determinants of health: it's time to consider the causes of the causes. *Public Health Rep*. 2014;129(Suppl 2):19-31. doi:10.1177/00333549141291S206

16. Sifat M, Chiang S, Montour T, Tate C, Kendzor D. Social determinant correlates of self-rated health among newly resettled Afghan refugees in Oklahoma City. *J Immigr Minor Health*. 2026. doi:10.1007/s10903-026-01886-z

17. Ho CH, Denton AH, Blackstone SR, et al. Access to healthcare among US adult refugees: a systematic qualitative review. *J Immigr Minor Health*. 2023;25(6):1426-1462. doi:10.1007/s10903-023-01477-2

18. Labor force participation rate, female (% of female population ages 15+) (modeled ILO estimate) – Afghanistan. World Bank Group. Accessed April 5, 2022. https://data.worldbank.org/indicator/SL.TLF.CACT.FE.ZS?locations=AF

19. Frost A, Wilkinson M, Boyle P, Patel P, Sullivan R. An assessment of the barriers to accessing the basic package of health services (BPHS) in Afghanistan: was the BPHS a success? *Global Health*. 2016;12(1):71. doi:10.1186/s12992-016-0212-6

20. Ezadi Z, Mohammadi N, Sarwari R, Jafari SM. Afghan women and access to health care in the past 25 years. *EClinicalMedicine*. 2021;43:101235. doi:10.1016/j.eclinm.2021.101235

21. Afghanistan. Sexual Rights Database. Accessed March 16, 2023. https://sexualrightsdatabase.org/countries/399/Afghanistan

22. Chandra-Mouli V, Braet K. Progress review: contraception use among adolescent girls. *The Guardian*. February 17, 2014. Accessed March 16, 2023. https://www.theguardian.com/global-development-professionals-network/2014/feb/17/access-to-contraception-birth-control

23. Afghanistan: Taliban 'Vice' handbook abusive: discriminatory rule, ignored protections. Human Rights Watch. Accessed December 22, 2024. https://www.hrw.org/news/2021/10/29/afghanistan-taliban-vice-handbook-abusive

24. Literacy rate, adult female (% of females ages 15 and above) - Afghanistan. World Bank Group. Accessed March 16, 2023. https://data.worldbank.org/indicator/SE.ADT.LITR.FE.ZS?locations=AF

25. Malik MS, Afzal M, Farid A, Khan FU, Mirza B, Waheed MT. Disease status of Afghan Refugees and migrants in Pakistan. *Front Public Health*. 2019;7:185. doi:10.3389/fpubh.2019.00185

26. Worabo HJ, Safi F, Gill SL, Farokhi M. "It's different here" Afghan refugee maternal health experiences in the United States. *BMC Pregnancy Childbirth*. 2024;24(1):479. doi:10.1186/s12884-024-06678-7

27. Reihani AR, Zimmerman HG, Fernando N, Saunders DR, Edberg M, Carter E. Barriers and facilitators to improving access to healthcare for recently resettled Afghan refugees: a transformative qualitative study. *J Health Soc Sci*. 2021;6(1):59-72. doi:10.19204/2021/bbr5

28. Minkler M. Community-based research partnerships: challenges and opportunities. *J Urban Health*. 2005;82(2)(suppl 2):ii3-ii12.

29. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Qual Health Care*. 2007;19(6):349-357. doi:10.1093/intqhc/mzm042

30. Tremblay MA. The key informant technique: a nonethnographic application. *Am Anthropol*. 1957;59(4):688-701. doi:10.1525/aa.1957.59.4.02a00100

31. Translators without Borders. Language data for Afghanistan. Accessed November 7, 2025. https://translatorswithoutborders.org/language-data-for-afghanistan/

32. Jones CP. Levels of racism: a theoretic framework and a gardener's tale. *Am J Public Health*. 2000;90(8):1212-1215. doi:10.2105/AJPH.90.8.1212

33. Title VI Of The Civil Rights Act Of 1964 42 U.S.C. § 2000d Et Seq. Civil Rights Division US Department of Justice. Accessed November 23, 2025. https://www.justice.gov/crt/fcs/TitleVI-Overview

34. Zandi-Navgran L, Askari-Nodoushan A, Afrasiabi H. Emotional experience of Afghan migrants in Iran. *Int J Intercult Relat*. 2023;96:101859. doi:10.1016/j.ijintrel.2023.101859

35. Patak L, Wilson-Stronks A, Costello J, et al. Improving patient-provider communication: a call to action. *J Nurs Adm*. 2009;39(9):372-376. doi:10.1097/NNA.0b013e3181b414ca

36. Patel P, Bernays S, Dolan H, Muscat DM, Trevena L. Communication experiences in primary healthcare with refugees and asylum seekers: a literature review and narrative synthesis. *Int J Environ Res Public Health*. 2021;18(4):1469. doi:10.3390/ijerph18041469

37. Donnelly A, Haintz GL, McKenzie H, Graham M. Influences on reproductive decision-making among forcibly displaced women resettling in high-income countries: a scoping review and thematic analysis. *Int J Equity Health*. 2023;22(1):179. doi:10.1186/s12939-023-01993-5

38. Suha M, Murray L, Warr D, et al. Reproductive coercion as a form of family violence against immigrant and refugee women in Australia. *PLoS One*. 2022;17(11):e0275809. doi:10.1371/journal.pone.0275809

39. Tervalon M, Murray-García J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *J Health Care Poor Underserved*. 1998;9(2):117-125. doi:10.1353/hpu.2010.0233

40. Crenshaw K. Demarginalizing the intersection of race and sex: a black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *Univ Chic Leg Forum*. 1989;1989(8). https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

SUPPLEMENT 1.
eAppendix. Interview Guide

SUPPLEMENT 2.
Data Sharing Statement