Afghan Women's Pursuit to Healthcare Services

By

Aeisha Rahimi

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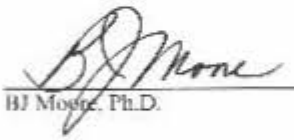

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Abstract

Challenges to accessing healthcare play a vital role in understanding the health inequalities and disparities that women face. Afghan women face many challenges in the pursuit of accessing healthcare. The purpose of this study was to understand the process from the perspective of Afghan women that have experienced differing environmental and cultural challenges. Interviews were conducted on eight Afghan women who live in the United States. The phenomenological research was to describe lived experiences and their responses were collected and analyzed. Three main themes and six categories were identified: 1) Cultural Norms, 2) Mobility, and 3) Affordability. Recommendations were based on the literature review, interviews and the results of this research. Recommendations included addressing community resources, affordable healthcare, education, and healthcare providers to improve quality of care for Afghan women.

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Chapter 1: Introduction

Background

Afghanistan is a landlocked-multiethnic country, located in the heart of central Asia and situated along important trade routes connecting southern and eastern Asia to Europe and the Middle East (seen in Figure 1) (Worldatlas.2017). The location has made it a prized possession going as far back as Alexander the Great, who invaded in 328 B.C. (Szczepanski, 2017). The Greeks were replaced by multiple other civilizations, including the Persians, until the invasion of Arabs in 642 AD, who brought Islam (Szczepanski, 2017). The Mongols invaded Afghanistan in 1220 AD. The descendants of the Mongols still remain in portions of northern Afghanistan forming the ethnic Hazaras (Szczepanski, 2017). The era marking the beginning of modern Afghanistan originated with the rise of the Durrani Dynasty in 1747; the Durranis were ethnic Pashtuns. Afghanistan remained a coveted region in "The Great Game" of the nineteenth century between Britain and Russia (Szczepanski, 2017). Afghan people remained resilient, fighting off invasion after invasion. Kings ruled the country until 1973 when Sardar Daoud proclaimed the country a republic (Szczepanski, 2017). The Russians recognized the instability and seized the opportunity by invading in 1979 (Szczepanski, 2017). The country never regained its stability and has experienced multiple regime changes leading to its current political climate.

Afghanistan's population is made up of multiple ethnic groups, resulting from descendants of previous reigns. The Pashtuns make up the largest number of Afghans at 42% and Tajiks and Hazaras form the next largest groups at 27% and 9%. The population of Afghanistan, according to most recent United Nations data, is estimated to be around 35.53 million people, less than the population of California (Dupree et al. 2017). Women make up

about 48% and men make up about 51% of the population (CentralStatisticsOrganization.gov, 2015). The majority of Afghans live in rural areas led by tribal groups with about 10% of the people residing in the capital city of Kabul (CentralStatisticsOrganization.gov, 2015).

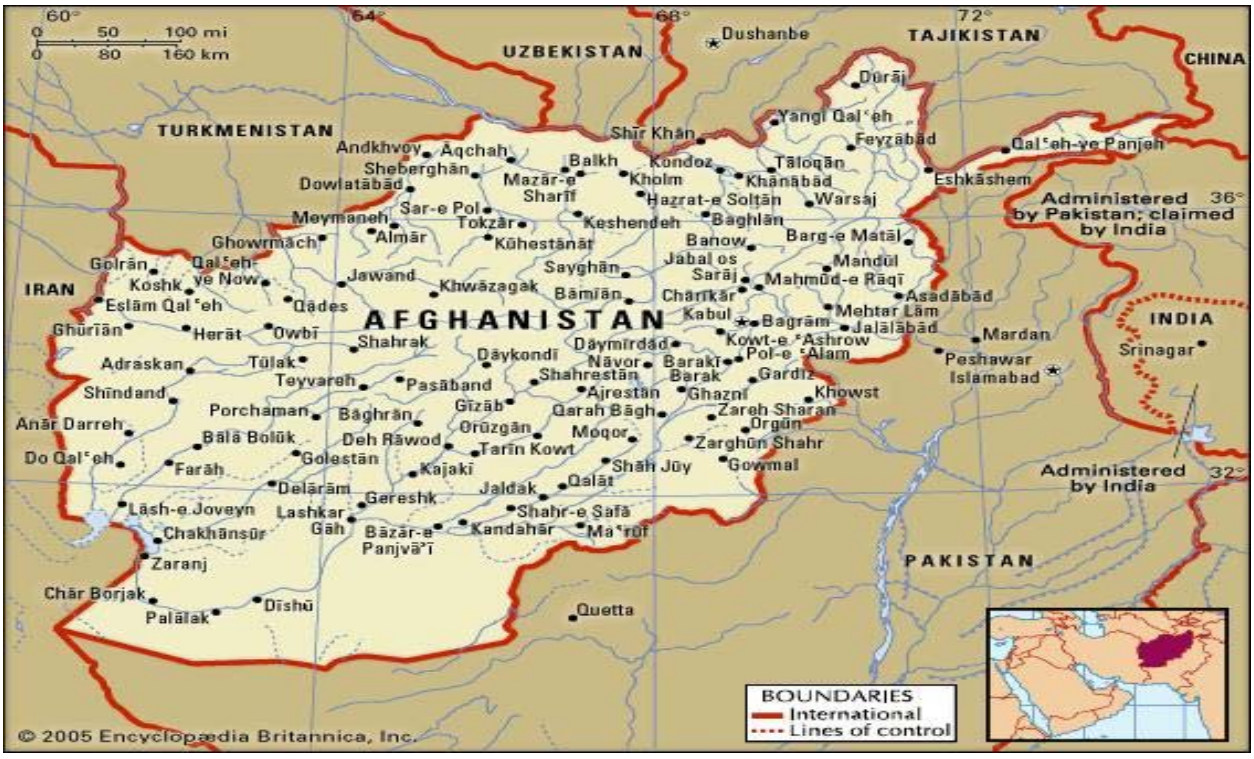

Figure 1. Map of Afghanistan (Dupress et al., 2017).

Afghanistan's two official languages are Pashto and Dari. Most Afghans are multilingual. Dari can be heard, as a common language, mainly in the central, northern, and western regions of the country. Dari is considered a modern dialect of the Persian language and is spoken as a first language by 49% of the population (Worldatlas, 2017). Pashto can be heard predominantly in urban areas located in the south, southwest, and eastern parts of the country. Pashto is spoken by 40% at a native level and 28% as a second language (Worldatlas, 2017).

Muslims account for the majority of the population of Afghanistan, with between 80% and 89% practicing Sunni Islam, while 10-19% are Shia (globalsecurity.org, 2012). In the 20th century, small communities of Baha'is, Buddhists, Christians, Hindus, Jews, and Sikhs lived in

the country. Most members of these communities emigrated during the civil war and Taliban rule (globalsecurity.org, 2012).

The current Afghan government was formed with the guidance of the United States after it toppled the Taliban regime. According to Institute for the Study of War (ISW), Several opposing factions met in Bonn Germany and as a result the Bonn Agreement was signed in 2001 (n.d.). Through this agreement, a new Afghan Constitution was written and approved by 2004 (ISW, n.d.). The new Constitution recognized Afghanistan as an "Islamic Republic." It established a democracy and called for the separation of powers under a presidential system, with a strong executive, a bicameral legislature, and a judiciary (ISW, n.d.).

