Review Article

Structural Social Determinants of Health Affecting Afghan Migrant Women's Access to Reproductive Health Services: A Scoping Review

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Abstract

Background: Health is vital for migrants and host countries, supporting human rights and sustainable development. With rising migration of Afghan women, tackling barriers to reproductive health services is critical. This scoping review synthesizes evidence on structural social determinants of health (SSDH) that affect Afghan migrant women's access to reproductive health services.

Methods: Using PRISMA guidelines and Arksey and O'Malley's framework with the PCC model (Population: Afghan migrant women of reproductive age; Concept: structural social determinants of health-influenced reproductive health access; Context: host countries), we searched Web of Science, Scopus, PubMed, and Google Scholar for studies from January 2000 to March 2025. Reference lists were screened. Eligible studies were empirical, quantitative, or mixed-methods, in English only.

Results: From 1,170 records, 18 studies were included. SSDH which influences access fell into six domains: Macroeconomic Policies, Social Policy, Social Class, Public Policy, Governance, and Culture & Social Norms. Key barriers included economic hardship, lack of insurance, undocumented status, low health literacy, and cultural-linguistic challenges, limiting service access. The identified sexual and reproductive health outcomes were identified in various domains, including maternal and perinatal outcomes, reproductive health service utilization, and other reproductive health outcomes, including mental health and awareness.

Conclusion: This review demonstrates that Afghan migrant women's reproductive health access is shaped by intersecting structural determinants that collectively generate compounded health inequities. Improving this requires upstream structural reforms encompassing legal protection, health system integration, and cultural sensitivity, rather than service-oriented approaches alone. Policies that ignore these SSDH will remain ineffective.

Keywords: Emigrants and immigrants; Health equity; Reproductive health services; Afghanistan; Social Determinants of health

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Introduction

Reproductive health, integral to human rights and the Sustainable Development Goals, is a global health priority encompassing physical, psychological, social, and cultural dimensions shaped by social, political, economic, and biological factors.[1, 2] For migrant populations, accessing reproductive health services is hindered by systemic barriers rooted in structural social determinants of health (SSDH), such as legal status, economic insecurity, and cultural norms.[3, 4] These barriers contribute to adverse outcomes like maternal mortality, preterm births, and inadequate prenatal care, underscoring the urgent need for targeted public health interventions to promote health equity for this vulnerable group.[4, 5]

Globally, over 281 million international migrants reside in low- and middle-income countries, with women comprising 48.4% of this population and outnumbering men in most regions except Africa and Asia.[6] Afghan migrant women, driven by ongoing conflicts, the rise of the Islamic State, and severe gender-based restrictions in Afghanistan, have increasingly sought refuge in neighboring countries, often under precarious legal and socioeconomic conditions.[7] These women face significant barriers, including limited access to healthcare facilities, fear of stigmatization by providers and host communities, and financial constraints, which collectively impede equitable access to reproductive health services.[8-12] Undocumented status and low literacy rates (~77% illiteracy among Afghan women) further exacerbate these challenges.[4, 13]

The World Health Organization (WHO)'s Commission on Social Determinants of Health framework provides a robust lens for understanding these disparities, categorizing determinants into structural factors (e.g., education, income, gender, governance, cultural norms) and intermediary factors (e.g., housing, health behaviors, healthcare access) that mediate their impact on health outcomes.[14] Structural determinants, such as restrictive migration policies and economic hardship, create systemic inequities, while intermediary determinants, including poor living conditions and limited health literacy, directly affect care-seeking behaviors.[14] For Afghan migrant women, studies highlight how cultural constraints, gender-based violence, and lack of insurance amplify barriers to care.[4, 5] Structural and social barriers significantly limit their access to reproductive health services. Cultural norms and economic insecurity restrict reproductive health behaviors, while gender-based violence is associated with unintended pregnancies.[4, 5] Limited legal rights, discrimination, and inadequate housing further exacerbate these challenges.[13, 15]

Existing studies on this topic often remain fragmented, focusing primarily on individual barriers such as cultural norms, economic insecurity, gender-based violence, limited legal rights, and discrimination,[3, 4, 13, 15] without adequately integrating the broader role of the SSDH. Due to the diversity of methodologies and contexts of existing studies, a scoping review was selected as an appropriate approach for synthesizing complex evidence. Unlike systematic reviews, which require uniform data, or narrative reviews, which lack structured analysis, a scoping review enables the integration of heterogeneous findings, identification of research gaps, and development of a cohesive framework to guide health interventions and policy-making.[16-20] This scoping review explores the structural social determinants of Afghan migrant women's access to reproductive health services worldwide.

Materials and Methods

To conduct this scoping review, we utilized a structured framework initially proposed by Arksey and O'Malley, which was further refined by the Joanna Briggs Institute (JBI) for scoping reviews.[16] To ensure systematic and transparent reporting, we followed the Preferred Reporting Items for Systematic Reviews and

Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) guidelines.[17] SSDH, defined per the WHO framework, encompasses macroeconomic policies, social policies, social class, public policies, governance, and cultural norms, which create barriers (e.g., lack of insurance, undocumented status) leading to adverse reproductive health outcomes (e.g., maternal mortality, preterm birth).[14]

The review was structured in multiple phases, each methodically aligned with the research objectives. The first stage focused on defining the research question. We sought to understand how SSDH influences Afghan migrant women's access to reproductive health services. To shape this question, we used the JBI's PCC framework, which stands for Population, Concept, and Context. The population was defined as Afghan migrant women of reproductive age, specifically those between 15 and 49 years. The concept centered on access to reproductive health services, particularly as affected by SSDH, such as policies, legal frameworks, and societal norms. The review focused on host countries, encompassing studies conducted in or relevant to various global contexts.

In the second stage, we aimed to identify relevant studies. A comprehensive search was carried out across international databases, including PubMed, Scopus, and Web of Science. To broaden the scope, we also used Google Scholar and performed backward citation tracking to uncover additional sources. Google Scholar, due to its non-specialized nature, also indexes non-empirical sources and gray literature.

