

ORIGINAL RESEARCH ARTICLE

Borders, bodies, and barriers: Legal vulnerabilities and reproductive health challenges of Afghan women immigrants in the host society of Pakistan

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Abstract

The study aimed to investigate the influence of legal status on reproductive health service availability for Afghan women immigrants and their adopted coping methods with obstacles. The study employed a qualitative design utilizing narrative in-depth interviews with twelve undocumented Afghan women, supplemented by five key informant interviews and field observations. The study findings revealed that legal uncertainty, along with cultural constraints, act as the main factor preventing undocumented women from accessing public healthcare facilities through their inability to present Proof of Registration (PoR) cards and breaking norms. Afghan women avoid hospital care because they face discriminatory treatment in addition to receiving unsupportive attitudes from medical workers and worries of deportation. Male guardianship policies combined with gender norm expectations reduce women's freedom to make reproductive decisions. As a result, many rely on informal healthcare providers, such as traditional birth attendants, despite the risks of maternal and neonatal complications. Using intersectionality and structural violence theories, this research contributes to migration and gender studies, as well as health inequity research, and recommends practical solutions for rights-based care policies. These theoretical frameworks illuminate how intersecting axes of oppression collectively shape reproductive health access and outcomes for undocumented Afghan women in Pakistan (*Afr J Reprod Health* 2025; 29 [9]: 124-147).

Keywords: women immigrants, healthcare access, structural violence, reproductive justice, legal precarity, intersectional health inequalities

Résumé

L'étude visait à analyser l'influence du statut juridique sur l'accès aux services de santé reproductive des immigrantes afghanes et les méthodes qu'elles adoptent pour faire face aux obstacles. L'étude a adopté une approche qualitative s'appuyant sur des entretiens narratifs approfondis avec douze femmes afghanes sans papiers, complétés par cinq entretiens avec des informateurs clés et des observations de terrain. Les résultats de l'étude ont révélé que l'insécurité juridique, conjuguée aux contraintes culturelles, constitue le principal facteur empêchant les femmes sans papiers d'accéder aux services de santé publics, en raison de leur incapacité à présenter une preuve d'enregistrement (PdR) et du non-respect des normes. Les femmes afghanes évitent les soins hospitaliers car elles sont victimes de discrimination, en plus du manque de soutien du personnel médical et de la crainte d'être expulsées. Les politiques de tutelle masculine, combinées aux attentes liées aux normes de genre, réduisent la liberté des femmes à prendre des décisions en matière de reproduction. Par conséquent, nombre d'entre elles font appel à des prestataires de soins informels, tels que les sages-femmes traditionnelles, malgré les risques de complications maternelles et néonatales. S'appuyant sur les théories de l'intersectionnalité et de la violence structurelle, cette recherche contribue aux études sur les migrations et le genre, ainsi qu'à la recherche sur les inégalités en matière de santé, et propose des solutions concrètes pour des politiques de soins fondées sur les droits. Ces cadres théoriques éclairent la manière dont les axes d'oppression qui se croisent façonnent collectivement l'accès et les résultats en matière de santé reproductive pour les femmes afghanes sans papiers au Pakistan (*Afr J Reprod Health* 2025; 29 [9]: 124-147).

Mots-clés: Femmes immigrées, accès aux soins de santé, violence structurelle, justice reproductive, précarité juridique, inégalités de santé intersectionnelles.

Introduction

The modern world lives under the influence of migration as millions of people flee from countries because of war, conflict, economic deprivation, and political strife.¹ Displaced women confront

distinctive marginalization, while undocumented migrant women endure the most extreme form of social, legal, and health-related challenges.^{2,3} The population of Afghan women stands as one of the most vulnerable among migrants because they lack official documentation while living in Pakistan.⁴

Undocumented women struggle to receive basic human rights services, particularly healthcare, because of numerous barriers.⁵ The condition of legal and social exclusion prevents people from receiving essential reproductive healthcare services that protect their wellness and support the health of their children.⁶ The absence of legal recognition creates more serious problems, leading to increased threats of death and illness during pregnancy for Afghan migrant women.⁷ It is essential to study the structural barriers that undocumented Afghan migrant women encounter when they seek reproductive healthcare in Pakistan because their multiple social identities intersect. The country of Pakistan functions as a key host nation for Afghan refugees, where 3.7 million Afghans lived in 2023, among whom a substantial number lack official documentation.⁸ The Soviet invasion of Afghanistan in 1979 triggered successive migration waves, which created a continuous presence of Afghan refugees in Pakistan, although Pakistan has never achieved consistent legislation for these migrants.⁹ A significant number of Afghan refugees lack Proof of Registration (PoR) cards, thus precluding them from basic rights, including healthcare access.¹⁰ Lack of legal recognition puts Afghan refugees at risk of restricted mobility while making them economically vulnerable and socially excluded to such an extent that women bear the majority impact. The Lack of legal documentation prevents Afghan women from accessing public healthcare facilities, where they face discrimination while being exposed to severe maternal risks, including death and health complications.¹¹ Undocumented immigrant women across the globe encounter significant healthcare challenges during pregnancy because they have limited access to professional care providers, along with subpar prenatal treatment, which results in higher risks for pregnancy complications.¹²

Most of the studies have been done throughout the migration literature field that have established the impact of migrants' legal status on their healthcare access. Irregular migration status creates barriers to healthcare access because undocumented migrants face deportation anxiety alongside discrimination from healthcare providers and relevant public health program exclusions.¹³ Undocumented migrants face reduced healthcare

service provision in settings with existing healthcare system limitations, thus increasing preexisting health inequality gaps.¹⁴ Pakistan faces severe public health challenges regarding maternal mortality because its reproductive healthcare system excludes Afghan migrant women.¹⁵ The Sustainable Development Goals (SDGs), which include reproductive health rights under universal health coverage, receive international support, yet undocumented women still confront healthcare obstacles.^{16, 17} Gender plays an additional role in creating vulnerabilities because cultural and societal restrictions block Afghan women from making their own reproductive health decisions. Research shows that Afghan cultural patriarchy makes it difficult for women to get healthcare on their own since they need male authorization or company, especially when they lack a spouse.¹⁸ The combination of Pakistani barriers to free movement and little money, along with low reading skills, wedges Afghan women from seeking appropriate maternity healthcare services.¹⁹ The undocumented condition maintains unrestricted barriers to health services, which triggers repetitive health inequities and promote sexual discrimination patterns. The scholarly works on migration and gender health interactions show that migrant women face multiply increased risks. Multiple studies of refugee populations across different contexts show how undocumented status results in worsened health disparities that prevent female patients from accessing maternity care and qualified medical attention throughout pregnancy and postpartum support.

Societal norms based on patriarchal structures, together with cultural traditions, frequently prevent migrant women from controlling their reproductive health through limitations on their physical mobility and decision-making abilities.²⁰ Academic research about undocumented Afghan migrant women in Pakistan remains scarce, even though the population of Afghan refugees in the country has grown steadily over the past forty years. While studies have addressed maternal healthcare challenges among refugees in North–South migration contexts, far less attention has been paid to South–South migration patterns, where developing countries with limited infrastructure host large displaced populations. This omission is

particularly stark in the case of Afghan women in Pakistan—a protracted refugee group that continues to face structural exclusion within a weak and discriminatory healthcare system. Moreover, existing maternal health policies in Pakistan lack formal inclusion mechanisms for undocumented immigrants, resulting in a critical policy vacuum. This study addresses these gaps by analyzing the intersection of migration status, gender norms, and institutional healthcare exclusion, offering new empirical insight from a Global South setting often overlooked in the reproductive justice literature. This study investigates the impact of undocumented status on Afghan women migrants who need reproductive healthcare in Pakistan. The study also examines the legal, institutional, and socio-cultural obstacles that determine healthcare accessibility and vulnerabilities of undocumented Afghan women. This study utilizes qualitative data collection methods to enhance knowledge about migrant health disparities. It contributes to broader studies about migration and gender effects on reproductive health while guiding maternal health services and policy directives supporting minority groups. To secure reproductive health equity and fulfill international human rights commitments about universal reproductive healthcare access, we must remove all barriers that undocumented individuals face.

Literature

Theoretical background

The research adopts two fundamental sociological models, namely, intersectionality theory (Crenshaw, 1989),²¹ and structural violence theory.²² The theories reveal an essential framework to interpret the synergistic effects of undocumented status, gender-based norms, and institutional discrimination on reproductive health exposure for Afghan migrant women in Pakistan. The specific combination of social oppressors like gender, together with ethnicity and legal status, results in new forms of cumulative disadvantage as described in intersectionality theory (Crenshaw, 1989).²¹ Undocumented Afghan migrant women in Pakistan endure multiple forms of discrimination because of their ethnicity, combined with their

undocumented status as well as their status as females, which makes them especially vulnerable to healthcare marginalization. The lack of formal recognition excludes Afghan women from healthcare facilities, while traditional family structures in both countries limit their choices about their bodies. This work investigates maternal healthcare barriers by using the intersectionality framework to understand the combination of exclusion factors that shape this issue. Structural violence theory,²² shows systemic inequalities within legal frameworks, economic systems, and healthcare systems, which expand suffering, specifically for marginalized communities.