Purpose and Importance of the Study

Challenges to accessing healthcare play a vital role in understanding the health inequalities and disparities that women face. Afghan women face many challenges in the pursuit of accessing healthcare. The purpose of this study is to understand the process from the perspective of Afghan women that have experienced differing environmental and cultural challenges. Access is about enabling a person in need to receive the right care, from the right provider, at the right time, in the right place, dependent on context (Frost et al., 2016). Afghan women's health is critical for societal development, both in Afghanistan and in the United States. While this need is commonly acknowledged, personal narratives are rarely considered when determining how the culture and environment impact Afghan women's pursuit of healthcare services. Nonetheless, without their respective personal input, well-intentioned health and education programs designed to improve health and well-being have often proved ineffective (Davlatshoeva, 2014). Current research has recognized several concerns for Afghan women attaining healthcare, including a high level of apprehension (Rabab, 2005) due to the culture and

environment (Miller, 2006; Cardozo, et al., 2005), deprived or non-existent health care services in ethnic areas, and limited mobility and inadequate educational opportunities under cultural Islamic traditions (Grima, 2002). The complexity of the health-care issues that Afghan women face is well established; however, the subjective recall of women's experiences of healthcare issues, especially in Afghanistan are not well understood (Gubrium, 2011). Little research, linking the impact of culture and the environment to Afghan women's pursuit of healthcare, has been conducted. Typical frameworks for explaining the complexities fail to adequately consider the important role social context plays, especially in Muslim countries, in influencing women's understanding of health issues. This knowledge gap leads to the research question: How does culture and the environment impact Afghan women's pursuit of healthcare services?

Chapter 2: Review of Literature

The goal of this research is to explore how culture and the environment have impacted Afghan women's pursuit of healthcare services. In this chapter, an analysis of multiple wars, spanning half a century, affecting Afghan women's health is thoroughly examined. This chapter explores the following five bodies of literature in order to situate this study: household, education, religious beliefs, social conditions and health. In addition, the literature of previous studies and the theory driving the research is presented.

Healthcare Structure of Afghanistan

Subsequent to a 10-year invasion and war with the Soviet Union from 1979-1989, Western interest and financial support for Afghanistan faded. Internal groups fighting for control of the land devastated much of the country's infrastructure; including what limited health care facilities existed (Accera, 2009). Exodus of trained, educated professionals was one of the main problems Afghanistan faced (Ruiz, 2011). The healthcare system was directly affected by the departure of those professionals and was left in shambles. According to the WHO, the continued war and conflict in Afghanistan has led to health workers' severe shortage mainly caused by out-migration, poor and unequal distribution in rural compared with urban settings, and lack of capacities for formal development of professional cadres (WHO, 2006). Subsequently, studies now show Afghanistan to be one of the unhealthiest countries in the world (Table 2). According to the United Nation Development Program (UNDP), Afghanistan is ranked at 169 out of 193 in the United Nations Human Development Index in 2015. Numerous infectious diseases such as diarrheal diseases, measles, acute respiratory infections, and malaria contribute to the burden of infectious diseases (Acerra, 2009). Also, malnutrition, psychological trauma, physical trauma, and human rights abuses are significant problems in the country (Acerra, 2009).

Table 2 *Health Indices in Afghanistan*.

	2015
Life expectancy at birth (years)	60.7
Adult mortality rate, female (per 1,000 people)	23.8
Adult mortality rate, male (per 1,000 people)	28.1
Deaths due to malaria (per 100,000 people)	0.20
Deaths due to tuberculosis (per 100,000 people)	44.0
HIV prevalence, adult (% ages 15-49), total	0.10
Infant mortality rate (per 1,000 live births)	66.3
Infants lacking immunization, DTP (% of one-year-olds)	18.0
Infants lacking immunization, measles (% of one-year-olds)	34.0
Under-five mortality rate (per 1,000 live births)	91.1

Source: Human Development Reports, (2015). UNITED NATIONS DEVELOPMENT PROGRAMME. Retrieved from http://hdr.undp.org/en/indicators/64306

Clinics, qualified health personnel, and other health resources are insufficient in number and mal-distributed (Ministry of Health, 2002). There are only 7.26 doctors, nurses, and midwives per 10,000 of the population (WHO, 2006). After the collapse of the Taliban in 2001, the health care system passed the conflict and emergency period and as of now is in the post conflict and developmental stage. The transitional Islamic state of Afghanistan and the Ministry of Public Health in 2003, provided emphasis on delivery of Basic Package of Health Services (BPHS) (WHO, 2006). The BPHS is the groundwork of the Afghan health system and has been the vital instrument in its development since 2001(Newbrander, 2014). The BPHS outlines the services that should be provided by every type of primary health care facility in the health system, essential health centers, clinics and district hospitals which specifies equipment, employees, diagnostic services, and prescription medications required to provide services for those in need (Newbrander, 2014). Ultimately, the BPHS is the basis for the primary health care system of Afghanistan and establishes its standards. The idea of implementing BPHS to undertake the most urgent health problems while rebuilding the health system was not a new

discovery, rather it had been established in other countries like Bosnia, Herzegovina, Cambodia Rwanda and Uganda (Newbrander, 2014).

Religion

The majority of Afghans adhere to Islamic principles and practice the mandate rituals on a daily basis. Islam is viewed as a way of life and governs aspects of behavior, politics, moral values, and modesty. There are various ways that Islam impacts the lives of Afghans, and healthcare is one of the most important. The Islamic Republic of Afghanistan is one of the soundest Muslim countries in the world, with 99.7% of the population practicing Islam (CIA.gov, 2017). Between 80% and 89% adhere to Sunni Islam, while 10-19% is Shia Muslims (Worldpopulation.com, 2018). According to the British Broadcasting Company (BBC), the title "Sunni" originates from the phrase "Ahl al-Sunnah", or "People of the Tradition" (2016). Shia Muslims are descendants of the followers of Ali who was the nephew of the Prophet Mohammad. Shias claimed that Ali was the rightful successor to the Prophet as a leader (Imam) of the Muslim community following the Prophets death in 632 AD (BBC, 2016). The main difference between the two sects in practice is that Sunni Muslims rely on the Sunnah, a record of the teachings and sayings of the Prophet Muhammad, to guide actions; while the Shias rely heavily on Ayatollahs, which are seen as an intermediary between God and man (Tasch, 2015). Both groups agree that Prophet Muhammad is God's messenger and follow the five pillars of Islam, which include the declaration of faith, five daily prayers, fasting during Ramadan, charity, and the Hajj, an annual pilgrimage to Mecca (Tasch, 2015). The two sects also share the holy book of the Quran, which Muslims believe to be the revelation of God.

It is believed that the recitation of the Quran has a therapeutic effect on the mind, body, and the heart. The Quran has specific guidelines on health and treatment of diseases (Athar, n.d.).

The Quran states "O mankind! Eat of what is lawful and good on earth" (2:168). "Eat of the things which God has provided for you lawful and good, but fear God in whom you believe" (Quran 5:9) Forbidden to Muslims are dead meat, blood and flesh of a pig (5:4), and intoxicants (Quran 5:93). Ingestion of pork is forbidden because it is believed to cause disease. Such verses and the practices of the Prophet Mohammad are guides for Muslims in many areas of life, especially healthcare.