The search strategy combined key concepts like Afghan women, migration, reproductive health services, and social determinants of health. We used terms derived from MeSH and Embase subject headings (EMTREE), such as "Emigrants and Immigrants"; "Health Equity"; "Reproductive Health Services"; "Health Policy"; "Afghan"; and "Social Determinants of Health". Boolean operators, like AND, OR, along with truncations, were customized for each database to ensure precision. The search encompassed the studies published in English between January

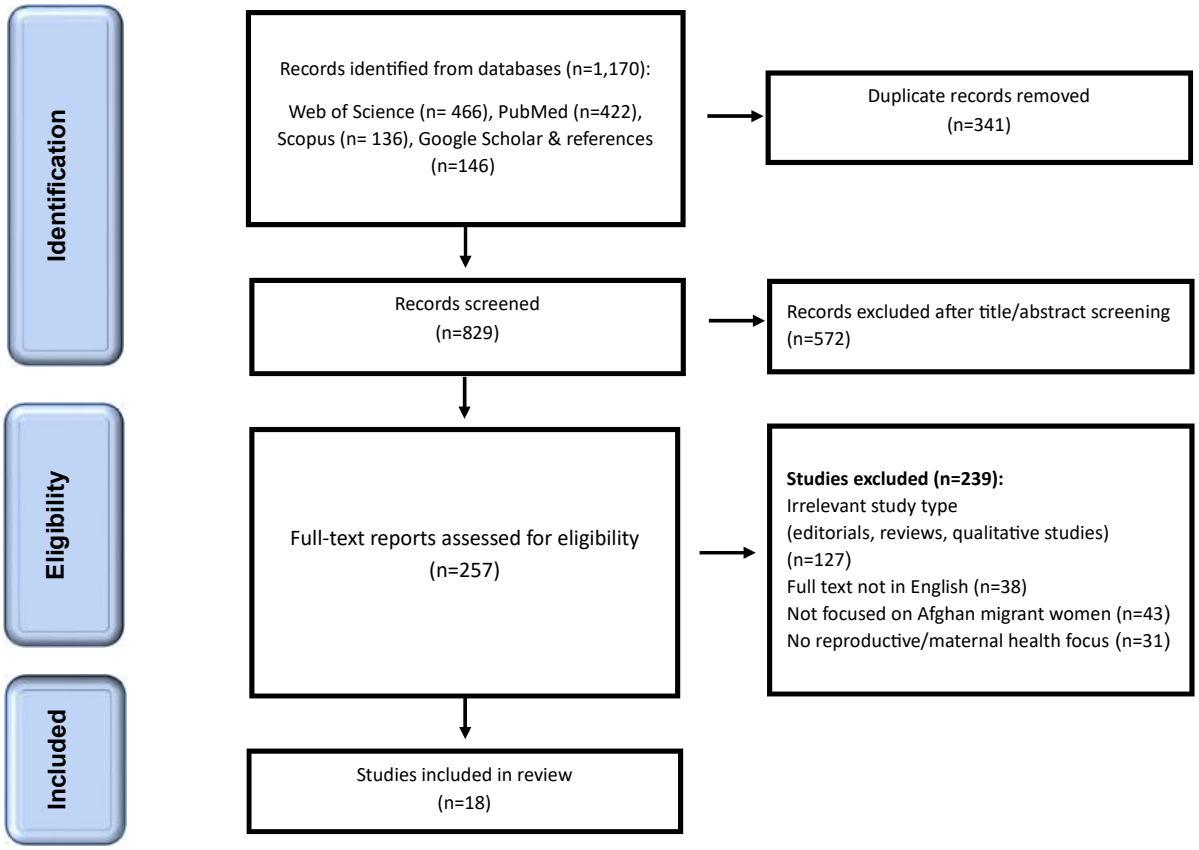

Figure 1: PRISMA flowchart for selection of articles

2000 and March 2025. Inclusion criteria were restricted to quantitative, descriptive, and mixed-methods studies that examined SSDH affecting Afghan migrant women's access to reproductive health services. Exclusion criteria comprised: (1) purely qualitative studies; (2) studies on non-Afghan migrant populations; (3) health outcomes unrelated to reproductive or maternal health; and (4) non-empirical publications (e.g., reviews, editorials, opinion pieces). The study selection process was documented using a PRISMA-ScR flowchart to ensure transparency (Figure 1). The search strategy for PubMed is shown in Table 1.

The third stage involved study selection. All records were imported into EndNote X9 for duplicate removal. Two reviewers (The first and second authors) independently screened the titles and abstracts against predefined eligibility criteria. Disagreements were resolved through discussion or consultation with a third reviewer (The fourth author). The process was documented using a PRISMA-ScR flowchart (Figure 1).

Table 1: Search Strategy for PubMed Database

Syntax
("emigrants and immigrants"[MeSH Terms] OR "Immigrants"[Title/Abstract] OR "Immigrant"[Title/Abstract] OR "Afghan people"[Title/Abstract]) AND ("Sexually Transmitted Diseases"[MeSH Terms] OR "STD"[Title/Abstract] OR "STI"[Title/Abstract] OR "pregnancy, unwanted"[MeSH Terms] OR "Pregnancy Complications"[MeSH Terms] OR "Adverse Birth Outcomes"[Title/Abstract] OR "Abortion"[Title/Abstract] OR "Menstruation Disturbances"[MeSH Terms] OR "Sex Offenses"[MeSH Terms] OR "Sexual Violence"[Title/Abstract] OR "cervical cancer"[Title/Abstract] OR "infertility"[Title/Abstract] OR "family planning"[Title/Abstract]) AND ("Health Services Accessibility"[MeSH Terms] OR "Access to Health Services"[Title/Abstract] OR "Contraceptive Availability"[Title/Abstract] OR "Delivery of Health Care"[MeSH Terms] OR "Reproductive Health Services"[Title/Abstract] OR "Maternal Health Services"[MeSH Terms]) AND ("Social Determinants of Health"[MeSH Terms] OR "Structural Determinants of Health"[Title/Abstract] OR "Socioeconomic Factors"[MeSH Terms] OR "Social Class"[MeSH Terms] OR "Economic Status"[MeSH Terms] OR "Educational Status"[MeSH Terms] OR "Employment"[MeSH Terms] OR "Unemployment"[MeSH Terms] OR "Income"[MeSH Terms] OR "culture"[MeSH Terms] OR "health policy"[MeSH Terms])