The violence exists as a system rather than a personal act, which manifests through public policies, along with institutional unwillingness to care and discriminatory healthcare practices that create continuous barriers for specific groups. The structural violence faced by Afghan women is expressed through three examples, which include public hospital exclusion, discriminatory healthcare provider behaviors, and reliance on unregulated health networks. The legal status of undocumented immigrants works as a system to exclude them, so maternity healthcare becomes institutionalized inequality rather than standard medical care. The study analyzes Afghan female reproductive problems by using intersectionality theory together with structural violence theory, thus placing their health problems in broader systemic contexts instead of presenting them as unique personal issues. The interconnected legal, institutional, and cultural barriers require theoretical analysis, which produces an understanding of how these frameworks affect undocumented migrant women's healthcare access.

Previous studies

Women who migrate or flee their homes with or without legal papers encounter substantial obstacles when trying to access positive reproductive healthcare services, which are basic human rights. Scientific evidence demonstrates that migrant populations face limitations in healthcare because of legal status and institutional discrimination, combined with gender constraints.²³ The review provides an evaluation of maternal healthcare

access for undocumented migrant women, beginning with global trends and ending with Pakistan-specific barriers.

Migration status converging with health issues related to reproduction stands as an essential public health matter that healthcare organizations around the globe need to address. Data reveals that undocumented migrant women face drastically elevated risks of death along with serious pregnancy complications because they encounter limited prenatal and postnatal care access, immigration concerns, and financial struggles.²⁴ The World Health Organization (WHO) identifies migrant women who lack legal documentation as one of the most at-risk maternal healthcare populations since they delay hospital visits during pregnancy out of concerns about legal prosecution or discrimination.¹² Healthcare access for undocumented migrant women frequently prevents them from obtaining coverage and public healthcare benefits, so they seek inadequate birth services from private providers, followed by emergency room attendance during labor.²⁵ Studies throughout Latin America, Africa, and Middle Eastern regions demonstrate that structural elements like legal discrimination and financial barriers, as well as communication difficulties, consolidate maternal healthcare inequalities for migrants.²⁶ Afghan refugee women and other displaced mothers living in war zones confront severe maternal health risks because they must use unofficial care networks instead of public health services while dealing with unstable housing and scarce medical facilities.²⁷ The study results confirm that migrant women's access to maternal health care represents more than a medical problem because immigration rules combined with social segregation and healthcare discrimination create barriers.

Advanced medical systems found in developed societies are not enough to help undocumented women access maternal healthcare because their access is limited by both governmental regulations and financial hurdles, and discriminatory medical systems. Research shows undocumented Latina women in the United States lack prenatal care more often than U.S.-born women because of their fear of deportation,

together with high medical costs and limited access to public health programs.²⁸ In Germany, along with France and the UK, undocumented migrant women face healthcare structural barriers as well as medical personnel discrimination and limited availability of localization-specific maternal healthcare services.²⁹ Under the Norwegian and Swedish healthcare systems, which provide coverage to all citizens, undocumented women fall outside the scope of universal health benefits, thus denying reproductive healthcare to many women.³⁰ Studies investigated had established those European migrant women encounter delayed prenatal care and inadequate postnatal care, as well as higher risks of pregnancy complications.^{12, 25} Healthcare system development does not ensure the healthcare availability of undocumented women because government policies and societal attitudes regarding migrant's shape access to services independent of national wealth.

Migrant women in developing countries encounter extra obstacles like poor health facilities, monetary shortfalls, and scarce medical staff that create additional barriers to reproductive healthcare.³¹ A combination of studies shows that undocumented migrant women must depend on NGO-run clinics or informal midwives for maternal healthcare because national health programs exclude them in Turkey, along with Lebanon and Jordan.³² Maternal health results in Rohingya refugee camps of Bangladesh show significant deterioration because refugees lack proper medical assistance during childbirth and experience traditional birth constraints and restricted birth control access.³³ New studies show Syrian refugee women face healthcare obstacles in Lebanon because their residency limits prevent them from accessing state hospitals, thus causing many pregnancies to end unsuccessfully at home.³⁴ The healthcare facilities in developing nations confront multiple obstacles because they lack robust healthcare systems, have minimal financial capabilities, and have strained public health organizations, which also hinder the provision of maternity care for undocumented immigrant women.³⁵ The understanding of these factors enables better comprehension of why Pakistan, along with other developing nations,

shares comparable obstacles in providing healthcare to Afghan immigrant women regarding their reproductive health needs.

Pakistan holds the position as host to the world's second-largest group of Afghan refugees, but undocumented Afghan women encounter major obstacles in seeking reproductive healthcare due to overlapping barriers from laws, institutions, and society's traditional norms.³⁶ The Soviet invasion of Afghanistan beginning in 1979 led to millions of Afghan refugees moving to Pakistan, while numerous refugees lack recognition through standard refugee protection systems.³⁷ Afghan women face an inability to receive public health care because hospitals demand Proof of Registration (PoR) cards to provide medical services.³⁸ Numerous studies analyzing Afghan refugees in Pakistan identify several primary barriers that prevent reproductive healthcare access for them. The absence of legal status prevents Afghan undocumented women from receiving government-funded hospital services, which leads to postponed or rejected prenatal medical care.³⁹ Healthcare discrimination in facilities leads Afghan migrant women to encounter verbal abuse combined with neglectful treatment and excessive waiting times in hospitals, thus discouraging their usage of formal healthcare services.^{40, 41}

Patriarchal social norms throughout Afghan communities maintain tight control over reproductive choices for women because they need spousal and familial consent to visit doctors.⁴² The maternal health condition of Afghan women worsens when they turn to the unlicensed dais or private medical facilities because of legal and financial impediments.⁴² The analysis of displaced populations' maternal health access demonstrates that legal uncertainty, together with institutional prejudices and cultural restrictions, affect Syrian refugees in Turkey and Rohingya women in Bangladesh.³¹ The existing healthcare policies, together with poor refugee health integration in Pakistan, augment the severe disparities in maternal healthcare access among Afghan women.⁴³ The existing studies show that undocumented migrant women face worldwide healthcare access limitations because of legal, economic, and cultural restrictions. Migrant women encounter financial and bureaucratic challenges to reproductive

healthcare from developed nations; at the same time, developing nations experience overburdened healthcare systems, together with legal barriers to healthcare access. Afghan migrant women seeking healthcare services in Pakistan encounter some of the worst healthcare barriers because of legal instability combined with discriminatory practices and cultural gender expectations.

Methods

Study design

This study uses qualitative methods through narrative analysis,⁴⁴ to examine the relationship between undocumented Afghan migrant women's legal situation and their healthcare access in Pakistan. It analyzed narratives to demonstrate in detail the healthcare exclusion experiences faced by undocumented Afghan migrant women in Pakistan. The analysis method reveals more than system barriers because it explores the feelings that female patients experience during their struggles and their ways of coping with restricted health access. The research methodology explores women's firsthand experiences to reveal essential knowledge about the interaction of legal standing, social gender roles, and institutional bias, which leads the way to implement reproductive rights-based policies and healthcare programs that serve migrant women. The research employed narrative analysis because this approach enables a comprehensive investigation into how migrant women interpret healthcare access to health services and their adaptive coping behavior. In addition, this method structures research to measure the social and legal factors together with institutional elements that determine healthcare availability for this disadvantaged demographic group.