Islam has a direct impact on Afghan culture. Afghanistan is a majority Muslim country; the conservative culture and the expectations of modesty can create a barrier towards the proper pursuit of healthcare for women. Modesty and respect is paramount, even at the cost of receiving proper healthcare. In rural areas, women need to be accompanied by a man to seek medical attention, which can ultimately hinder the woman's ability to pursue healthcare. A male doctor must ask the male guardian for permission to engage in physical contact with the female patient. Women may even forgo treatment if the only healthcare provider is a man. Ultimately, all healthcare treatments must comply with the stringent cultural requirements of Afghanistan for them to be effective.

Approaches in Healthcare

Afghans believe that good health is influenced and maintained through daily exercise, a balanced diet, and sufficient rest. Additionally, Afghans believe that health and illness are manifested in 3 distinct ways: a) illness and healing are viewed as being Gods will, b) Illness can be healed through reading the Quran, and c) Relevant verses from the Quran are written down and carried around by the sick (Merrill et al., 2006).

Health and illness are now approached using traditional western medicine practices and western medications in urban areas of Afghanistan (Merrill et al., 2006). Western medicine

utilizes doctors and other healthcare providers diagnosing patients and symptoms with prescription medications, surgical operations, various forms of therapy and radiation (Vandergrift, 2017). Doctors are usually university trained medical professionals who are revered and given high esteem. On the opposite spectrum of Western Medicine is Eastern Medicine, practiced by those in rural areas, which relies on the bond of mind, body and spirit (Vandergrift, 2017). Afghan Eastern Medicines rely on herbs, tea, prayer, and medicinal plants (Merrill et al., 2006). Such Afghans believe that the treatment of illness relates to the temperature of food and beverage (Merrill et al., 2006). For example, consuming food or drink that is cold would by contrast reduce a fever (Merrill et al., 2006). In both these regions, the women are the ultimate caregivers to the families. As result of all the challenges they face accessing Western Medicine, they rely mostly on the Eastern Medicine approach of herbal medicines, teas and temperature foods.

Family Structure

The family unit, whether nuclear or multigenerational, remains the single most important aspect of an Afghan's life. Within a typical Afghan household, an Afghan family will consist of extended members of the family, which include three or four generations that will all live under the same roof (Cultural Atlas, n.d). The home is designed in walled compounds, which contain small domestic units for each husband and wife, but the entire extended family shares a courtyard (Cultural Atlas, n.d). Afghan families typically involve the bride moving into the husband's home at the time of marriage, where the bride will learn to work alongside the other women and raise and educate the children together (Cultural Atlas, n.d). The men carry the financial weight of the family and have to support the entire household single-handedly, which includes the financial responsibility to support his wife, children, and any parent or in-law living

in the home (Cultural Atlas, n.d). Also, the brothers and sons are expected to contribute financially and support the family, protect, and discipline any misbehavior and protect the families' honor (Cultural Atlas, n.d).

Broadly, men dominate the public sphere and women only have authority in the domestic realm over the children and other women (Cultural Atlas, n.d). The senior male usually controls the household spending and the women are fundamentally responsible for the domestic chores, which include: food preparation, cooking, raising the children, entertaining guests and catering to the needs of the man of the house and health status of the families (Cultural Atlas, n.d). Mobility of women is dependent on the husbands because women are not lawfully able to drive and or leave the house without a male escort (Cultural Atlas, n.d). Consequently, if the husband is unavailable to the wife because of work or if transportation cannot be afforded, the wife is left without the ability to be seen by a healthcare provider.

Education

Education has a direct impact on women's pursuit of healthcare in Afghanistan. According to United Nations International Children's Emergency Fund, women who live in rural areas have low education levels, which lead to low levels of vaccinations and a high mortality rates (Pearlman, 2012). Generally, the urban areas of Central Afghanistan are where more-educated, wealthier women live and have higher instances of access to contraceptives, although still only about 30 percent of women use any contraception in those areas (Pearlman, 2012). The area with the lowest use of contraception use was the Northeast, a rural area (Pearlman, 2012). Lower levels of education tend to lead to a reliance on misinformation and home-made remedies. This results in mistreatments and unnecessary ailments and death.

Afghanistan's system of educational comprises of K–12 and higher education, which is

supervised by the Ministry of Education in Kabul, Afghanistan (Mohe.gov). There were at least 10.5 million students attending schools, a country with a population of 35.53 million people (Adina, 2013). Approximately 60% of Afghan students were studying in unprotected structures like tents, and some parents refused to let daughters attend schools in such conditions (BBC, 2007). A lack of women teachers was another issue that concerned some parents, especially in more conservative areas. Parents in conservative areas did not allow daughters to be taught by male teachers. Additional concerns for parents were the devastation and destruction of schools by the Taliban, especially schools for girls (Hicks, 2017). Following the obliteration of over 100 buildings which included schools in one year, many parents doubted the government's ability to protect the children (Hicks, 2017). All these unfortunate circumstances ultimately leave girls uneducated or undereducated. Women who are educated are less likely to suffer from common acute and chronic diseases (heart condition, stroke, diabetes, asthma) (Hernandez-Murillo, 2017). Consequently, the more educated people tend to be better informed and make better choices when it comes to health-related issues.

War

Historically, Afghan women have been marginalized, rendered subordinate status and directly impacted by war. The long years of war and violence in Afghanistan, has resulted in an unstable political and economic situation, which have had a particularly severe impact on women (Kaur, 2009). There were some attempts to introduce reforms to women's rights throughout the years; however, these were often met by strong tribal and religious opposition and resistance from conservative patriarchal forces, and later undermined during the Soviet War in the 1970's, civil war in the early 1990s and Taliban rule (Kaur, 2009). The rights of women were eroded even further when the Taliban came into full power in 1996. With such fundamentalist religious

forces taking the dominant position in society, the position of women suffered a major setback and even took a retrogressive turn (Kaur, 2009). During the rule of the Taliban, women were treated worse than in any other time. They were forbidden to work, leave the house without a male escort, and or seek medical help from a male doctor, and they were forced to cover themselves from head to toe (burqa), even covering the eyes (Kaur, 2009). Many families are forced to move into refugee or displaced person camps, where they wait for years in miserable circumstances for normal life to resume (Santa Barbara, 2006).

Since the present regime came to power in 2001, the political and cultural position of Afghan women has shown improvement to some extent. A robust policy framework has been put in place by the government for the welfare of women. Notable among the core strategic documents that make up this framework are the Afghanistan Compact, Afghanistan National Development Strategy (ANDS), and National Action Plan for the Women of Afghanistan (NAPWA) (Kaur, 2009). These developments have been successful in keeping the issue of women's empowerment high on the country's development agenda (Kaur, 2009). The decline in access, lack of hospitals, lack of healthcare professionals, lack of government provided resources to healthcare, creates major barriers to women's pursuit of healthcare in Afghanistan.