Table 2: Characteristics of the studies included in this scoping review

Author, Year	Aim	Location Study	Population	Method	Main Result	Sexual and Reproductive Health Outcome	Structural Determinants of Health
Badshah S, 2011[18]	Compare maternal risk factors between Afghan refugee and Pakistani mothers	Pakistan	1,039 mothers' records (125 Afghan refugee women, 914 Pakistani)	Cross-sectional	Afghan refugee mothers had significantly higher adverse outcomes in pregnancy; increased abortion/ miscarriages, short inter-pregnancy interval	Spontaneous abortion, preterm birth, low birth weight, neonatal mortality	Low family income, low maternal age, low husband's educational level, lack of pregnancy registration
Yaghoubi F, 2022[19]	Assess risk factors for severe maternal outcomes	Iran	312 Afghan immigrant women	Retro-spective cohort	High parity, low education, inadequate prenatal care	Maternal mortality, maternal near-miss, postpartum hemorrhage, pre-eclampsia, severe maternal outcome	Low educational level, lack of health insurance, low educational level in husband, high parity

Table 2: Continued

Author, Year	Aim	Location Study	Population	Method	Main Result	Sexual and Reproductive Health Outcome	Structural Determinants of Health
Akerman E, 2019[20]	Investigate knowledge about use of sexual and reproductive healthcare (SRH) services among immigrant women	Sweden	288 immigrant women (speaking Arabic, Dari, Somali or English) attending Swedish language schools	Cross-sectional	Low knowledge of sexual and reproductive health services, one-third unaware of contraceptive counselling locations, 56% unaware of HIV testing sites, and cultural barriers preventing contraception use in 25% of women	Unmet need for contraceptiv counseling, risk of unintended pregnancy	Language barriers, cultural barriers, low educational level
Raheel H, 2012[21]	Evaluate the effect of health subsidies on contraceptive uptake	Pakistan	650 Afghan refugee women	Cross-sectional	Significantly higher contraceptive knowledge and modern contraceptive use among women with health subsidies, overall low contraceptive prevalence	Reduced number of pregnancies and children, increased contraceptive uptake	Lack of healthcare subsidies, low educational level, economic barriers
Bartlett LA, 2002[22]	Assess maternal mortality rates	Pakistan	134,406 Afghan refugees' women	Cohort	Increase Maternal mortality rate	High maternal mortality ratio	Limited healthcare access, cultural barriers, displacement-related hardships
Dadras O, 2021[23]	Investigate factors associated with adverse pregnancy outcomes	Iran	424 Afghan women	Cross-sectional	Poor antenatal care, intimate partner violence, and poor mental health negatively impact pregnancy outcomes	Preterm labor, abortion, stillbirth, eclampsia, preeclampsia, early rupture of membranes, gestational hypertension, gestational diabetes, intrapartum hemorrhage, infections	Undocumented/ irregular legal status, illiteracy, unemployment, low socioeconomic status, lack of health insurance

Table 2: Continued

Author, Year	Aim	Location Study	Population	Method	Main Result	Sexual and Reproductive Health Outcome	Structural Determinants of Health
Purdin S, 2009[24]	Assess maternal mortality among Afghan refugees	Pakistan	96000 Afghan refugee women	Cohort	Decreased maternal mortality (291 to 102 per 100,000 live births) and substantial increase in skilled birth attendance, prenatal care, and postnatal care coverage	Maternal mortality, childbirth without skilled medical care, pregnancy complications, failure to utilize preventive services, infant mortality, low birth weight	Inadequate facility availability, restricted delivery room access, lack of refugee healthcare staff; Absence of 24-hour services, deficits in reproductive health knowledge
Sharifi M, 2021[25]	Investigate sources of information and related factors among pregnant Afghan migrant women	Iran	280 pregnant Afghan women	Cross-sectional	Healthcare providers as the primary source of information, followed by relatives; higher education and first pregnancy associated with more diverse information sources	Inadequate prenatal care	low educational level, low socioeconomic status, undocumented/ irregular legal status
Khan S, 2022[26]	Explore reproductive health issues, practices, and challenges faced by Afghan refugee women in specific urban settlement	Pakistan	120 Afghan refugee women	Cross-sectional	High prevalence of early marriages, large family sizes, low utilization of modern contraceptive methods due to cultural and religious misconceptions	High maternal morbidity, poor antenatal care coverage, Frequent home deliveries assisted by unskilled birth attendants	Poverty, undocumented/ irregular legal status, patriarchal norms and gender inequality, Low educational level, high parity, early marriage age
Roe JV, 2024[27]	Address reproductive health inequalities via health engagement sessions	Kosovo	57 Afghan women	Descriptive (Case Study)	Engagement sessions improved health literacy and trust in the health system.	Improved reproductive health awareness; improved health literacy, access to maternity services	Cultural barriers; Lack of language proficiency, challenges in integration into host health system, low health literacy