Study population and sampling

The statistical research targets undocumented Afghan migrant adult women aged above 18 years. Many Afghan refugees have settled in Pakistan, specifically in Peshawar, which was purposefully selected for this study see figure 1. The researchers use purposive sampling, which enables them to include women who represent different socioeconomic positions, together with married and

unmarried participants, and women who have different healthcare backgrounds. The researchers have selected this sampling approach because it allows them to choose participants who possess valuable information about the healthcare access difficulties faced by undocumented Afghan women. The study also employs key informants' interview (KII) protocols to speak with healthcare providers, as well as policymakers and NGO representatives who help migrant populations to investigate structural and institutional barriers to healthcare access. A total of twelve interviews were conducted with Afghan women immigrants with the help of 3 enumerators based on the saturation point of data collection, and five key informant interviews were conducted with key informants. The decision to conclude data collection after twelve narrative interviews was based on both empirical and theoretical saturation principles. Saturation was observed when no substantially new themes, codes, or narrative structures emerged from the last few interviews—a common benchmark in narrative and qualitative research.⁴⁵ The richness and depth of personal accounts provided comprehensive insight into the intersection of legal precarity, gender norms, and healthcare exclusion. Additionally, since the study employed purposive sampling and narrative analysis—both emphasizing depth over breadth—this sample size was deemed methodologically sufficient for revealing patterns across diverse socio-cultural contexts within the undocumented Afghan women population in Peshawar. This decision is supported by existing qualitative studies that demonstrate thematic saturation can often occur within 12 interviews when working with a relatively homogenous group and when interviews are in-depth and contextually rich. The recruiting criteria were Afghan migrant women who have resided in Pakistan and do not possess valid documentation, including Proof of Registration (PoR) cards and the National Database & Registration Authority (NADRA) status, who have given birth in the last twenty years. On the other hand, the study excludes Afghan refugee women who hold official legal refugee status, and both those who do not consent to participate and healthcare providers or policymakers who work in refugee healthcare. Figure 1

Data collection methods

The research methodology combines in-depth narrative interviews with key informant interviews to collect broad evaluations of this matter. The researcher chose this research method to achieve data triangulation, which leads to an extensive grasp of structural and personal barriers that disrupt healthcare access. Narrative in-depth interviews were conducted with undocumented Afghan women to investigate their experiences of reproductive healthcare services, along with the barriers they encountered and how they dealt with them. Each participant had the freedom to describe their reproductive health experiences, starting from their legal status until their service utilization and healthcare encounters. This study employed the narrative approach because it enables women to construct their life stories through their words to demonstrate personal difficulties as well as systemic discrimination. Narrative analysis with this methodology succeeds in collecting factual information together with emotional responses, personal perceptions, and decision-making capabilities that standard thematic methods usually do not capture.

Researchers chose narrative in-depth interviews over other methods because they present participants with flexible yet systematic ways to share experiences throughout their free-form responses.

The first author in this study used family socioeconomic background, ethnicity, cultural suitability, and regionality in selecting participants for a better understanding of the research problem. In addition, in Pashtun culture, men cannot interact with females from other kin,⁴⁶ hence 3 female enumerators were hired to assist in data collection. Through their exposure to health access and areas of residence, cultural norms, and nationality, the enumerators were able to interpret the participants' informal conversation into the narrative analysis. These similarities also made participants of the study more open-minded and comfortable about sharing their experiences regarding status, gender, and nationality during their reproductive health access; their demographic profiles are presented in Table 1.

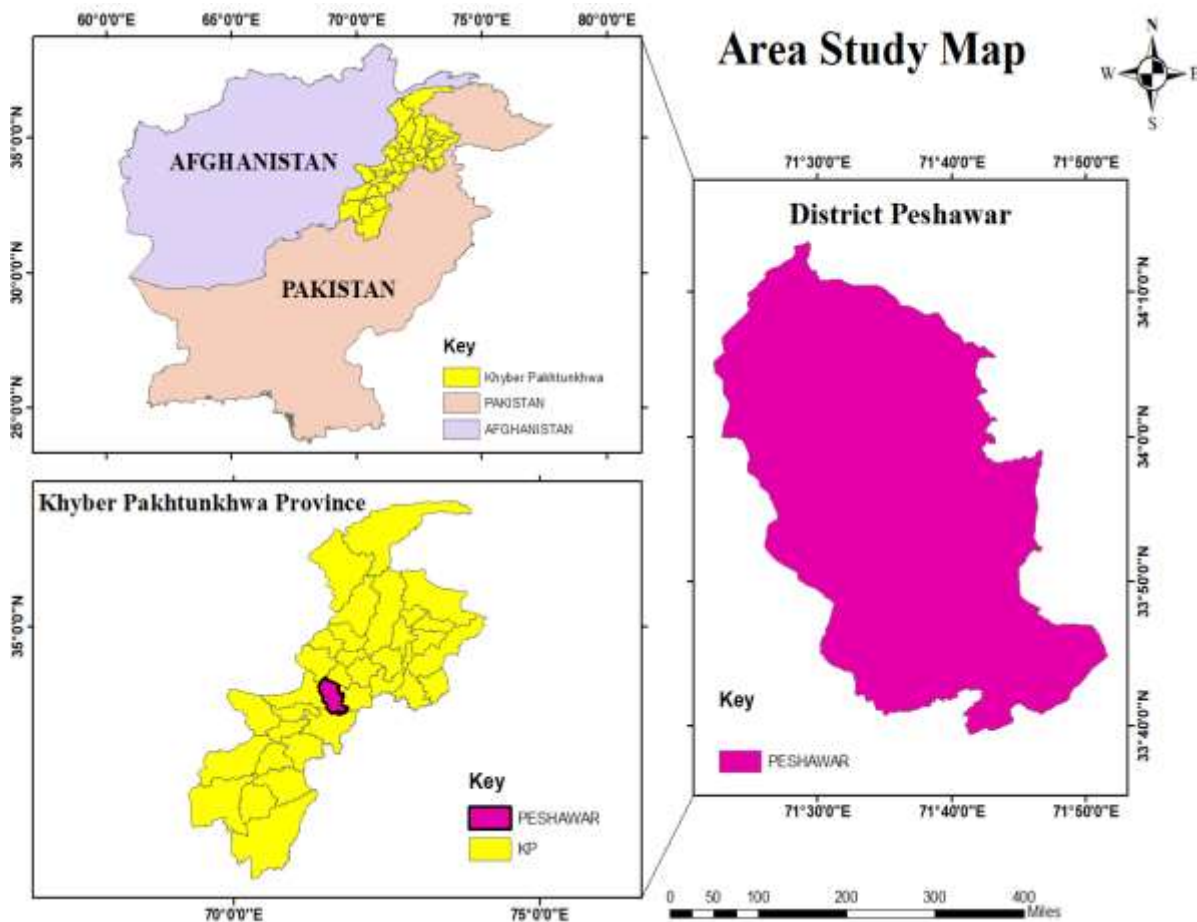


Figure 1: Area study map. This figure was originally published as Figure 1 in Iqbal, K *et al* (2024). A challenge in access to social services of undocumented Afghan immigrants in the host society of Peshawar, Pakistan. Discover Global Society. <https://doi.org/10.1007/s44282-024-00111-2>. Reproduced under the terms of the Creative Commons CC BY license.

Table 1: Demographic profile of narrative in-depth interview participants

S. No	Code	Occupation	Age	Marital Status	Housing	Family System	Stay in Pakistan
1	Story1	Housewife	39	Married	Rented	Joint	10 years
2	Story2	Housewife	30	Married	own house	Joint	7 years
3	Story3	House made	41	Married	Rented	Nuclear	15 years
4	Story4	Religious Teacher	52	Married	Rented	Extended	25 years
5	Story5	Housewife	43	Married	live-in camp	Nuclear	17 years
6	Story6	House Maid	46	Divorced	Rented	Nuclear	6 years
7	Story7	Cloth sillier	33	Married	own house	Joint	25 years
8	Story8	Religious Teacher	37	Married	live-in camp	Nuclear	20 years
9	Story9	Housewife	48	Married	live-in camp	Joint	4 years
10	Story10	Housewife	50	Married	Rented	Extended	9 years
11	Story11	House mad	30	Unmarried	live-in camp	Joint	4 years
12	Story12	Cloth sillier	38	Married	live-in camp	Nuclear	18 years

Table 2: Key informant interview profile

S. No	Code	Gender	Age	Marital Status	Family System	Role/ Status
1	KII1	Male	47	Married	Nuclear	Healthcare provider
2	KII2	Female	29	Unmarried	Extended	NGO employ
3	KII3	Male	45	Married	Joint	Community leader
4	KII4	Female	30	Married	Nuclear	Academician
5	KII5	Male	33	Unmarried	Joint	Lawyer

The interviews were conducted in Pashto and Dari and took around 70-90 minutes, depending on the study participant's knowledge level and experiences while sharing during the interviews. At the beginning, all participants were clear about the aim and purpose of the study and provided detailed information about their participation. They were then asked for their permission and willingness to proceed with the interview. Table 1.

Furthermore, healthcare providers, together with NGO staff and policymakers, participated in key informant interviews to understand institutional restrictions and policy voids facing Afghan migrant women; their details are shown in Table 2. They also provided guidance about healthcare solutions for this population. Women's personal experiences found confirmation through participant interviews with key informants who described systemic issues that validated structural realities. The research incorporates interviews with experts who discuss policy and institutional barriers that build upon the firsthand experiences of Afghan migrant women.

Moreover, the researcher and enumerators documented notes through fieldwork activities throughout meetings with hospital staff, community health clinic members, and irregular health providers. Participatory observation revealed essential nonverbal clues while confirming social relationships as well as environmental settings that increased the interpretive value of personal story analysis by demonstrating their real-life settings.