Exodus of Afghans

In the mid-20th century, Afghans began migrating to the United States for educational and professional purposes. According to Pew Research Center, the general estimate of Afghans living in the United States is roughly 300,000 (Krogstad & Radford, 2017). Most Afghans entered the United States in the 1980s in the wake of the Soviet invasion. Afghans were officially designated as refugees and granted political asylum (Eigo, n.d). About 2,000 to 4,000 Afghans arrived every year until 1989, when the Soviet Union withdrew its troops (Eigo, n.d).

As of 2007, about 50,000 Afghans have migrated to the United States with special visas. Recipients of these special visas served as interpreters or translators or performed other key jobs in Afghanistan for the U.S. government and in doing so put themselves and their families in danger (Krogstad & Radford, 2017). More than two-thirds of special immigrant visas have gone to Afghans since 2007 (Krogstad & Radford, 2017). The special visas were issued to the principal applicants and families that worked for the U.S. government. The special visas issued make up a small population, about 1% of the 300,000 Afghans residing in the United States (Krogstad & Radford, 2017). Top resettlement states from 2007 to 2017 include California, Texas and Virginia. Recipients of these special immigrant visas can receive refugee resettlement benefits form the U.S. government, which include 30 to 120 days of financial assistance. This resettlement agency assistance includes housing for the first 30 days, cash aide and assistance to healthcare and employment through the social services in the county the refugee is residing (travel.state.gov, 2017).

Theories that Drive the Research

In this research, two theories will be utilized to understand how Afghan women respond to the culture and the environment in an effort to obtain healthcare. The first theory, Andersen Behavioral Model of Healthcare, focuses on associations among stigma-related stressors, adverse experiences with culture and environment, personal and physician-related enabling factors, access, physical health needs, and healthcare utilization. The second theory, Maslow's Hierarchy of Needs, focuses on needs as motivators for human behavior. These needs are arranged hierarchically with base, physiological needs being the most essential and the most motivating; the fulfillment of these needs provides a necessary foundation so that higher level needs can be pursued (Actforlibraries.org, 2017).

The research study will examine factors in the Andersen Behavioral Model of Healthcare and it will also examine the principles of Maslow's Hierarchy of Needs. A series of multivariate and meditational analyses will be conducted to determine the connections among predisposing factors, enabling resources, needs, health beliefs, and behavior. Using the principles of Andersen's Behavior Model of Healthcare, and Maslow's Hierarchy of Needs, data will be collected and analyzed to explore how culture and environment impact afghan women's pursuit of healthcare services.

Behavior Model of Healthcare

The Andersen Behavioral Model of Healthcare, as seen in Figure 2.1, is a conceptual model, which demonstrates the factors that lead to the use of health services (Andersen, 1995). According to the model, usage of health services (including inpatient care, physician visits, dental care etc.) is determined by three dynamics: a) predisposing factors; b) enabling factors; and c) need. Predisposing factors can be characteristics such as race, age and health beliefs. Enabling factors can be family support, culture, access to healthcare, and the environment (Andersen, 1995). Need constitutes both perceived and actual need for healthcare. The model was formed to offer measures of access to healthcare. Anderson presented four concepts within access that can be viewed through the conceptual framework of the model. Potential access is the presence for enabling resources, allowing the individual to seek care as needed. Realized access is the actual use of care, shown as the outcome of interest in the model. Equitable access is driven by demographic characteristics and need whereas inequitable access is a result of social structure, health beliefs and enabling resources.

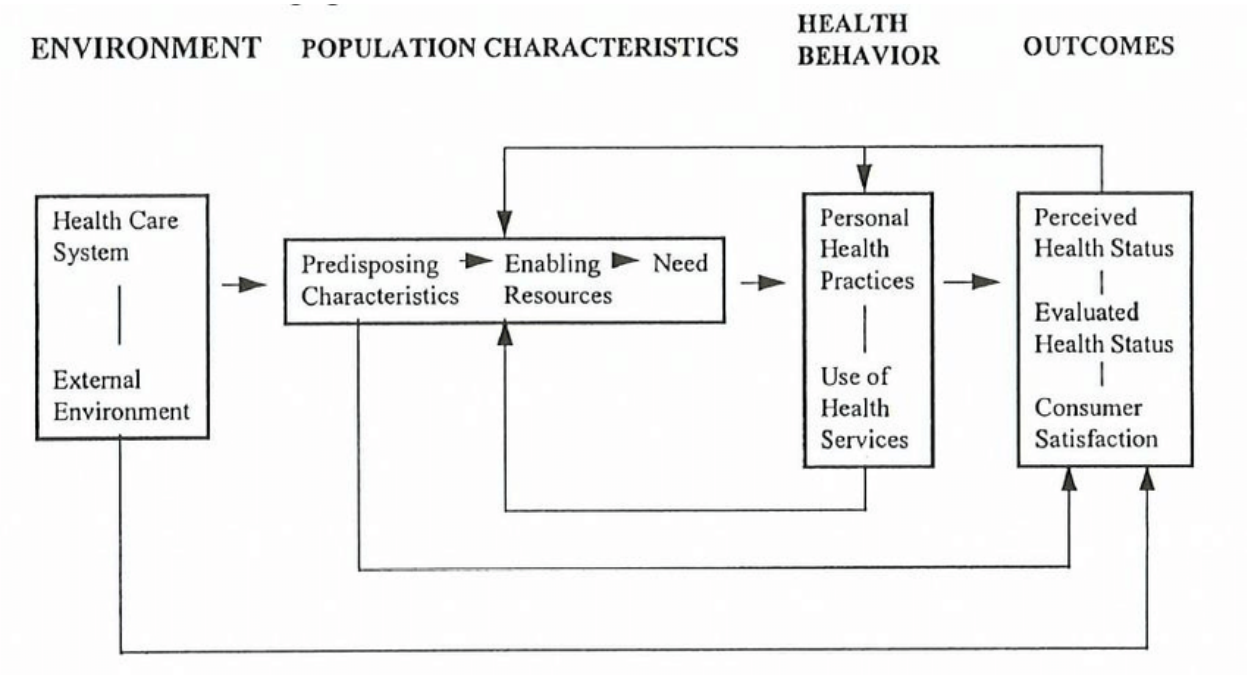

Figure 2.1. Andersen's Behavior Model of HealthCare. Retrieved form https://www.researchgate.net/figure/Andersens-behavioural-model-of-health-services-use-J-Carrillo-et-al-described-an_fig1_314285382

Maslow's Hierarchy of Needs

Maslow's Hierarchy of Needs, as seen in Figure 2.2, is a theory that identifies key motivators behind human behavior. Needs are placed in a hierarchical manner with the basic and most essential needs forming the basis. Maslow placed needs in the following order: physiological needs, safety needs, need of love and affection, need to belong, need for esteem and need for self-actualization (Bourne et. Al., 2010). All of the needs operate in an order of prepotency. In the hierarchy, one need has to be satisfied before the next level can be met. The theory can be used as a guide for understanding how humans fulfill the most basic of needs to obtaining greater needs such as love and happiness (Bourne et. Al., 2010). In the same manner, the theory can be used for gaining a more insightful perspective on how Afghan women pursue

healthcare.