Table 2: Continued

Author, Year	Aim	Location Study	Population	Method	Main Result	Sexual and Reproductive Health Outcome	Structural Determinants of Health
Inci MG, 2020[28]	Assess unmet family planning needs	Germany	288 immigrant/ asylum seeking women	Cross-sectional	High unmet family planning needs despite free access to services.	Unintended pregnancy, low use of modern contraceptive methods	Lack of health system knowledge, language barriers, undocumented/ irregular legal status
Dehghan M, 2020[29]	Compare maternal–fetal attachment and domestic violence among Iranian and Afghan pregnant women	Iran	288 women (146 Iranian, 142 Afghan)	Cross-cultural Descriptive	Afghan pregnant women by positive and significant correlation between maternal-fetal attachment and sexual violence	High prevalence of domestic violence during pregnancy, impaired maternal-fetal attachment, negative impact on maternal mental health	Low socioeconomic status, patriarchal cultural norms
Delkhosh M, 2019[30]	Study intimate partner violence and reproductive outcomes	Iran	188 Afghan refugee women	Cross-sectional	High prevalence of physical and emotional intimate partner violence, poor reproductive health outcomes	Unintended pregnancy, lower use of modern contraception.	Low educational level, Economic dependence, refugee status vulnerability, duration of displacement, early marriage age, large family size
Changizi N, 2023[31]	Examine health status and factors affecting maternal mortality and morbidity among Afghan mothers in Iran	Iran	168,488 Afghan mothers' deliveries (2017–2019)	Cohort	Main causes of maternal mortality rate included non-pregnancy-related reasons, bleeding, and blood pressure disorders; severe obstetric complications were twice as high as in Iranian mothers	High maternal mortality. high-risk deliveries, postpartum mortality, preterm birth, low birth weight, reduced quality of life	Low educational level, lack of medical insurance; limited healthcare access, early marriage age, cultural barriers, and traditional belief

Table 2: Continued

Author, Year	Aim	Location Study	Population	Method	Main Result	Sexual and Reproductive Health Outcome	Structural Determinants of Health
Kizilkaya MC, 2022[32]	Examine awareness of breast cancer	Turkey	420 Afghan refugee women	Cross-sectional	Low awareness of breast cancer signs, self-examination, and screening needs; language, cultural, and information access barriers were key factors	Low awareness of reproductive health services	Inadequate knowledge of health services, cultural barriers, language barriers
Balsara ZP, 2010[33]	Determine prevalence reproductive tract infections (RTIs), describe knowledge of women about RTIs, and assess physical and behavioral factors contributing to the development of RTIs	Pakistan	634 Afghan refugee women	Cross-sectional	High prevalence of genital infections (fungal and bacterial), low awareness and access to preventive and treatment services, cultural, linguistic and economic barriers	Increase prevalence of genital tract infections, increased prevalence of pelvic pain, menstrual disorders, infertility, maternal mortality, poor mental health, low-quality care	Limited healthcare access, inadequate knowledge of health services, shame
Korkut B, 2022[34]	Assess the obstetric characteristics of refugee women and evaluate their knowledge and usage of contraception methods	Turkey	400 Afghan refugee women	Cross-sectional	Lower contraceptive use compared to global averages; cultural, economic, and linguistic barriers hinder access to family planning	High use of permanent contraceptive methods, low use of modern contraceptive methods, increased abortion rate, increased unwanted births	Low educational level, unstable economic status, low family income, short length of stay in host country
Dadras O, 2020[35]	Identify barriers to prenatal care utilization	Iran	424 Afghan women	Cross-sectional	Low education, lack of health insurance, economic status, and cultural differences hinder prenatal care access; social support and awareness improve utilization	Inadequate prenatal care	Low family income, low educational level, undocumented/irregular legal status, institutionalized discrimination and fear of state authorities, religious and cultural concerns, unemployment

In the fourth stage, we charted the data. A structured table, presented in Table 2, was used to organize the extracted information from the selected studies, ensuring a clear and systematic compilation of relevant findings. Finally, in the fifth stage, we collated, summarized, and reported the results. A descriptive and thematic synthesis approach was employed to analyze the findings.

We mapped the results onto the WHO's Commission on Social Determinants of Health framework, categorizing determinants into structural factors, such as policy, legal status, class, governance, and social norms (Table 3). Emerging themes were coded and grouped to identify recurring barriers and facilitators to Afghan migrant women's access to reproductive health services. This approach allowed us to present a comprehensive overview of the factors shaping access to health services for this population.

Ethical approval was granted by the Joint Ethics Committee of the School of Nursing and Midwifery and the School of Rehabilitation at Tehran University of Medical Sciences (Ethical Code: IR.TUMS.FNM.REC.1402.090).

Results

Of 1,170 articles initially identified, 18 met the inclusion criteria after title/abstract and full-text screening, as detailed in the PRISMA-ScR flowchart (Figure 1). Regarding the methodological distribution of the included studies, the majority of the research (12 cases) employed a cross-sectional design. This was followed by cohort and retrospective cohort studies, which comprised 4 of the identified papers. Additionally, one study was categorized as a descriptive case study, while a single study utilized a cross-cultural descriptive approach to analyze the data. Studies were conducted in Iran (n=7), Pakistan (n=6), Turkey (n=2), Germany, Kosovo, and Sweden (n=1) for each.

Key SSDH identified across the 18 included studies were socioeconomic deprivation, low educational attainment, cultural and linguistic disparities, lack of health insurance, and undocumented legal status. These barriers collectively restricted Afghan migrant women's access to essential reproductive health services, including antenatal care and contraception.

Table 3: Classification of Structural Social Determinants of Health Among Afghan Migrants

Category	Structural Determinant of Health	Category	Structural Determinant of Health
Macroeconomic Policies	Low family income;[18, 30, 35] Economic barriers;[21] Poverty;[26] Economic dependence;[30] Unstable economic status;[34] Lack of healthcare subsidies[21]	Public Policy	Limited healthcare access;[22, 31, 33] Inadequate knowledge of health services;[24, 28, 32, 33] Health literacy;[27] Inadequate access to skilled birth attendants;[24] Poor quality of health services;[24] Inadequate healthcare infrastructure and facility availability[24]
Social Policy	Lack of health/medical insurance;[19, 23, 31] Lack of pregnancy registration;[18] Short length of stay in host country;[34] Challenges in integration into host health system[27]	Governance	Undocumented/irregular legal status;[23, 25, 26, 28, 30] Unemployment and labor market exclusion;[23, 30, 35] Institutionalized discrimination and fear of state authorities;[35] Forced displacement and conflict-driven vulnerabilities[22, 30]
Social Class	Low educational level;[18-21, 23, 25, 26, 30, 31, 34, 35] Low husband's educational level;[18, 30] Illiteracy;[23] Low socioeconomic status;[25, 29] Low socioeconomic status;[34] Low maternal age;[18, 30] High parity and large family size[19, 26, 30]	Culture & Social Norms	Language barriers;[20, 27, 32, 28] Cultural barriers;[20, 22, 27, 31, 32] Patriarchal norms and gender inequality;[26, 29] Cultural and religious concerns;[35] Early marriage age;[26, 30, 31] Shame;[33] High parity and large family size[19, 26]