Data analysis and coding: Narrative approach

Research investigators recorded interviews together with key informants' interviews in field notes, transcribing the verbatim before performing English translations for analytical purposes. Researchers applied Riessman's (2008) approach, which involved three analysis steps: Attending to

Narratives, detecting women's methods of organizing healthcare stories through important events and challenging moments alongside their adaptive processes.⁴⁴ The analytical process explores verbal, vocal, and organizational aspects through which women present their challenges by recognizing recurrent statements alongside pauses and emphasized words that demonstrate intended meaning. The process examines how legal obstacles, gender-based norms, and institutional discrimination evolve throughout individual case stories. The narrative data were manually coded using an open, inductive approach informed by Riessman's (2008) framework, with emergent codes clustered into broader narrative elements as mentioned earlier. Coding was conducted by the first author and cross-verified by two trained qualitative researchers familiar with narrative and migration studies to ensure interpretive rigor. To enhance credibility, all coders independently reviewed a subset of transcripts and reached consensus through discussion on the interpretation of key narratives. Intercoder agreement was not quantified but assessed through iterative dialogue to minimize subjectivity. Triangulation was achieved through the integration of field notes, key informant interviews, and repeated reading of transcripts to validate the consistency of themes. Saturation was determined when no new narrative forms or themes appeared in the final three interviews, indicating conceptual redundancy and analytical closure. Social contexts receive analysis through narrative interpretation that demonstrates how healthcare exclusion operates within legal systems and gender-based power dynamics. This method used open coding rather than thematic classification to aid in understanding how subjects created meaning from their experiences and thereby demonstrated the influence of legal statutes, along with discriminatory treatment and patriarchal authority, on their healthcare-seeking choices.

Ethical considerations

The research adheres to serious ethical standards because the topic requires care, and the study population needs protection. Ethical approval was obtained from the Department of Sociology, School of Public Administration, Hohai University, Nanjing, China, prior to data collection. All participants received a complete explanation about the study through their language of preference. The research method utilized both written and oral consents for participation in the study. Participant data were received with total confidentiality through anonymization procedures and the elimination of all identifying information. The research team alone access to stored data that rests securely on protected systems. The researchers received training regarding sensitive topic management alongside the provision of support service referrals, such as mental health counseling, for participants experiencing distress.

Results

A sociological narrative analysis

The research provides outcomes from in-depth interviews with undocumented Afghan women migrants who reside in Pakistan regarding their journey to reproductive healthcare services. The study results that emerged from the narrative analysis of interview data present essential sociological factors discovered in the interviews. Authenticity is preserved through the consideration of direct verbatim statements obtained directly from respondents, which present their actual lived experiences from their expressions. An analysis of undocumented Afghan women immigrants' reproductive healthcare reveals four major connected narrative elements, which include fear and Legal Precarity as reproductive insecurity, discrimination and structural exclusion in a healthcare setting, gendered norms and silence of reproductive health autonomy, and coping strategies and everyday resilience in the face of exclusion. Figure 2 shows four major connected narrative elements with the emerged codes. Reproductive health vulnerabilities experienced by Afghan women immigrants in Pakistan emerge from the structural violence that combines with

legal exclusion along gender normative practices. This study uses intersectionality theory as described by Crenshaw (1989) and structural violence theory as Farmer (2004) interpreted narratives to produce sociological insights about Afghan women facing legal and social insecurity.

Fear and legal precarity as reproductive insecurity

The undocumented status creates fundamental changes in how Afghan women handle or refrain from accessing reproductive healthcare services. Many women choose to skip medical care or turn to untrained birth helpers due to their complete anxiety about deportation risks, together with police bullying and service denials.

“During the pregnancy of my second child, I faced excruciating pain while my husband recommended going to the hospital, but I refused due to my fear of being deported. What if they ask for papers? What if they call the police? The old midwife from my community attended my birth because I decided to remain at home” (Story, 12).

The story demonstrates that women refrain from using formal medical facilities because of their fear of legal threats to their protected status. These real-life stories demonstrate how legal uncertainties enter people's bodies to affect their maternal health choices while raising their potential health dangers. People who lack proper healthcare documentation must use inexperienced birth attendants who fail to provide adequate medical support for pregnancy complications, which increases the risks of maternal death and infant death.

“When I visited the hospital with a feeling that my baby needed care, the staff denied treatment based on missing documentation. I implored them, but they did not respond favorably to my plea. They knew that I couldn't take any legal action against them because of the documentation. Of course, I can't take it because I am worried that instead of them, I will be arrested. As a result, I lost my baby that night” (Story, 7).

This testimony proves how bureaucratic exclusion causes serious health threats because undocumented status acts as a dangerous barrier to accessing basic healthcare needs.

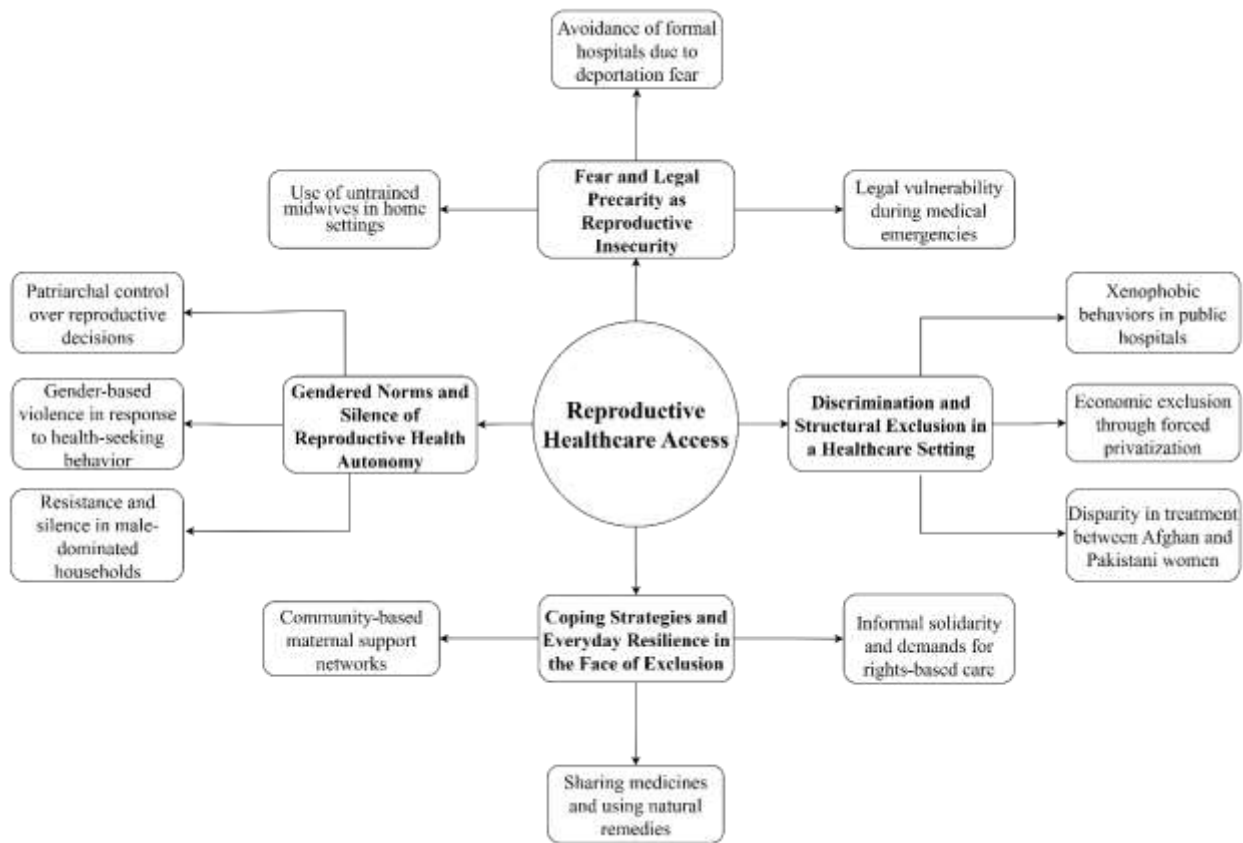


Figure 2: Major narrative elements and emergent codes of the study. Source field survey

Healthcare denial due to immigration status leads directly to preventable deaths that strengthen health inequalities. Caring institutions deny critical medical treatments to people because of missing documentation, which creates legislative breakdowns and prevents deaths that should not have happened that way.

Discrimination and structural exclusion in a healthcare setting

Afghan women must face verbal abuse, together with institutional discrimination toward them at public healthcare facilities while trying to seek care. Healthcare providers show xenophobic behavior that results in Pakistani citizens receiving better care with shorter waiting times, while Pakistani healthcare staff show disregard for Afghan patients. The discriminatory behaviors suffered by Afghan women appear in two forms: through institutional structures that create delays and poor service quality, as well as through individual medical staff

members who display dismissive attitudes. The healthcare system marginalizes and excludes migrant communities because of institutional discrimination in different healthcare processes.