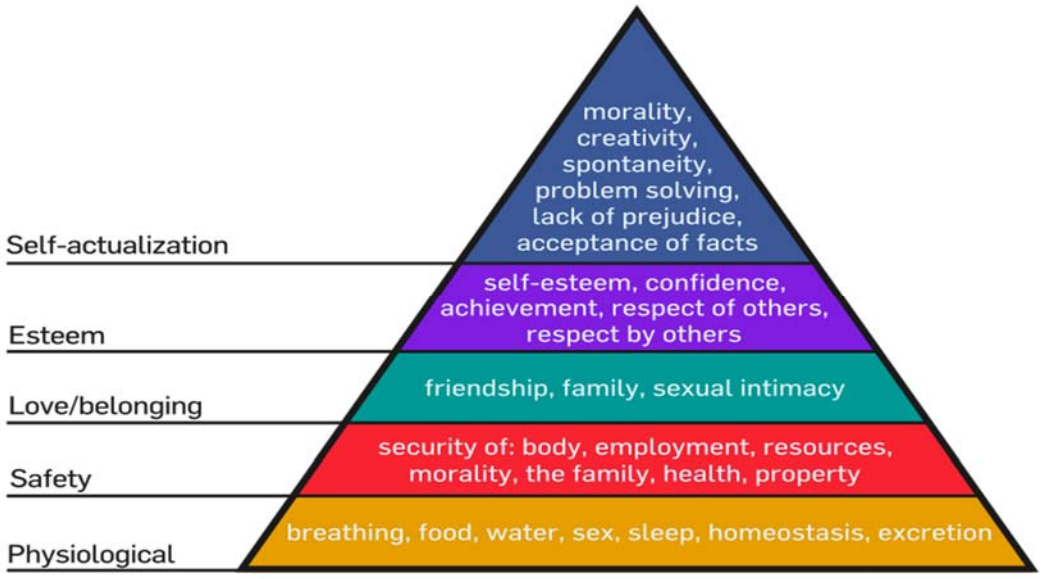

Figure 2.2. Maslow's Hierarchy of Needs. Retrieved from http://www.interfaces.com/blog/2013/09/health-human-rights-and-maslows-hierarchy-of-needs/

Chapter 3: Methods

The purpose of Chapter Three is to describe the research design and processes. The goal of qualitative phenomenological research is to describe a "lived experience" of a phenomenon (Waters, 2017). This approach is also appropriate because it includes the participant's experiences, attitudes and perceptions of health and war. Chapter Three contains the research method, research population, and method of data collection, snowball sampling method, research questions, data analysis method, internal and external validity, and the reliability of research instrument.

Sample Frame

The eligibility criteria for interviews will be Afghan women over the age of 18 years; who have lived in Afghanistan during times of war. In the interviews, the participants must speak English, Pashto and or Farsi. The exclusion criteria will be males, non-Afghan, under the age of 18, and non-English, Pashto or Farsi speakers.

Sample Size

To fulfill the purpose of the study, the sample size will include 8 to 12 willing participants utilizing the purposeful, snowball-sampling method, which will involve word of mouth, including suggestions and recommendations from all participants.

Data Collection

This research study will explore how culture and the Afghan women get their health care needs met in times of war using one collection method of "the long-interviewed method" (McCracken, 1988). Data will be collected during a 60-90-minute interview which may include more than one session, which will be conducted in-depth, face-to-face utilizing open-ended questions to understand the participant's experiences. The interviews will be conducted at the

location selected by the participants which may include their homes, café' and or library. Principles and guidelines for McCracken's *The Long Interview* will be utilized to maximize and standardize data collected (McCraken, 1988). A thorough explanation of the study will be introduced in the beginning of the interview. The researcher will use an interview schedule to guide the researcher in the interview process. (See Appendix)

Each interview will occur in a private location, where others cannot overhear the interviewer and the interviewee. The participants than will be given informed consents written in English explaining the purpose of the study, procedures, risks, benefits, confidentiality, compensation, contact information, voluntary participation and consent. During the interviews, the names of the participants will not be mentioned; before, during or after the interview. The participants will also be informed about the right to withdrawal at any time during the study and their right to refrain from answering any question during the interview. The participants will be informed that the interviews will be digitally recorded on a hand-held recorder and will be deleted as soon as the transcript is transferred to a password protected file on the computer. The participants will be informed that the conversations will ultimately be destroyed in accordance with the Internal Review Board after the textual material was transcribed, coded, categorized, and displayed in this work. All collected research data (journal and flash drive) when not needed, will also be stored in a double locked cabinet in Dr. BJ Moore's office in the Business Development Center Building at California State University, Bakersfield for three years. The names of the participants will not be used in any part of the research process including the interview and or transcripts. Instead, a code for each interview will be created. Audio files will be contained in folders under their coded name and will be in a separate flash drive used just for the data recorded, which the researcher will have access to the flash drive. The audio data

recorded will be deleted at the tie the research is acknowledged, followed by the flash drive being destroyed. The original recorded data on the digital recorder will be deleted after the transfer of data to the separate flash drive. The information scribed in the journal from the observations will not have any identifying information. The observation data will also be destroyed once the research is accepted.

Data Analysis

Data will be analyzed using content analysis, explain cultures and textual analysis to identify any common themes amongst the participants. Any data collected with sensitive information such as participants name will be removed and will be correctly transcribed into coded themes based on the interviews.

Institutional Review Board Approval

The Institutional Review Board is a committee chosen by CSUB to review and approve research projects that involve human subject researches. The primary purpose of the IRB is to protect the rights and welfare of human subjects involved in research activities being conducted under its authority (University of Pittsburg, 2017). Before the starting the research, the researcher completed the Collaborative Institutional Training Initiative (CITI) course followed by an exam. The researcher fulfilled the requirements of the CITI successfully with a passing score of 100%. With this passing score, the researcher is qualified to conduct a thorough research for this study. This research project required the participation of living individuals through interaction with the researcher, thus involving human subjects. Consequently, the researcher needed approval from the IRB. The application for the IRB required a detailed description of the study to analyze how human subjects would be involved in the research. See Appendix for approval letter and training certificate.

Limitations

This research study presents a time constraint that limits the capability of information obtained on this topic study due to the project completion date. This constraint has put restrictions on the amount of time that used in the research.

Chapter 4: Findings

The purpose of Chapter Four is to analyze the data collected from the interviews. Chapter Four contains themes and categories identified from the interviews and quotes from the participants.

Interview

In the spring of 2018, the researcher interviewed eight participants originally from different parts of Afghanistan. Qualitative responses to eight open ended questions with many specific themes emerging: 1) Cultural restrictions, 2) Mobility, and 3) Affordability. From the Cultural theme, 1 sub-theme emerged: 1) Gender roles. From the second them, Mobility, two sub-themes emerged: 1) Infrastructure, and 2) Transport. Lastly, two sub-themes emerged from Affordability: 1) No Work, and 2) Private Pay. A table of the themes and emerging categories are provided below (Figure 4).

Cultural Norms	Mobility	Affordability
Gender Roles	Infrastructure	Unemployment
Education	Transport	Out of Pocket

Figure 4. Afghan Women Perspective: Themes and categories identified from the interviews

Cultural Norms

A recurring theme from all of the interviews conducted showed the significant role that culture plays in all aspects of life in Afghanistan. From a young age, Afghan women are educated on the virtues of upholding cultural norms. This education goes beyond the home. It extends through school and social settings, helping Afghan women understand what is considered appropriate and unacceptable. The strong adherence to the established cultural norms result in the emergence of the following two categories: Gender roles and Education. As one of

the participants stated:

> It is different for women in Afghanistan because men dominate outside the home. I had the same responsibilities, but I did not have as much freedom to make decisions for my family and me.