The identified sexual and reproductive health outcomes were categorized into three domains. First, maternal and perinatal outcomes included maternal mortality, obstetric complications, such as preterm labor, stillbirth, eclampsia, preeclampsia, gestational hypertension, gestational diabetes, intrapartum hemorrhage, low birth weight, and postpartum mortality. Second, reproductive health service utilization was compromised across studies, manifesting as inadequate prenatal care, home deliveries assisted by unskilled birth attendants, unmet contraceptive counseling needs, low use of modern contraceptive methods, and unintended pregnancies. Third, additional reproductive health outcomes included genital tract infections, intimate partner violence, impaired maternal-fetal attachment, poor mental health, and low awareness of reproductive and preventive health services.

Detailed characteristics of the included literature are displayed in Table 2, while the thematic classification of SSDH is outlined in Table 3.

The SSDH identified in the 18 included studies was categorized into six subcategories.

1. Macroeconomic Policies

Macroeconomic policies refer to the broad economic frameworks and market conditions that determine household purchasing power, labor market opportunities, and the distribution of financial resources. In the reviewed studies, low family income, unstable economic conditions, and absolute poverty were identified as the primary economic barriers hindering access to maternal health.[18, 26, 34, 35] Furthermore, the economic dependence of migrant women and struggles related to housing and daily living costs, combined with a lack of healthcare subsidies, significantly restricted the utilization of reproductive health services.[21, 30]

2. Social Policy

Social policy encompasses governmental interventions designed to reduce inequalities through support systems such as social welfare, housing, and insurance. Findings indicate that the lack of health or medical insurance coverage is one of the most critical structural barriers for Afghan women.[19, 23, 31] Additionally, the absence of formal pregnancy registration and the duration of residency in the host country were highlighted as key variables affecting health outcomes.[18, 34] The degree of integration into new health systems in developed countries also acts as a decisive social policy factor.[27]

3. Social Class

Social class pertains to an individual's position within the societal hierarchy based on education, occupation, and income, which dictates their access to power and resources. Low educational attainment and illiteracy (of both the woman and her spouse) were identified as the dominant determinants across nearly all studies.[18-23, 25, 26, 30, 31, 34, 35] Variables like marital status, maternal age, and general socioeconomic status also fall within this category, directly influencing women's autonomy in reproductive decision-making.[18, 22, 25, 29, 34] High parity and large family size were additionally identified as contributing structural factors within this domain.[19, 26]

4. Public Policy

Public policy refers to the government's operational strategies in the health sector, including service distribution and health promotion. Limited access to healthcare facilities and a lack of systemic knowledge regarding available services are significant structural findings.[22, 28, 31-33] One study emphasized that deficiencies in reproductive health education, inadequate healthcare infrastructure, and the limited involvement of refugee staff in service delivery constitute major institutional barriers to reproductive health access.[24]

5. Governance

Governance involves the political, legal,

and administrative structures that manage the relationship between the state and migrant populations. Undocumented legal status and the lack of residency permits function as a governance factor that creates a persistent fear of deportation and avoidance of public services.[23, 25, 26, 28, 30] Fear of discrimination within state systems and the hardships resulting from forced displacement and conflict are additional components that place migrants in a state of structural vulnerability.[22, 35]

Governance involves the political, legal, and administrative structures that manage the relationship between the state and migrant populations. Undocumented legal status and the lack of residency permits function as a governance factor that creates a persistent fear of deportation and avoidance of public services.[23, 25, 26, 28, 30] Unemployment and economic precarity further compound structural vulnerability among undocumented migrants.[23, 35] Fear of discrimination within state systems and the hardships resulting from forced displacement and conflict are additional components that place migrants in a state of structural vulnerability.[22, 35]

6. Culture and Social Norms

This category includes the values, beliefs, and behavioral patterns accepted within a society that impact health-seeking behaviors. Language barriers and patriarchal norms in decision-making processes were among the most prominent cultural factors.[20, 26-29] Furthermore, traditional and cultural barriers, early marriage, and phenomena such as social shame or isolation were identified as significant barriers.[20, 29, 31, 33, 35] Migration-related stressors and domestic violence also emerge as environmental norms that negatively impact reproductive health outcomes.[29]

Discussion

This scoping review synthesized evidence to identify the SSDH of access to reproductive health services among Afghan migrant women. The qualitative synthesis indicates that these determinants are not isolated factors but are deeply embedded within macroeconomic, social, and governance frameworks that dictate the trajectory of maternal and neonatal outcomes.

Based on our findings in this review, low family income, economic barriers, economic dependence, unstable economic conditions, and lack of healthcare subsidies were identified as the primary obstacles within Macroeconomic Policies as the SSDH.[18, 21, 26, 30, 34, 35] These economic barriers do not operate in isolation; intersectionality theory posits that they interact with occupational status, gender, and ethnicity to generate compounded layers of health deprivation among migrant populations.[36] Empirical evidence from European and North American contexts confirms that migrant generation, occupational position, and gender jointly shape reproductive health inequities in ways that no single structural determinant can independently explain.[37, 38] Financial pressure combined with undocumented legal status has been identified as a key driver of reproductive health service avoidance among Afghan migrant women, pushing them toward informal care pathways with inherently higher risks.[35, 39] Furthermore, while our findings focused on the absence of healthcare subsidies, research in developed countries such as France reveals that even when financial infrastructure exists, administrative complexities and structural discrimination act as systemic barriers, delaying access to prenatal care.[40] This intersection of poverty and bureaucratic obstacles exerts a synergistic negative effect on the reproductive health of refugee women. Additionally, macroeconomic shocks such as global inflation disproportionately affect refugees, forcing difficult choices between daily survival and reproductive healthcare — choices rooted in deep structural inequalities.[41]

Social policies function not merely as isolated services, but as tools for structural integration that define the boundary between social inclusion and exclusion for refugees. While this review emphasized the vital role

of formal pregnancy registration, length of residency, and integration into host health systems as structural prerequisites for reproductive health access,[18, 23, 31, 34] the lack of health or medical insurance coverage was identified as one of the most critical structural barriers for Afghan women.[19, 23, 31] Recent systematic evidence has mapped new dimensions of these systemic barriers across diverse host country contexts.[42] Meaningful health system integration extends far beyond administrative enrollment. Recent studies demonstrate that even in countries with advanced support systems, administrative complexity and illegibility of registration processes act as policy bottlenecks, causing significant delays in initial antenatal care.[40, 42] This highlights an intersection between "legal status" and "systemic literacy," where the mere existence of a supportive policy loses its efficacy for vulnerable populations without the simplification of formal registration processes.