“The healthcare provider examined me before remarking on how Afghans approach healthcare facilities like vulnerable individuals who should return to their place of origin. People in Pakistan tell us to return to our home nation. The wait lasted for many endless hours, although I suffered terribly from pain. After me, a woman of Pakistani nationality received priority medical treatment” (Story, 3).

The widespread xenophobic attitudes among American citizens demonstrate why undocumented Afghan women stay away from healthcare settings. They are thus dehumanized and treated with discrimination. When women experience discrimination in healthcare settings, they become unwilling to use medical facilities again, which

compounds their health risks and forces them to leave professional healthcare services. The public hospital functions as an institution where racial discrimination controls access to timely care by excluding those who are not citizens.

“Doctors don’t care about us. They understand completely that we lack all types of power and have no way to speak up. The government officials referred me to a private medical facility for treatment. How can we afford that? The healthcare staff seek to eliminate us from their facilities” (Story, 11).

The quoted testimony demonstrates how medical care became inaccessible because of economic hurdles from private healthcare services. Undocumented Afghan women face setbacks to their health because they cannot afford private clinics, so they must rely on casual healthcare settings operated by non-expert medical practitioners. Structural violence theory explains how healthcare institutions neglect undocumented women by sending them to expensive private healthcare facilities that they cannot pay for. These trends produce widened health inequalities between different groups and create the persistence of poverty together with poor health results.

Gendered norms and the silence of reproductive health autonomy

Patriarchy in Afghan family units creates major barriers that prevent women from obtaining reproductive health care. Participants referred to how male family members take over healthcare choices to block them from seeking individual medical care. Women face dual barriers to reproductive autonomy because patriarchy polices their freedom while also conforming to traditional gender norms about their healthcare autonomy.

“I wanted to visit a physician during my pregnancy, but my father-in-law insisted all female relatives deliver their babies at home without doctor assistance. Why do you need doctors?’ I had no other options since my husband, along with my father-in-law, supported his view” (Story, 5).

The tale proves that patriarchal family power restricts Afghan women from managing their healthcare choices independently. The subordination of women based on gender generates delayed medical care, which consequently heightens the possibility of problems during pregnancy. Gendered household leadership structures control how women reach healthcare, even without institutional blockages.

“When I wanted to schedule an appointment for family planning, the discovery by my husband triggered his extreme anger. He asked harshly when he learned about my intentions to prevent giving birth to his children. He hit me that night” (Story, 13).

The mentioned situation demonstrates how domestic violence serves as an additional challenge that prevents women from obtaining healthcare services. The above account demonstrates how gendered violence affects reproductive healthcare by dividing maternal health services into defiance and self-care. Women who seek treatment for reproduction, including birth control, tend to receive punishment from men who view their actions as disobedience. Reproductive health operates as a domain where men control women's bodies along with regulating their physical reproductive functions. These outcomes match worldwide discussions about reproductive rights, which show how patriarchal power systems prevent women from taking control of their reproductive destinies.

Coping strategies and everyday resilience in the face of exclusion

The structural barriers to healthcare access have not stopped Afghan women from formulating methods to survive their exclusion from official healthcare networks. Community-based healthcare systems, together with informal support programs and traditional healers, provide the available healthcare options for Afghan women. Broadcast healthcare networks function as safety mechanisms, yet they cannot match the requirements of systematic health services.

“The female members of our Afghan community support one another through mutual assistance. In cases of illness, we gather funds as a loan to secure care from a private medical setting for the affected person. People inside our community also share medicines among themselves while teaching fellow community members about natural remedy methods” (Story, 9).

The Afghan migrant community proves its resilient and cohesive nature through collective health care solutions that reduce the results of institutional negligence. Despite providing some support, these random medical systems create unstable health conditions for women by denying emergency treatments or qualified professional medical assistance.

“It would be beneficial to have clinics that patients could access while feeling secure. The medical profession must include providers who deliver human care without treating patients as offenders” (KII, 3).

This statement's central demand of Afghan women involves receiving medical services that provide both human dignity and equality. The statement emphasizes healthcare as a fundamental human right that should apply to undocumented women and demands new policies for dismantling public health service barriers that exclude migrant women. It presents reproductive healthcare as both a medical right and a fundamental need to achieve recognition and respect, and obtain justice and humane treatment.

Sociological interpretation: The intersection of legal status, gender, and structural violence

This investigation demonstrates how undocumented Afghan migrant women experience complete denial of reproductive healthcare access due to their immigration status, cultural gender roles, and discriminatory institutional practices. Legal insecurity and patriarchal domination, together with structural prejudice, structure an overwhelming barrier that strips these women of their right to medical attention.

According to structural violence theory, institutional inequalities cause pain to vulnerable populations when examined through these findings. The legal system functions to treat Afghan women as non-legal residents, and both formal and cultural structures limit the freedom of their bodies. Healthcare facilities tend to exacerbate discriminatory practices by denying refugee women access to resources and adopting xenophobic behaviors. The women demonstrate strong coping behaviors, yet these survival strategies stem from structural subordination because they need to depend on unofficial social networks instead of accessing their fundamental human rights. The analysis proves that reproductive healthcare services exist within a political realm that grants power to decisions about border control and gender identity, and citizenship. The intersectionality theory demonstrates how various forms of oppression, including legal status and gender, and ethnic elements, unite to create prohibitive healthcare systems. Sexual and reproductive healthcare accessibility for Afghan women represents a complex sociopolitical matter because it demands organization-level reforms and human rights-based solutions.

The healthcare system for Afghans marginalizes its most vulnerable populations by implementing legal and procedural restrictions while maintaining social barriers against Afghan migrant women. Despite the hazardous reproductive healthcare situation of Afghan women immigrants, they adapted various informal care strategies, such as traditional birth attendants, neighborhood support, community assistance, and other informal network support. The barriers, vulnerabilities, and access to reproductive health of Afghan women immigrants are shown in Figure 3. Besides, the resolution of their difficulties demands comprehensive healthcare reforms and gender-aware interventions that uphold reproductive healthcare services for all women with no regard to their immigration status. In addition, the analysis demands immediate legislative changes that break all barriers to healthcare access, eliminate institutional bias, and marriage-centric policies promoting female reproductive independence.

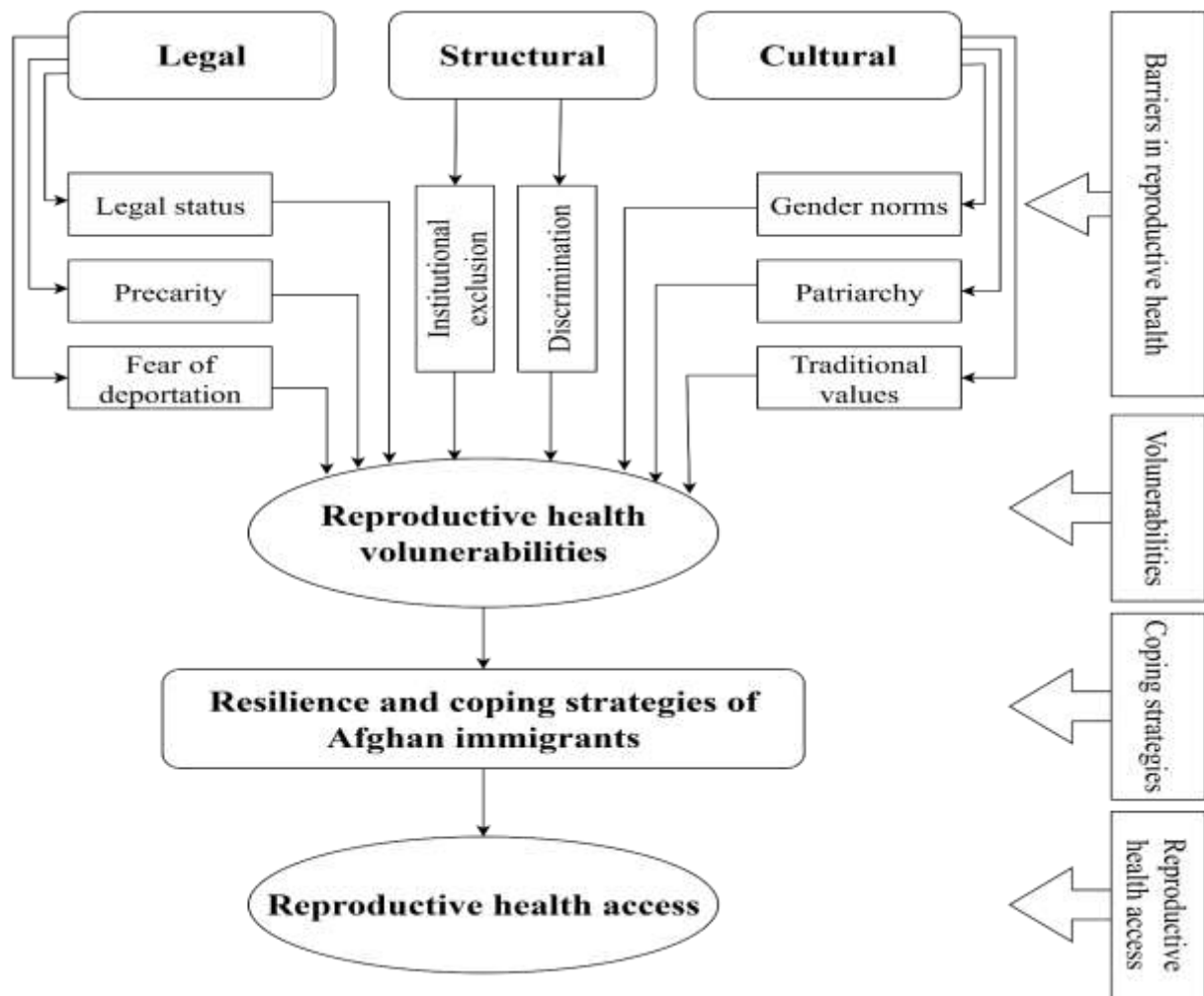


Figure 3: Barriers, vulnerabilities, and access to reproductive health of Afghan women immigrants. Source field survey