Gender roles.

The differences between Afghan men and women have been created and are preserved through the observance of cultural norms. There is no dispute of the centrality of women in Afghan society. Respect for Afghan women is a notable characteristic that the culture values. The argument arises over the differing perspectives of what constitutes acceptable behavior for women. Afghan women have to uphold many expectations and are held to a higher standard as the cornerstone of a family. As mentioned in Chapter Two, Afghan women carry the honor of the family, the community and are controlled, as well as required, to maintain moral purity. The women are expected to be the keepers of their homes, which require them to prioritize domestic duties. These demands to maintain moral and domestic expectations result in the creation of restrictions that prevent Afghan women from receiving the best healthcare available. The cultural restrictions deriving from gender roles vary depending on the specific regions of Afghanistan. Regions that practice more conservative religious based values require that women minimize their contact with the outside world. This results in inadequate access to healthcare. Even in more progressive regions, women are expected to put the needs of the family over their own. Women sacrifice their healthcare needs to avoid burdens on the family.

> I was 16 when I got married. I went from my father's house to my husband's house. I was very young and I knew my responsibilities were to take care of my husband and his family.

Education.

Cultural norms also have a direct impact on the education that Afghan women receive.

Different cultural values are practiced depending on the region of Afghanistan. These values determine if an Afghan woman will go to school and for how long. In areas of Afghanistan where the women get married at a very young age, school is not considered a priority. There is much more emphasis placed on learning domestic skills. Even in regions of Afghanistan where there is a greater value placed on education for women, there are financial and safety restraints that permit women to receive only a limited amount of education. The insufficient knowledge that stems from an inadequate level of education leads many Afghan women to receive poor healthcare. They do not have the proper education to understand the importance of seeking appropriate healthcare. As a result, women attempt to combat illness and ailments with home remedies.

> I was lucky because I have a high school education and my parents wanted me to be educated. But I got married right after high school at 16. I really want my daughter to be educated and become a doctor here in the United States.

Mobility

Mobility creates different challenges for Afghan women seeking healthcare. A recurring theme from all of the interviews conducted showed that Afghan women were less likely to seek healthcare because of the difficulties in mobility. Women that seek healthcare are faced with a diminished infrastructure that is on the verge of complete failure. The roads are destroyed, the medical facilities are limited, the medical professionals are lacking, and the required resources to receive adequate healthcare are not available. There is very little public transportation in most parts of the country and a majority of the people have to walk in rough terrain to get access to healthcare. In most regions of the country it is considered inappropriate for women to travel on their own. Consequently, the majority of Afghan women do not know how to drive. Most women rely on a male relative for transportation making it that much more difficult to gain

access to healthcare. Afghan women are also expected to maintain modesty while outside the home. In certain regions, this means that they must wear a *burqa* in public. These requirements result in extra barriers for Afghan women seeking healthcare. If a woman feels traveling alone or going into a male dominated area of town will jeopardize their modesty, more than likely they will forgo any attempts to seek healthcare. The challenges that arise from mobility result in the emergence of the following two categories: Infrastructure and Transportation.

> I would wear my *burqa* before I walked out the front door. There were tiny holes in the top of the *burqa* to see through, but visibility was extremely limited. I wore it to prevent any undesired or unwanted attention while I was out of the house.

Infrastructure.

Decades of war, a harsh climate, and neglect have left much of Afghanistan's infrastructure in rubble, hobbling efforts to rebuild. Many homes do not have electricity or heat in the winter. Clean running water for drinking, cooking and cleaning, is not available for everyone creating a major public-health challenge. Underdeveloped roads hamper movement of goods to markets and make it more difficult for Afghan women to obtain healthcare, especially for those living in isolated villages. The devastated infrastructure results in a scarcity of medical resources and professionals making it virtually impossible for Afghan women to receive the proper healthcare.

> The roads are bad. When we went on the road in a taxi we were scared because the roads were in such a bad condition. I remember hearing of a bus flipping over because of the terrible condition of the roads. It is a great relief not to have to worry about such things when I am driving.

The consensuses throughout the interviews were how great the infrastructure is within the U.S.

> Here in the U.S. there are really no worries I have about the roads. The streets are clean and smoothed to drive on. I don't worry about my family's safety when we drive. It is very different than Afghanistan. The roads there are made of dirt and are unsteady.

Transportation.

Afghan women have difficulty getting to a healthcare provider because of the challenges they face in transportation. Societal values and a lack of safety require women to be escorted by a male family member when they are going anywhere outside the home. Even when they have met the social requirements to be outside the home, there are very few options for transportation. Very few areas provide public transportation and even those are considered unreliable. Many people do not own cars so the only remaining options are to walk or pay for a cab. The cost of paying for a cab are high so most people walk whenever possible.

> In Afghanistan I could not travel without a male escort. There was little safety and the roads were in bad condition. In the US, I am able to drive myself without worrying about being safe or needing to rely on others.

In the U.S, the participants came with a consensus of how transportation is somewhat difficult but a lot better than living in Afghanistan. In the United States, there are buses, Uber, affordable cars, and any other type of modes of transportation. all of the participants at this point owned 1 to 2 cars in their households. The women have driver license and drive their own cars. This was very liberating to them. In Afghanistan, the women did not drive, even though there is no law prohibiting Afghan women to drive, there is a stigma to women driving because it brings "shame" to the family.

> I am able to drive my own car, we can pay a taxi and we actually can walk to the hospital nearby. I don't have to wear a *burqa* when I walk, drive or leave my house, which is liberating. I feel a sense of freedom.

Affordability

Economic hardships are a major obstacle in the pathway of Afghan women seeking healthcare. A recurring theme from all of the interviews conducted showed that difficulties in affordability resulted in Afghan women not getting any healthcare or getting suboptimal care.

Most Afghan homes are single income families. The reliance on one income makes it even that much more difficult when the main provider, usually the male, is not alive or does not have a job. As a result of the ongoing wars in Afghanistan there are women who have lost their husbands. This is not only devastating emotionally, but also financially because the family loses the primary source of income. Most of these women have to move back with other family members or attempt to provide for themselves and their children in a dangerous environment. Even when there is a male figure capable of working it is still difficult to find employment. The work that is available is usually medial. The lack of financial stability makes it that much harder for Afghan women to obtain proper healthcare since most of the time it has to be paid for in cash. The challenges that arise from affordability result in the emergence of the following two categories: Unemployment and Self-Pay Healthcare.

> Thank God, my husband made enough money for us to afford doctor appointments. We had enough money for vaccinations and medications. We went to a hospital in Kabul, which is the best hospital around. We didn't want to go to the hospital a lot because we knew that it would end up costing our family a lot of money. When we came to the United States, thank God, we were very lucky that America helped us with our healthcare. My son was born in an American hospital with a hole in his lower back. He got surgery the next day and the doctors and nurses were so nice and wanted my son to be healthy. If my son were born in Afghanistan, I would not know if he would live.

Unemployment.