Moreover, while our findings emphasized "length of stay", studies in high-income countries indicate that "legal precarity" (the stability or instability of residency status) has a more profound impact than the duration of presence in the host country. Instability in resettlement policies and frequent changes in welfare laws have led to structural anxiety and diminished trust in health systems.[42] Furthermore, evidence suggests that social policies lacking "multicultural and multilingual" approaches actively reproduce inequality; even insured refugees fail to navigate complex healthcare systems due to a lack of cultural mediators or specialized interpreters.[40] Therefore, social policies will only be effective when they move away from generic approaches toward migration-sensitive universal health coverage.

Regarding social class, this review found that education and illiteracy (of both women and their spouses) were the most decisive variables in accessing resources and power.[18-21, 23, 25, 26, 30, 31, 34, 35] However, contemporary research analyzes social class beyond traditional indicators of income and education, framing it as systemic capital and reproduced agency within migratory contexts.[43] Recent evidence suggests that in migratory environments, even moderate educational attainment does not necessarily translate into better access to reproductive health . Instead, Afghan refugee women confronted with fundamentally different medical protocols in the host country experience a form of educational mismatch, whereby prior health knowledge and decision-making norms become incongruent with the new system, ultimately undermining their agency and self-efficacy in reproductive decision-making.[44] This indicates that social class in the context of migration is not a static status but is redefined at the intersection of systemic health literacy.

Furthermore, while our findings emphasized maternal age and marital status as factors shaping women's reproductive autonomy,[18, 25, 29, 34] evidence also points to the role of spousal education as a structural catalyst; low husbands' educational level has been shown to reinforce patriarchal norms and reduce the uptake of contraceptive methods among Afghan migrant women.[18, 26] High parity and large family size were additionally identified as contributing structural factors within this domain.[19, 26] Conversely, another study in Europe argues that the social class of refugees in developed countries is influenced by "network isolation," meaning that even educated refugees remain at the bottom of power hierarchies due to a lack of social connections in the host society, directly affecting the speed of receiving specialized reproductive services.[38]

In the analysis of public policy, the findings of this review indicate that the gap between governmental strategies and refugee needs has contributed to limited healthcare access and inadequate knowledge of available services among Afghan migrant women.[22, 28, 31-33] Health literacy was identified as an additional structural barrier shaping the migrants' capacity to navigate host

health systems.[27] Furthermore, inadequate healthcare infrastructure and the absence of skilled birth attendants remain critical structural barriers to reproductive health service delivery in host settings.[22] Subsequent studies have extended this analysis beyond physical service availability, highlighting that equitable access requires addressing reproductive health literacy and women's capacity to independently locate and use health information — including through digital platforms — as policy-level determinants of reproductive health outcomes.[42, 45] Emerging evidence indicates that physical proximity to health facilities is insufficient to ensure equitable reproductive health outcomes for Afghan migrant women; rather, access is contingent upon women's capacity to navigate unfamiliar health systems, comprehend available services, and exercise informed decision-making, dimensions collectively captured under the construct of reproductive health literacy.[42, 45] For instance, evidence from a framework for analysis and action indicates that in the absence of policies supporting digital literacy, digitalized health systems — including complex online appointment platforms — have become a structural barrier for migrant and refugee women, restricting access to care among those with the greatest need.[46]

Furthermore, while our findings highlighted deficiencies in reproductive health education, evidence from the literature points to the transformative potential of technology in bridging these gaps. A study in Pakistan demonstrated that telehealth could overcome geographical constraints in delivering sexual and reproductive health services, provided it is accompanied by community-based training of local health workers.[47] These findings suggest that digital health solutions, when embedded within community structures, hold particular promise for underserved migrant populations. However, realizing this potential requires more than access to technology alone; it demands that health literacy be understood not as an individual trait, but as a systemic capacity shaped by digital infrastructure, governance, and policy design.[46, 47]

The findings of this review demonstrated that uncertain legal status and lack of residency permits were more than administrative hurdles; they are profound psychological factors that, by creating a constant fear of deportation, lead to widespread avoidance of public health services.[23, 25, 26, 28, 30] Unemployment and labor market exclusion further entrench economic marginalization and compound structural vulnerability among undocumented migrants.[23, 35] Other evidence confirms that legal precarity not only limits physical access but is directly linked to increased mental disorders, including postpartum depression. In fact, through the mechanism of legal status, the state exercises a form of "bordering of bodies" that makes the right to health conditional upon residency documentation.[48]

Cultural barriers, including language,[20, 27, 28] patriarchal norms,[26] traditional beliefs,[31] and religious beliefs,[35] significantly restrict women's reproductive autonomy. However, research suggests that these cultural barriers are often a strategic choice to avoid discrimination within health systems.[49] Moreover, focusing solely on women's education is insufficient; new studies emphasize male participation and spousal health literacy as key factors in breaking contraceptive taboos.[42] These findings suggest that cultural norms are reinforced in a complex interaction with negative experiences within the host system.[44]

One of the main strengths of this review is its use of the WHO's Social Determinants of Health framework. This framework enabled us to move beyond a purely biomedical approach and examine how structural factors such as governance, social policies, and legal status intersect with intermediary determinants like psychosocial stressors and health system barriers. Furthermore, by applying an intersectional lens and reviewing studies from diverse geographical contexts, we gained a deeper understanding of how the convergence of gender, ethnicity, and legal

precarity creates unique layers of vulnerability in the reproductive health of Afghan migrant women.