Discussion

Legal exclusion, gendered power, and the reproductive marginality of Afghan migrant women in Pakistan

The research evaluated how undocumented Afghan migrant women in Pakistan face reproductive health challenges due to their legal vulnerability, discriminatory institutions, and traditional gender-based social rules. The research revealed how female reproductive paths show intense connections to operating discriminatory frameworks within institutional structures.

Researchers uncovered those undocumented women encounter healthcare barriers that go beyond practical issues because they experience the expression of state authority through social systems that simultaneously reinforce gender inequalities. This paper analyzes these research results using the combination of intersectionality theory (Crenshaw, 1989),²¹ together with structural violence analysis,²² to understand how reproductive marginalization affects women within their social environment. This paper links its discoveries to current research about refugee health, migration governance, and gender inequality before suggesting ways to reform policies through rights-based approaches.

The stories prove that legal status serves as the main barrier that excludes individuals from the healthcare system. Fear of deportation, denial of service, and bureaucratic inaccessibility shape Afghan women's decisions to forgo essential maternal healthcare. The study confirms the findings of ³¹ from Turkey that undocumented status establishes substantive barriers in addition to symbolic dividers that separate migrant women from public health institutions. Study participants continuously portrayed healthcare centers as surveillance institutions instead of care facilities because undocumented status led to being unseen or labeled a criminal. The fear of legal risks compels undocumented Afghan women to seek home births with unqualified help instead of institutional care. Modern global health policy and the regulation of migrant bodies expose their treatment within medical facilities.

The health service practice of denying care to patients who lack Proof of Registration (PoR) cards represents a political exclusion policy through which they instill a belief that medical help should be restricted to exclusively fall upon citizens. The healthcare system's imposition of documentation requirements acts as structural violence, according to Farmer (2004), because it creates unnecessary suffering and death among undocumented patients. The mixture of discriminatory legal policies and nationalistic prejudice in Pakistan represents a complex problem for Afghan migrant women who have spent numerous years living in the nation without obtaining citizenship. The protection systems of UNHCR provide minimal legal protection to select Afghan refugees, but most undocumented women remain undocumented from healthcare services, which exposes them to increased reproductive health risks.⁴⁷ Studies support the essential argument that citizens should not need documentation to receive maternal healthcare services. The World Health Organization (WHO, 2019), together with the United Nations Human Rights Council (UNHCR, 2022), supports programs for total maternal healthcare provision toward all individuals without citizenship limitations because healthcare is an essential human right, exceeding privileges based on nationality.

Many Afghan women who reach public hospitals face dual problems because healthcare providers deliver racially biased treatment and practice institutional mistreatment of patients. The healthcare system of Pakistan uses implicit institutional xenophobia to keep migrants excluded from healthcare services, which reinforces their marginal status. Data showing medical discrimination against migrant and refugee women fits with worldwide research about undocumented women remaining away from specialist pregnancy care because of provider negativity, excessive waiting times, and refused care.^{48, 49} Research on African migrant communities across Europe demonstrates that medical professionals frequently understand migrant women as financial charges who only need assistance, but are not actual medical customers.²³ Research on Middle Eastern migrants in the United States demonstrates that healthcare providers neglect the reproductive needs of refugee women by assuming they lack independence in healthcare choices.⁵⁰ Afghan migrant women in Pakistan encounter additional barriers to healthcare access due to financial limitations and healthcare services moving from public to private ownership. Numerous surveyed Afghan women encountered private medical facilities that were out of their financial reach, as this pattern highlights the economic challenges faced by minority migrant populations. The situation regarding maternal healthcare accessibility in Rohingya refugee camps of Bangladesh,⁵¹ matches the findings since refugees deal with financial hurdles and discriminatory healthcare protocols. While parallels exist with refugee maternal health challenges in Bangladesh, similar structural exclusion is also evident across African contexts, such as among South Sudanese women in Uganda and Somali migrants in Kenya. In these cases, despite humanitarian support, many undocumented or displaced women rely on informal health systems due to bureaucratic delays, legal ambiguity, or limited public hospital access. However, a key distinction in the Pakistan–Afghanistan context lies in the protracted nature of displacement combined with the absence of refugee-specific healthcare policy infrastructure. Unlike East African countries, where refugee health services are often supported

through international humanitarian coordination mechanisms, Pakistan lacks institutionalized health responses for undocumented populations. This makes Afghan women's reliance on informal networks not just circumstantial, but structurally necessary. The absence of formal safety nets, combined with legal precarity and cultural marginalization, uniquely intensifies maternal risk in this South–South migration context. Healthcare facilities need to establish anti-discrimination policies as a solution to rectify systemic inequalities. The public healthcare system needs to provide cultural competency training for its staff to create anti-racist policies and develop initiatives for Afghan-speaking medical staff to expand healthcare accessibility to Afghan women. Healthcare institutions must make these institutional reforms to stop structural violence from exacerbating maternal health inequalities in medical care.

The study reveals both institutional and legal exclusion barriers, but emphasizes that inner household patriarchal dominance affects how people decide about their reproductive health. Women remain subject to restrictions in their movement as well as access to prenatal care and contraception through their husbands' or fathers-in-law's control and wider family cultural standards. Reproductive autonomy experiences heavy constraints inside private spaces through both non-violent and violent forms of control, according to the stories. Intersectional feminism firmly supports the idea that gender stands as inseparable from other forms of marginalizing experiences. The exposure of Afghan women to danger stems from how legal restrictions combine with their ethnic background along traditional male authority positions.⁵² Migration status, together with gendered power principles, intensifies exposure to reproductive risks for affected groups. Intimate partner violence functions as a leading barrier that hinders South Asian migrant women in the UK from accessing reproductive health services, particularly when spouses or in-laws reject contraceptive practices.^{53, 54} The observed data aligns with previous research about healthcare equity across gender lines in South Asian and Middle Eastern cultures that impede women from using prenatal services and family planning

options.⁵⁵ The research on undocumented migrant women in Canada confirms their inability to access maternal healthcare because their dependency on abusive partners remains strengthened through immigration status.⁵⁶ The research shows that women receive intimate partner violence (IPV) when pursuing family planning care, so reproductive justice needs to extend past service accessibility.⁵⁷ The concept of access in migrant health must include components of safety, consent, and autonomy, which do not receive sufficient attention in humanitarian or policy-oriented discussions. Any program seeking to advance reproductive health services for Afghan women requires the transformation of the extensive power dynamics that ascribe authority to men in the household and local domains. Community-based maternal health programs need to use gender-sensitive approaches as a solution for overcoming present challenges. The challenge of restrictive gender norms requires maternal health intervention through male education about reproductive health, together with women-focused health counseling areas and specific awareness programming on maternal rights. Humanitarian and non-governmental organizations must provide Afghan women access to private reproductive healthcare services to avoid any risk of judicial penalties or family-based repercussions.