Gainful employment is very difficult to find in Afghanistan. In most regions of the country there is very little employment. The jobs that are available pay very little and are taken by men. The government is not stable, which leads to a volatile economy. There are many people competing for very few positions. This environment makes it very difficult for women in Afghanistan to pursue any type of employment. Even if they overcome the societal stigmas of working they still face the challenges of trying to find a job in a competitive market that has very

little to offer.

> Women would not think about working. It was not heard of to work especially in our family. I am grateful that I can work in this country without any shame. I wear my veil and work in the supermarket. I can contribute to our income and help my husband pay the bills. My husband supports me in my career choices.

Self-Pay Healthcare.

Most of the healthcare in Afghanistan has to be paid out of pocket. Any form of healthcare that can be obtained through subsidized assistance is insufficient and at time dangerous. This creates great barriers for Afghan women who are seeking healthcare. With the rampant unemployment and the inability for most Afghan women to have their own income, seeking healthcare becomes much more difficult. Most of the time the women will spend the limited funds on what they deem to be more critical needs such as food and clothing for the children.

> I needed to go see a doctor, but I waited because I did not have the money to pay upfront. It was hard because we only had one person in the family working so we had to spend carefully.

Discussion

The purpose of this study was to understand how differing environments and cultures impacted Afghan women's pursuit of healthcare. In Afghanistan, women faced various challenges, ranging from cultural practices, transportation and affordability as shown in Table 1. Those women were exposed to a different environment and culture once they migrated to the United States. While certain challenges, such as safety, were left behind in Afghanistan, new challenges emerged in the United States. The interviews revealed that Afghan women could adapt to a new culture and environment in their pursuit of healthcare.

According to Maslow's Hierarchy of Needs, when the women were in Afghanistan they sought to have physiological and safety needs met. The environment and culture forced them to

focus on meeting the basic needs, which include: food, water, shelter, sexual reproduction and shelter. The basic needs were not always met so women's efforts were consumed with seeking to fulfill those needs. Consequently, they did not have the ability to attain the higher needs. For certain Afghan women, seeking healthcare was considered a higher need and therefore, remained unfulfilled. In the United States, those fundamental needs were met. As the women spoke about living in the United States, the researcher saw a shift in Maslow's Hierarchy of Needs, displaying such things as love, acceptance and belonging. The women stated that since physiological and safety needs were realized they could pursue the attainment of higher needs. With the opportunities available, the women showed they could adapt and pursue greater needs such as healthcare.

Andersen Behavioral Model of Healthcare explains the dynamics Afghan women encountered while obtaining healthcare. All three dynamics played a direct role in determining if Afghan women sought and received healthcare. As previously mentioned, predisposing factors such as health beliefs have a major impact on how Afghan women seek healthcare. The other dynamics of enabling factors and need were just as important determinants. Once the women moved to the United States, the framework for the model did not change, however; the dynamics did shift. Health beliefs changed as the women began to assimilate to the new culture. The new environment brought greater safety and more opportunities to obtain healthcare. Even though healthcare needs would be neglected in Afghanistan due to cultural and environmental restrictions, the interviews showed that Afghan women were capable and willing to take advantage of the new opportunities in the United States.

Chapter 5: Summary and Recommendations

Summary

In the preceding chapters, the research assessed multiple interviews and the literature review to understand how culture and the environment impact Afghan women's pursuit of healthcare. The researcher determined that this subject is important for women and reveals that health care, education, cultural norms, employment, income, and mobility, are significant determinants for healthcare.

Recommendations

Based on the interviews and the review of the literature, three recommendations have been developed in effort to help improve how culture and the environment impact Afghan women's pursuit of healthcare.

Recommendations 1: Community resources.

While most Afghan women were eager and willing to adapt to the new environment, the process can still be difficult. Considering that Afghans live in a communal environment it would be very effective to provide resources to those communities to help promote proactive and preventative healthcare measures for Afghan women. It is at the community level that old beliefs can be dispelled through education. Providing educational pamphlets at the mosque can be a very effective method of reaching Afghan women. Offering presentations by healthcare representatives at community gatherings is another resource that can help Afghan women have a better understanding of the healthcare system in the United States. The more understanding they have the more likely they will be to seek healthcare.

Recommendation 2: Affordable Healthcare

While Afghan women are able to leave behind most of the challenges they face in

Afghanistan, the one that can still create obstacles in the United States is the cost of healthcare. Even if Afghan women understand the importance of obtaining healthcare and they are safe in that pursuit, they will not seek healthcare if the costs are unbearable. Affordable healthcare will help encourage Afghan women to seek the care they need in a proactive manner rather than waiting until they have no choice, which will result in increased costs due to emergency care and hospitalization. Local social service programs are a great way for Afghan women and their families to get the financial support they need to make healthcare more affordable.

Recommendation 3: Education.

As eager as Afghan women were to adapt and take advantage of the new opportunities provided to them in the United States, they would be extremely limited without education. Providing education to Afghan women offers many benefits. Education can help combat old beliefs, understand the new culture and environment, and provide confidence to take advantage of the resources available. Afghan women can be educated at night school or courses for adults. The courses do not have to focus strictly on healthcare. Any form of education will improve the possibility of Afghan women taking advantage of the healthcare system. If the women speak English they will be more likely to pursue healthcare because they will be better equipped to understand how the healthcare system works and better fit to use it through making appointments and paying for services.

Recommendation 4: Healthcare providers to improve quality of care.

There are many challenges that discourage Afghan women and their families from accessing or receiving quality health care in the United States. Broadly, however, the challenges include a complex array of political, social and health system-related rules and requirements, as well as factors relating to the culture of the patient, the family and the health care provider

(Caulford, 2014). Awareness of barriers to accessing healthcare can assist healthcare professionals to be sensitive to the challenges faced by their patients. Healthcare providers can overcome or reduce some of these challenges to improve patients' access and quality of care. Here are some steps that health professionals can take: 1) Educate and train staff about culturally competent care by Health care coverage eligibility for new immigrants, policies at local hospitals or clinics concerning eligibility and emergency care, and circulate clear guidelines for staff regarding care entitlements of different groups, 2) Provide support to new immigrant families accessing healthcare services by eligibility status, education on how to navigate the healthcare system and connect patients with primary care doctors and 3) Promote effective communication with new immigrants by understanding the importance of interpreters, educate about cultural dynamics and sociocultural perceptions of health and lastly, provide pamphlets and other healthcare materials in multiple languages (Caulford, 2014).

The researcher is a member of the Afghan community and will work closely with those communities to help overcome cultural and environmental barriers that Afghan-American women face in their pursuit of healthcare. The effort will be multi-pronged with an emphasis on education and resources. The researcher will work with the local community leaders to create educational brochures and pamphlets to teach and empower Afghan women and their families about the importance of seeking healthcare. The education will broaden into an understanding of the healthcare system and eligibility for different services. The researcher will help alleviate the burden of costs by introducing resources available for Afghan-American women. The process will further lead into connecting those women with social services such as; insurance, public transportation, interpreters, financial aid, settlement services, and legal agencies.