However, the present study also has several limitations. Due to practical constraints and adherence to international indexing standards, the search was limited to English-language articles. In addition, the considerable heterogeneity in healthcare systems and migration policies across the included countries means that the generalizability of some findings and policy recommendations should be interpreted with caution.

Conclusion

This review demonstrates that Afghan migrant women's access to reproductive health services is primarily influenced by deep social determinants of structural factors. Poverty, unstable economic conditions, lack of health insurance, undocumented legal status, illiteracy, unemployment, and patriarchal cultural norms do not act in isolation but interact to create compounded layers of deprivation. The findings underscore that improving these women's reproductive health requires more than just service-oriented approaches; it necessitates structural changes. Policies that focus solely on service delivery without addressing legal status, labor market exclusion, systemic health literacy, male involvement, and cultural sensitivity will remain ineffective. Ultimately, the reproductive health of Afghan migrant women is not just a medical issue but a social and human rights concern, shaped by the SSDH. Without addressing these root determinants, from macroeconomic precarity and governance failures to cultural barriers and public policy gaps, adverse maternal and reproductive outcomes will continue to persist in host countries. Future research should prioritize designing and testing holistic interventions using community-based participatory methods and cross-country comparisons to develop scalable, context-specific strategies for advancing reproductive health equity.

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Authors' Contribution

ZB, ZM, AT, ZT, and STM contributed substantially to the study conception and design. ZB led the literature search, data extraction, and data analysis. ZM contributed to methodology design and data analysis. AT participated in conceptualization, data synthesis, and policy analysis. ZT performed data charting and initial screening. STM supervised the overall project and conducted the secondary review of the data and articles. ZB drafted the initial manuscript, and all authors participated in critically revising the manuscript for important intellectual content. All authors approved the final version of the manuscript and agreed to be accountable for all aspects of the work. The corresponding author attests that all listed authors meet authorship criteria.

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Conflict of Interest

None declared.

Declaration on the use of AI

The authors used Google Gemini 1.5 (web interface, accessed via https://gemini.google.com/ at time of writing) solely as a language editing assistant to improve the clarity, grammar, and style of certain paragraphs originally

written by the authors. The authors take full responsibility for the integrity and accuracy of the manuscript.

References

1 World Health Organization. Reproductive health. Geneva: World Health Organization; 2022. [Cited 2025 Sep 8]. Available from: https://www.who.int/southeastasia/health-topics/reproductive-health

2 United Nations. Population and Development: Program of action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994. New York: United Nations; 1995.

3 Hacker K, Houry D. Social needs and social determinants: the role of the Centers for Disease Control and Prevention and public health. Public Health Rep. 2022;137:1049-52.

4 Sadeghi R, Mahmoudian H, Boroomandzadeh M. Reproductive health behaviors of Afghan immigrant women and its determinants in Tehran Province, Iran. Sociol Rev. 2023;30:167-83. [In Persian]

5 Mahdi ZM, Aguilera Ávila L, Álvarez Lorenzo M. Gender-Based Violence Against Migrant Women From Islamic Background: A Systematic Review of International Studies. Trauma Violence Abuse. 2025. [Online]

6 McAuliffe M, Oucho LA. World migration report 2024. Geneva: International Organization for Migration; 2024.

7 United Nations Human Rights, Office of the High Commissioner. Afghanistan: UN experts say 20 years of progress for women and girls' rights erased since Taliban takeover. Geneva: United Nations Human Rights; 2023. [Cited 2025 Sep 8]. Available from: https://www.ohchr.org/en/press-releases/2023/03/afghanistan-un-experts-say-20-years-progress-women-and-girls-rights-erased

8 International Organization for Migration. Healthy migrants in healthy communities: promoting and delivering quality health care for migrants and host communities. Geneva: International Organization for Migration; 2017.

9 Edward J. Undocumented immigrants and access to health care: making a case for policy reform. Policy Polit Nurs Pract. 2014;15:5-14.

10 Biswas D, Toebes B, Hjern A, et al. Access to health care for undocumented migrants from a human rights perspective: a comparative study of Denmark, Sweden, and the Netherlands. Health Hum Rights. 2012;14:49-60.

11 United Nations High Commissioner for Refugees. UNHCR global strategy for public health 2021–2025. Geneva: United Nations High Commissioner for Refugees; 2021.

12 Karp RJ, Rhee D, Feldman D, et al. Outreach to immigrant communities: teaching pediatric residents about access to health care. J Health Care Poor Underserved. 2007;18:510-5.

13 UNESCO Institute for Statistics. Literacy rate, adult female (% of females ages 15 and above) – Afghanistan. Paris: UNESCO; 2018.

14 World Health Organization. A conceptual framework for action on the social determinants of health. Geneva: World Health Organization; 2010.

15 Rahimitabar P, Kraemer A, Bozorgmehr K, et al. Health condition of Afghan refugees residing in Iran in comparison to Germany: a systematic review of empirical studies. Int J Equity Health. 2023;22:16.

16 Arksey H, O'Malley L. Scoping studies: towards a methodological framework. Int J Soc Res Methodol. 2005;8:19-32.

17 Tricco AC, Lillie E, Zarin W, et al. PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation. Ann Intern Med. 2018;169:467-73.