Women who face exclusion from the healthcare system adopt various informal care strategies, which span from community assistance to the use of traditional birth attendants (dais). These coping tactics showcase solidarity, creativity, and resilience, but show how formal healthcare institutions have failed to protect equitable justice. The essential nature of community-based care does not eliminate the institutional duty of accountability. Findings highlighted how women share medical funds to maintain healthcare, which demonstrates community care, but also shows how marginalized groups face additional care responsibilities. These practices need structural support because they threaten to create instead of eliminate health inequities. Research on Sub-Saharan Africa and Latin America refugee settings demonstrates that informal healthcare networks occupy institutional gaps but struggle to handle maternal cases.⁵⁸ Integration represents the

fundamental solution because community networks need state backing to develop professionalism rather than handling state abandonment responsibilities. The essential safety services provided by informal healthcare networks expose women to severe dangers because they operate without professional medical care to handle prenatal issues. Research conducted by migration experts in Sub-Saharan Africa established those non-regulated midwives combined with birth services at home create significant risks for both maternal bleeding after birth and the death of newborns.⁵⁹ Studies of Syrian refugee women in Jordan indicate the rise of maternal sepsis and infant death rates because these women depend on community-based birth attendants.⁶⁰ National healthcare strategies should adopt community-based health interventions to connect formal and informal maternal healthcare services. Governments and NGOs should provide professional training to traditional birth attendants regarding emergency obstetric care. The establishment of mobile healthcare services for pregnant women should become available within refugee settlement areas. Community midwives should receive assistance from the hospital to direct their patients toward public facility healthcare. When healthcare interventions focus on integrating safe practices into informal medical networks, they create an effective solution to reduce maternal health inequality among undocumented Afghan women.

The current analysis helps grow existing research about health inequalities regarding migration while filling knowledge gaps that exist in the Global South region due to limited scientific studies. Research has extensively documented how undocumented female migrants face health inequalities across both the United States and European territories, yet insufficient studies focus on South-South migration patterns among Afghan migrants residing in structurally limited Pakistan. Furthermore, the introduction of a narrative approach in this research improves our understanding of empirically studied phenomena by focusing on original voices alongside their meaning construction and emotional dimensions, which policy reports and surveys typically overlook. The research shows how Afghan women create their

lived experiences by highlighting their personal decision-making power in the face of social separation between their agency and captivated concepts of strength. Moreover, the research findings demonstrate the acute requirement to advance migrant health investigations past epidemiological measurements into detailed intersectional and justice-focused studies that analyze systematic causes of exclusion.

Theoretical contributions: Reimagining intersectionality and structural violence in migration studies

Through its application of intersectionality and structural violence theory, the study both structures its findings while helping these concepts grow as theories. Through its analysis, the study demonstrates how legal status, together with non-citizenship, positions itself as the primary form of oppression that operates throughout Southern nations. This type of violence manifests in common areas of healthcare, including medical facilities, as well as within household environments. Legally undocumented women experience “slow deaths” Berlant⁶¹ as documented in the study through the interplay of legal documentation, institutional attitudes, and gender normative structures. The research offers a situation to highlight Afghan migrant women's stories to motivate theory development that both critiques and reflects lived experiences within specific local contexts.

Implications for policy and practice

The study produces essential theoretical and practical findings to grasp and manage reproductive health inequality experienced by undocumented Afghan migrant women in Pakistan. The study generates knowledge for sociological migration research combined with gender and healthcare access patterns and assists in developing maternal health policies targeting vulnerable groups.

Social and feminist theoretical knowledge expands through empirical testing that demonstrates how migrant women experience healthcare disadvantages because of their legal standing, combined with gender and institutional restrictions. This work demonstrates the extension

of intersectionality theory (Crenshaw, 1989),^{62,21} and structural violence theory,²² when researching undocumented migrant women's reproductive health experiences. Research data indicates that reproductive health gaps worsen when the legal system, ethnicity, and societal gender rules work together. Multiple forms of marginalization affect Afghan migrant women because these systematic barriers deliberately limit their access to maternal healthcare services. Researched studies about healthcare exclusion among migrants in Europe and North America show that undocumented status, along with racial discrimination, creates barriers to care. This investigation builds intersectionality scholarship by establishing legal status as an independent systematic form of discrimination that blocks healthcare opportunities.

The study demonstrates that legal status provides the same level of authority as gender and race in creating health inequality between groups and shows a similar impact as other traditional variables. Research should continue investigating what happens when legal precarity meets other health-determining social factors to create multi-level vulnerabilities within migrant communities. In addition, through analysis, the study demonstrates that healthcare institutions function as exclusionary frameworks that discriminate against undocumented Afghan women. According to Farmer (2004), structural violence exists as inherent discriminatory elements found within legal frameworks, economic structures, and healthcare institutions that lead to the disproportionate harm of marginalized populations. Pakistan's healthcare system produces active health equity disparities that manifest as follows: The recording process for obtaining entry to public healthcare facilities constitutes one of the main entry barriers. Discriminatory treatment by healthcare providers and financial inaccessibility of private maternal health services. Similar barriers exist in Global South healthcare systems because undocumented migrant status interacts with economic marginalization to create healthcare access barriers. The study demonstrates that medical exclusion from care stems primarily from migration regulations and health service privatization systems. The study demonstrates that maternal health gaps among Afghan migrant women go

beyond medicine since these problems stem from the sociopolitical framework of local reproductive healthcare systems. Migrant healthcare requires both healthcare reforms and legal protections, and anti-discrimination policies, which should establish migrant health as a basic human right.

Policy-makers, along with healthcare providers, should use these findings to design interventions and community services that aim at improving reproductive health services for undocumented Afghan women in Pakistan. Multiple strategies from policymakers and healthcare providers, together with humanitarian organizations, should include solutions for legal and institutional framework problems and cultural obstacles that stand in the way of maternal healthcare services. Since legal status determines the main access to healthcare, policy changes need to separate medical access from the need for legal documentation. Government entities, together with international institutions, should develop the following measures: The World Health Organization (2019) promotes, along with SDG Goal 3 Universal Health Coverage, a recommendation to provide essential maternity care, which should be available to all migrants. Public hospitals should allow undocumented women unrestricted access to maternal health care through the abolition of the documentation requirement of the PoR card. The exclusion of undocumented mothers from public hospital maternity care should end through the removal of childcare requirements associated with the PoR card. A legal structure that protects the healthcare rights of migrants and refugees must be established to prevent healthcare facilities from denying care based on citizenship status. Pakistan should implement healthcare access policies similar to Canada's Interim Federal Health Program (IFHP) which gives maternal healthcare to refugees and undocumented women who lack legal status. Pakistan should evaluate the implementation of such policies to reduce maternal death rates for undocumented Afghan women. Besides, public healthcare facilities in Pakistan must adopt several changes to defeat discrimination and exclusion patterns based on race. Nurses and physicians need cultural competency education to give fair and nondiscriminatory healthcare to Afghan women.

Medical staff who speak Afghan should work in healthcare facilities to enhance speaking communication skills and help patients build trust in hospital services. The setup of maternal healthcare facilities focused on Afghan women's needs, NGO, and international organization management. Research conducted in Lebanon and Turkey demonstrates how healthcare facilities designed for refugees lead to better maternal healthcare results when they deliver specialized ethnic and cultural services. Pakistan can use a healthcare approach that matches the British model to remedy the systemic discrimination against Afghan migrant women.

Furthermore, the interventions requiring immediate implementation should address the reproductive health autonomy of Afghan women since patriarchal norms continue to restrict their decision-making abilities. Maternal health education programs need to reach both genders in populations through community outreach to change restrictive gender cultures. Women require protected health care forums where they can make choices about their health care with confidential contraceptive consultations available. Studies aim to support men in reproductive health education, and they teach families about maternal healthcare access through supportive relationships. Research supports worldwide maternal health efforts, including UNFPA's gender-wide maternal care initiatives in war zones that improve contraceptive delivery and eliminate sexual discrimination in healthcare. Moreover, the formal integration of informal healthcare networks that support undocumented Afghan women is necessary to improve both network safety and clinical effectiveness. Policymakers and NGOs should: Additional training for traditional birth attendants who provide dais services about emergency obstetric care would lower maternal death risks. Community midwives should establish a system to direct patients toward public hospital care as a way to enable rapid medical treatment. The government should establish mobile healthcare facilities in Afghan migrant settlements to offer all maternal healthcare services at no cost to pregnant women throughout pregnancy and after birth. Research in Rohingya refugee camps across Bangladesh indicates the success of safe childbirth education

delivered to traditional midwives in decreasing birth complications. A corresponding program should focus on Afghan women in Pakistan to connect their healthcare needs between conventional medical services and traditional care models.

Conclusion

The findings from this research, based on narrative methods, demonstrated Pakistani institutions and social dynamics that systematically prevent undocumented Afghan women immigrants from accessing reproductive healthcare because of their legal status and gender hierarchy. The study delivers vigorous information about legal obstacles as well as institutional exclusions and gender-specific practices that influence the reproductive healthcare outcomes of Afghan women immigrants within Pakistan. This study confirms worldwide studies about migrant health disparities by showing how legal discrimination combines with structural prejudice and patriarchal customs as interconnected eradication mechanisms. Undocumented status exists as much more than a technical legal categorization since migrants directly suffer from its negative consequences, which produce panic responses alongside social isolation and medical service disruptions, leading to fatal results sometimes. The research applies intersectionality along with structural violence theory to show that healthcare barriers to reproduction exist as a result of structural mechanisms. Healthcare facilities operate as a subdivision of the state border enforcement system, which reallocates state control to serve national, ethnic, and gender exclusions. Systemic barriers to maternal health care require combined national and institutional policies that establish healthcare services as basic human rights instead of citizen-based privileges.