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Appendix A

Interview Schedule

1. Tell me about your life in Afghanistan
2. Can you tell me about some challenges you faced in attaining healthcare services during your time in Afghanistan?
3. What affected your ability to receive healthcare while living in Afghanistan?
4. What affected your ability to receive healthcare while living in the United States?
5. How have the conditions in the United States affected your ability to receive healthcare compared to the conditions in Afghanistan?
6. How has the American culture and its view on healthcare impacted you?
7. If you had to list three positive things about getting healthcare while living in Afghanistan, what would they be?
8. If you had to list three positive things about getting healthcare while living in United States, what would they be?

Appendix B

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Project Title: How have culture and the environment impacted Afghan women pursuing healthcare services?

PURPOSE OF STUDY

You are being asked to take part in a research study. Before you decide to participate in this study, it is important that you understand why the research is being done and what it will involve. Please read the following information carefully. Please ask the researcher if there is anything that is not clear or if you need more information.

I understand that the purpose of this non-experimental qualitative research study is to determine how culture and the environment impact Afghan women's pursuit of healthcare services.

Participation

I understand that I will answer multiple personal questions and will be interviewed by a researcher at a mutually convenient time and in a private location of my choosing. The initial interview will be in English and require 60 to 90 minutes and will be tape-recorded. I also understand that I may be contacted for a second interview to verify meaning and discuss findings.

CONFIDENTIALITY

I understand that this Interview and Survey will be confidential. I understand that every effort will be made by the researcher to preserve your confidentiality including the following:

- Assigning code names/numbers for participants that will be used on all research notes and documents.
- My name will not be used in any written records, reports and or presentations of the study findings.
- Keeping notes, interview transcriptions, and any other identifying participant information in a locked file cabinet in the personal possession of the researcher.

RISKS

I understand that I will experience a minimum risk, discomfort, or stress while participating in this study; however, some questions may be personal and though provoking, or emotional in nature. If I do become uncomfortable or hesitant during the interview, the interview process will be stopped immediately.

BENEFITS

I understand that this research study may or may not be of direct benefit to me. It has not been designed to provide direct health-related benefits to participants. Rather, it is hoped that the knowledge gained from this research study will help improve and promote Afghan women seeking health care services.

COMPENSATION

I understand that there is no compensation will be received for your participation in this study.

VOLUNTARY PARTICIPATION

I understand that my participation in this study is voluntary. I understand that it is up to me to decide whether or not to take part in this study. I understand that if I decide to take part in this study, I will be asked to sign a consent form that I fully understand. I understand that after I sign the consent form, I will feel free to withdraw or stop the interview at any time and without giving a reason and with no consequences.

PRINCIPAL INVESTIGATOR

Researcher:

Aeisha Rahimi
Phone: 925-305-6418
Email: arahimi@csub.edu
Department: Public Policy and Administration School of Business and Public
Address: 9001 Stockdale Hwy. Rm. 129. Bakersfield, Ca. 93311-1022

Lead Investigator

Dr. BJ Moore
9001 Stockdale Hwy. Rm. 129. Bakersfield, Ca. 93311-1022
Phone: 661- 654-3026
Email: bjmoore@csub.edu

Research Ethics Review Coordinator:

Dr. Isabel Sumaya
University Research Ethics Review Coordinator
Institutional Review Board/Human Subjects
Research Department of Psychology
California State University, Bakersfield, CA 93311-1099
(661) 654-2381
rerc@csub.edu

CONTACT INFORMATION

If I have questions regarding your rights as a research participant, or if problems arise, which you do not feel you can discuss with the Lead Investigator I can contact, Dr. BJ Moore at (661) 654-3026 Email: bjmoore@csub.edu. And I may contact Isabel Sumaya at (661) 654- 2381 Email: isumaya@csub.edu

CONSENT

I have read and I understand the provided information and have had the opportunity to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost. I understand that I will be given a copy of this consent form. I voluntarily agree to take part in this study.

Participant's signature _____ Date _____

Investigator's signature _____ Date _____

Appendix C

IRB Approval

CSU Bakersfield
Academic Affairs
Office of Grants, Research, and Sponsored Programs (GRaSP)

Mail Stop: 24 DDH Room 108
9001 Stockdale Highway
Bakersfield, California 93311-1022
(661) 654-2231
(661) 654-3342 FAX
www.csub.edu

California State University, Bakersfield: FWA00013908
Human Subjects Institutional Review Board

Date: 17 April 2018

To: Aeisha Rahimi, Student Investigator, Masters of Science Health Care Administration

BJ Moore, Faculty Advisor, Masters of Science Health Care Administration

cc: Roseanna McCleary, IRB Chair

From: Isabel Sumaya, University Research Ethics Review Coordinator

Subject: **Authorization for Protocol 18-21**

I am pleased to inform you that your protocol **18-21, "How Has Culture and the Environment Impacted Afghan Women Pursuing Healthcare Services,"** has been approved following expedited review. Authorization is based on the original protocol received on March 2nd, 2018, and your revision submitted on April 13th, 2018, in response to the reviewer comments.

This authorization is strictly limited to the specific activities that have been authorized by the IRB. In conducting this research, the investigator must carefully review the final, authorized, version of the protocol to ensure that the research is conducted as authorized by the IRB. If you want to modify these activities, notify the IRB in advance so proposed changes can be reviewed and approved. If you have any questions, or there are any unanticipated problems or adverse reactions, please contact me immediately. Use of the Psychology Department subject pool is not authorized in this protocol.

The PI is responsible for ensuring that all research personnel who participate in data collection and/or obtaining informed consent are HSPT-Certified and approved in the protocol. The following person[s], only, are authorized to interact with subjects in collecting data, in obtaining informed consent, or interacting with data having personal identifiers

Human Subjects Protection Training Certified:

Aeisha Rahimi: Student-CITI 3/2/2018 & BJ Moore: CITI-SBE 12/12/2017

This authorization will be valid until April 17th, 2019.

Continued on Page 2

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Academic Affairs
Office of Grants, Research, and Sponsored Programs (GRaSP)
Mail Stop: 24 DDH Room 108
9001 Stockdale Highway
Bakersfield, California 93311-1022
(661) 654-2231
(661) 654-3342 FAX
www.csub.edu

[IRB Protocol 18-21, Rahimi, Moore, Authorization Letter Page 2]

Any signed consent documents must be retained for at least three years to enable research compliance monitoring and in case of concerns by research participants. Consent forms may be stored longer at the discretion of the principal investigator [PI]. The PI is responsible for retaining consent forms. If the PI is a student, the faculty supervisor is responsible for the consent forms. The consent forms must be stored so that only the authorized investigators or representatives of the IRB have access. At the end of the retention period the consent forms must be destroyed [not re-cycled or thrown away]. Please destroy all audio tapes after scoring if applicable.

Isabel Sumaya, University Research Ethics Review Coordinator

Appendix D

Collaborative Institutional Training Initiative

CITI PROGRAM

Completion Date 13-Sep-2017
Expiration Date 12-Sep-2021
Record ID 24597320

This is to certify that:

aeisha rahimi

Has completed the following CITI Program course:

Students conducting no more than minimal risk research (Curriculum Group)
Students - Class projects (Course Learner Group)
1 - Basic Course (Stage)

Under requirements set by:

California State University, Bakersfield

CITI
Collaborative Institutional Training Initiative

Verify at www.citiprogram.org/verify/?w7c9d650b-d14d-4527-b4d2-60e90558591d-24597320