18 Badshah S, Mason L, McKelvie K,

et al. Maternal risk factors in Afghan refugees compared to Pakistani mothers in Peshawar, NWFP Pakistan. J Pak Med Assoc. 2011;61:161-4.
19 Yaghoubi F, Akbari N, Kashanian M, et al. Severe maternal outcome in Afghan immigrant women: a study in Tehran, Iran. Int J Gynecol Obstet. 2022;159:302-12.
20 Åkerman E, Larsson EC, Essén B, et al. A missed opportunity? Lack of knowledge about sexual and reproductive health services among immigrant women in Sweden. Sex Reprod Healthc. 2019;19:64-70.
21 Raheel H, Karim MS, Saleem S, et al. Knowledge, attitudes and practices of contraception among Afghan refugee women in Pakistan: a cross-sectional study. PLoS One. 2012;7:e48760.
22 Bartlett LA, Jamieson DJ, Kahn T, et al. Maternal mortality among Afghan refugees in Pakistan, 1999–2000. Lancet. 2002;359:643-9.
23 Dadras O, Nakayama T, Kihara M, et al. The prevalence and associated factors of adverse pregnancy outcomes among Afghan women in Iran; Findings from community-based survey. PLoS One. 2021;16:e0245007.
24 Purdin S, Khan T, Saucier R. Reducing maternal mortality among Afghan refugees in Pakistan. Int J Gynecol Obstet. 2009;105:82-5.
25 Sharifi M, Amiri-Farahani L, Kariman N, et al. Sources of information and related factors during pregnancy among Afghan migrant women in Iran. Nurs Open. 2021;8:975-81.
26 Khan S, Riaz S, Ahmed N. The reproductive health issues and practices among the Afghan refugee women (with special reference to Afghan Basti in Karachi and Quetta). Pak J Int Aff. 2022;5:365-77.
27 Roe JV, Webster P. Health engagement sessions as a means of addressing reproductive health inequalities in a population of Afghan women during Operation Allied Solace. BMJ Mil Health. 2024;170:186-7.
28 Inci MG, Kutschke N, Nasser S, et al. Unmet family planning needs among female refugees and asylum seekers in Germany – is free access to family planning services enough? Results of a cross-sectional study. Reprod Health. 2020;17:115.
29 Dehghan M, Farokhzadian J, Ferdosi H, et al. Maternal–fetal attachment and domestic violence against Iranian and Afghan pregnant women: a cross-cultural study. Violence Gend. 2020;8:213-8.
30 Delkhosh M, Merghati Khoei E, Ardalan A, et al. Prevalence of intimate partner violence and reproductive health outcomes among Afghan refugee women in Iran. Health Care Women Int. 2019;40:213-37.
31 Changizi N, Afshar NE, Farahani Z, et al. Improving the health status of Afghan mothers living in the Islamic Republic of Iran. East Mediterr Health J. 2023;26:861-9.
32 Kizilkaya MC, Kilic SS, Bozkurt MA, et al. Breast cancer awareness among Afghan refugee women in Turkey. EClinicalMedicine. 2022;49:101459.
33 Balsara ZP, Wu I, Marsh DR, et al. Reproductive tract disorders among Afghan refugee women attending health clinics in Haripur, Pakistan. J Health Popul Nutr. 2010;28:501-8.
34 Korkut B, Sevinç N, Adahan D. An evaluation of obstetric characteristics and contraceptive use among refugee women. Cureus. 2022;14:e24045.
35 Dadras O, Dadras F, Taghizade Z, et al. Barriers and associated factors for adequate antenatal care among Afghan women in Iran; findings from a community-based survey. BMC Pregnancy Childbirth. 2020;20:427.
36 Wandschneider L, Miani C, Razum O. Decomposing intersectional inequalities in subjective physical and mental health by sex, gendered practices and immigration status in a representative panel study

from Germany. BMC Public Health. 2022;22:683.
37 Im H, Tefera GM. Discrimination and intersecting inequities to healthcare access among refugee newcomers in the United States. Archives of Public Health. 2026;84:1.
38 Gkiouleka A, Huijts T. Intersectional migration-related health inequalities in Europe: exploring the role of migrant generation, occupational status and gender. Soc Sci Med. 2020;267:113218.
39 Iqbal K, Liang H. Safety nets beyond borders, bodies, and barriers: informal reproductive healthcare adaptation and coping strategies of undocumented Afghan women migrants in Pakistan. Int J Qual Stud Health Well-being. 2026;21:2625287.
40 Naseri S, Ridde V, Naseri S, et al. Assessing antenatal care access among Afghan women migrants, refugees, and asylum-seekers in France: a mixed methods study. SSM Health Syst. 2025;5:100128.
41 Shafiq Y, Muhammad A, Suhag ZH, et al. Navigating challenges in access to antenatal and intrapartum care: Afghan refugee women's experiences amidst the COVID-19 pandemic in Pakistan. Womens Health (Lond). 2025;21:17455057251347081.
42 Stirling-Cameron E, Almukhaini S, Dol J, et al. Access and use of sexual and reproductive health services among asylum-seeking and refugee women in high-income countries: a scoping review. PLoS One. 2024;19:e0312746.
43 Großkreutz C, Gürbüz B, Borde T, et al. Equal Alternatives or Lower Standards for Immigrant Women-Analyzing Obstetric Care for Immigrant Women in Berlin Within the Framework of Cultural Health Capital. J Racial Ethn Health Disparities. 2024;11:2689-98.
44 Worabo HJ, Safi F, Gill SL, et al. "It's different here" Afghan refugee maternal health experiences in the United States. BMC Pregnancy Childbirth. 2024;24:479.
45 Thiel de Bocanegra H, Yama A, Pirzada AF, et al. Assessing the Effectiveness of Reproductive Health Literacy Trainings on Access To Care for Arab and Afghan Refugee Communities. J Immigr Minor Health. 2025;27:967-76.
46 Matlin SA, Hanefeld J, Corte-Real A, et al. Digital solutions for migrant and refugee health: a framework for analysis and action. Lancet Reg Health Eur. 2024;50:101190.
47 Hirani R, Muzzamil M, Khurram SS, et al. Sexual and reproductive health access among Afghan refugee women using telehealth in Pakistan. Pak J Pub Health. 2025;15:105-10.
48 Zakian Khorramabadi F, Moazzen V, Parsapour A, et al. Access to health care for Afghan immigrants and refugees: an ethico-legal analysis based on the Iranian health law system. J Med Ethics Hist Med. 2023;16:12.
49 Almeida LM, Casanova C, Caldas J, et al. Migrant women's perceptions of healthcare during pregnancy and early motherhood: addressing the social determinants of health. J Immigr Minor Health. 2014;16:719-23.