The study shows that undocumented Afghan women face the biggest healthcare access challenge because public hospitals refuse to provide maternal care except through Proof of Registration (PoR) cards. Migrant women encounter dual barriers to healthcare because of legal restrictions and because public healthcare institutions in Pakistan discriminate against them racially and treat Pakistani citizens differently. In addition,

within Afghan families, gendered restrictions prevent women from making independent reproductive health decisions because their male relatives block medical care access and extend abuse during attempts to get contraception and maternal healthcare. Women in Afghanistan seek maternal care from unlicensed traditional birth attendants, along with community midwives and hidden clinics, because their options remain limited by the increased medical risks at such informal healthcare centers. Furthermore, the findings of this research demonstrate that reproductive health extends beyond medical boundaries because it represents a political-social issue that develops through legal frameworks and institutional biases, and gender-based systems of power. The denial of health care to undocumented Afghan women during pregnancy in Pakistan exists as a multi-faceted problem because proper intervention must happen at structural and legislative, and community levels. Institutional xenophobia, along with legal insecurity, proves to be a major barrier preventing access to reproductive healthcare. However, women living in oppressive conditions still show strong determination by establishing informal care systems that involve shared coping mechanisms among them. Community and non-governmental organizations, along with formal health services, provide essential support to undocumented women, but they do not serve as suitable substitutes for comprehensive state-based inclusion programs. These developments make it necessary to immediately develop new policies that should protect dignity and basic rights for all. The conclusions from this study create manifold opportunities to enhance reproductive health care delivery for undocumented Afghan women residing in Pakistan.

The study implements intersectionality and structural violence frameworks to confirm how legal disenfranchisement, gender bias, along institutional discrimination create maternal health risks. The practical analysis shows healthcare professionals need to immediately implement fixes for inequities, including universal medical care accessibility, along with anti-discrimination systems in healthcare institutions and gender-specific medical approaches, and support for informal healthcare services. The study suggests

that undocumented Afghan women need improved maternal health outcomes in Pakistan, which can only happen through policy reforms and gender-sensitive healthcare, and inclusive models. The study also summarized that all individuals need protection for their reproductive health, including undocumented Afghan women, because reproductive rights represent fundamental human rights. The adoption of a rights-based, gender-sensitive approach is vital for Pakistan because it will enable maternal healthcare inclusion for undocumented Afghan women and create systems that embrace their experiences. To move from recognition to transformation, Pakistan must urgently decouple healthcare access from legal status, institutionalize anti-discrimination protections in the public health system, and adopt gender-responsive service models that respect women's autonomy. A national maternal health framework must guarantee care for all women—regardless of documentation—by embedding refugee-inclusive policies within public hospitals, scaling community-based clinics in informal settlements, and formally integrating traditional birth networks into the healthcare system. Without decisive policy action, the systemic denial of reproductive care to undocumented Afghan women will continue to violate basic human rights and undermine Pakistan's commitments to universal health coverage and gender equality. Reproductive justice cannot be deferred; it must become a central pillar of health reform in Pakistan. Besides, policy partnerships with NGOs, international donors, and civil society actors can also help mitigate resource gaps while building capacity for longer-term institutional change.

Study limitations and future research directions

Due to legal concerns, undocumented migrant women avoided joining the study. The recruitment process included involvement from local Afghan population members as a solution to this issue. Social desirability bias affects possible participant responses so researchers use rapport-building procedures to minimize distortion in their answers. The subjective nature of narratives introduces personal memory, while social and individual

preferences affect the data. The investigator validated the findings with their knowledge from key informants, along with their field observations, to overcome these issues. The study presents contemporary findings without investigating the effects on maternal health throughout time. Studies should implement extended research methods that monitor health progression over time. Furthermore, this research studies healthcare barriers through qualitative means, but it fails to present statistical information regarding maternal and infant death rates suffered by undocumented Afghan women. Research should advance by integrating qualitative human stories with official health statistics because this combination produces enhanced maternal health knowledge. Moreover, the employment of enumerators in the study might have brought challenges of interpretation bias, which occurred as enumerators' understanding of the study participants' responses is predisposed by their cultural backgrounds and perspectives. Therefore, the enumerators' interpretations may not completely align with the intended meanings conveyed by the participants. Building trust and rapport between the researcher and participant may be more complex and may limit the authenticity of the participants' answers during the interview process. Future research should prioritize three main directions following analysis of the study and research weaknesses: First, comparative studies examining maternal health among migrant groups, and second, longitudinal analysis of maternal and child health. Longitudinal Studies on Maternal and Child Health Outcomes – Six-month monitoring of undocumented Afghan women and their newborns over time would create essential health data about pregnancy problems and postnatal outcomes, thus enabling targeted maternal health initiatives. In addition, research should analyze legal frameworks and policy modifications that affect migrant women's reproductive healthcare access to determine their effectiveness in creating better outcomes. Furthermore, future studies could address IPV barriers to reproductive care and measure their occurrence among Afghan migrant women by developing care strategies that specifically support victims.

Policy recommendations

The investigation develops a strategic policy framework that unites reproductive justice principles with human rights and inclusive public health governance to address thorough reproductive health inequities faced by undocumented Afghan migrant women within Pakistani borders. This set of recommendations originates from both the observed narratives and theoretical principles, along with practical solutions applied to similar migration scenarios. Public health institutions must disconnect provisions of healthcare from proof of documentation status.

Pakistan should establish a public healthcare service provision model across all facilities that offers maternal health services to all women without asking for their legal status documents. This includes: All Pakistani public hospitals should remove Proof of Registration (PoR) cards as mandatory admission requirements. Public healthcare facilities must provide undocumented populations with both temporary health cards as well as community-based health IDs for identification. Healthcare institutions must establish legal protections that stop healthcare workers from alerting immigration authorities about undocumented patients. Institutionalize anti-discrimination mechanisms in healthcare. Healthcare providers require the necessary knowledge and education to identify and eliminate xenophobic mistreatment, along with ethnic discrimination methods. Recommended actions include: Every staff member within medical facilities needs to complete both cultural competency and anti-racism training programs. Patients should have access to complaint resolution systems that handle reports of discriminatory behavior. Health professionals with language fluency in Pashto and Dari should be hired to create better care experiences through enhanced communication with Afghan patients. Outfits must allocate funds to implement community-based and mobile maternal healthcare services. A program targeting marginalized populations located in informal settlements and underserved areas must implement these measures to succeed: Professional

medical staff should coordinate prenatal and delivery, and postnatal medical services through mobile healthcare units established for maternal care. The organization must work together with NGOs to build specific health clinics for undocumented migrants who live in urban and peri-urban areas. Telehealth services should be expanded to offer reproductive health counseling and native language education for patients. Standard birth attendants should receive training to participate officially within formal medical institutions. The existing system of exclusion has forced people to depend on informal care because there are no alternatives: Training must be provided to traditional birth attendants through programs that teach activities for safe delivery along with basic obstetric care. Dais and community midwives need to have established referral processes that lead them to formal health facilities when caring for high-risk pregnancies. Community health worker networks should develop bridges for connection between undocumented women who need institutional care.

The process of supporting gender-sensitive interventions must occur throughout reproductive healthcare services. Various measures should be implemented to overcome gender-based obstacles which will grant more autonomy to women. The implementation of public information initiatives should focus on presenting the vital significance of maternal healthcare and the prevention of unplanned pregnancies. Set up protected medical settings for reproductive counseling that concentrate on protecting vulnerable women against abuse by intimate partners violence (IPV). Twice a year organize educational programs involving religious and community leaders to teach them about altering patriarchal beliefs and building mutual responsibility in family planning. Legislators must adopt rights-based regulations that provide healthcare access to migrants. Policymakers need to approve legal frameworks that match international human rights standards as well as worldwide health guidelines for public healthcare.

Health policy experts should develop the Migrant Health Rights Charter which ensures all essential healthcare services for undocumented people. The UN and civil society organizations work together with the purpose of developing

monitoring systems for assessing health equity among migrant communities. The active involvement of migrant women in health policy development processes should occur to allow their insights to shape both program design procedures and implementation standards.

Conflict of interest

The authors declare that there is no conflict of interest regarding the publication of this article.

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Data availability statement

The datasets generated and analyzed during the current study are available from the corresponding author on reasonable request.

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Contribution of authors

Kashif Iqbal led the conceptualization, methodology, data collection, data analysis, visualization, and drafting and refining of the original manuscript. Hu Liang provided supervision, conducted literature review, formal analysis, and contributed to reviewing and editing the manuscript. Both authors reviewed and approved the final version of the manuscript.

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