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SOCIO-CULTURAL FACTORS INFLUENCING DELAYS IN TUBERCULOSIS TREATMENT-SEEKING AMONG AFGHAN MIGRANTS IN RAWALPINDI, PAKISTAN

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Abstract

Tuberculosis (TB) is one of the key public health issues in Pakistan, especially in migrant populations who face numerous obstacles to access healthcare in time. Although free TB services are available, the fact that people take long before seeking treatment still sabotages the process of controlling the disease. The qualitative case study is focused on the socio-cultural and structural issues of delayed TB treatment seeking among Afghan migrants living in Rawalpindi District, Pakistan. The research was conducted based on the in-depth and semi-structured interviews of fourteen Afghan migrants and examined based on the thematic analysis with references to the complex theoretical framework that was based on the Health Belief Model, Social Determinants of Health, and Gender and Migration Theory. The findings suggest that the delays to treatment seeking are caused by multiple factors, such as displacement-related instability, insufficient knowledge of TB signs and services, stigma fears, gender-based mobility and decision-making limitations, and language barriers in the healthcare facility. The factors affect the recognition of symptoms, its disclosure, and access to formal care, which causes long delays. The paper points to the fact that TB treatment-seeking delays among Afghan migrants are socially entrenched phenomena due to structural vulnerability, but not to individual decisions, which implies the necessity of culturally competent, gender responsive, and migrant inclusive TB intervention.

INTRODUCTION

Although there have been tremendous improvements in technologies to diagnose tuberculosis (TB) and the accessibility of treatment, the delay in the diagnosis and seeking of treatment still jeopardizes the control of tuberculosis in the world (Shah et al., 2022). These delays are extremely damaging, with the main effect of worsening the severity of diseases, worsening patient recovery, and infecting others in the community (Cowling & Aiello, 2020). Those obstacles indicate that biomedical advancement is not enough to guarantee the prompt access to TB services.

The current research shows that the intricate combination of social, cultural, and structural factors determines the delays in seeking TB treatments. Lack of awareness about symptoms of TB and available healthcare services, poverty, self-medication, fear of stigma and low access to formal health services have all been cited as causative factors. Notably, such delays cannot be satisfactorily attributed to individual decisions and inabilities. Instead, they are

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integrated into more general social conditions, such as poverty, gendered power dynamics, and stigma at the community level, which affect the perception and the action of illness (Cowling and Aiello, 2020).

Migrant and displaced populations face an increased susceptibility towards TB infection as well as delays in getting treatment (Knipper et al., 2021). Displacement has often been linked with overcrowded housing, inadequate sanitation, low nutritional diet, and poor access to authentic health information, which not only makes the patients more vulnerable to TB but also pose a barrier to care. Alongside this, migrants tend to encounter language barriers, lack of knowledge of healthcare systems in their host countries, fear of discrimination or legal actions. These aspects may deter health services early interaction and cause long-term delays in the diagnosis and treatment (Zaidi, 2024).

TB has been a significant issue of public health in Pakistan with the country ranking among the highest TB-burden countries in the world (Abdullah et al., 2022). Afghan migrants constitute a significant proportion of Pakistan's displaced population, many of whom reside in urban settlements characterized by economic insecurity and limited access to healthcare services. Despite the fact that Pakistan has a National TB Control Programme that provides free TB diagnostics and treatment services, it has been observed that delays in seeking TB treatment is a significant problem among migrant population. Although the literature presents general impediments to TB treatment, the authors lack qualitative data in their work to understand the impact of intersecting social, cultural, and structural aspects on treatment-seeking behavior among Afghan migrants in cities (Zaidi, 2024).

This paper attempts to fill this gap by analyzing the lived experience of Afghan migrants living in Rawalpindi District. The study will help produce context-specific findings that can be used to inform more culturally sensitive and inclusive TB control by exploring the interactions between displacement-related instability, gender norms, stigma, language barriers, and limited health knowledge and their consequences in delaying the process of seeking treatment.

1. Objective of the Study

The objective of this study was to explore the social, cultural, and structural factors contributing to delayed tuberculosis treatment-seeking among Afghan migrants in Rawalpindi District and to understand how displacement-related experiences influence the timing of care-seeking.

2. Literature Review

Late-onset of TB treatment-seeking is considered a longstanding barrier to good TB control, especially in the low- and middle-income countries (Teo et al., 2021). Previous literature differentiates between delays in treatment seeking due to patient, and health system delays which occurs after patient comes to healthcare for TB treatment (Sabawoon et al., 2011). Although this distinction has been handy in mapping points of intervention, there is a wide range of studies which tend to consider these delays as individual choices as opposed to the processes that are interdependent. Consequently, a wider social context of the influencing behavior of patients and responsiveness of the health system is not adequately studied. More and more researchers argue that the delay in the treatment process should be viewed not as an outcome of personal negligence or the lack of motivation, but as a socially constructed one. (Biswas et al., 2018)

There is a significant amount of literature that has indicated a low level of awareness regarding the symptoms of TB, routes of transmission, and access to treatment as a major factor in delayed care-seeking. Research always indicates that the symptoms like persistent cough, fatigue, and weight loss are often perceived as small or non-lasting diseases, and people tend to rely on home treatment or medication themselves at the initial stages of the disease (Rahimi, 2021). Nonetheless, most of this literature follows a deficit based approach which places an emphasis on patient lack of knowledge without comprehensively discussing the issue of structural marginalization that inhibits access to credible health information. Poor awareness of free services on the diagnosis and treatment of diseases among the marginalized and displaced populations is an issue of low health literacy as well as poor integration between the migrant populations and health systems. This means that the perceived

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severity of illness and perceived benefits of early treatment are low and extends delays in seeking care.

Stigma of suffering from TB develops as one of the most frequently documented obstacles to seeking treatment on time. The stigma of being neglected by society, discrimination, and fear of infecting other family members makes people reluctant to publicize symptoms or seek help especially in societies with close-knit communities (Courtwright and Turner, 2010). TB in collectivist social contexts is morally coded as a display of weakness, impurity or self-failure which supports secrecy and avoiding of health facilities. Although a number of studies report on the existence of TB-related stigma, less are conducted on the dynamics of stigma that exist on the interpersonal, community, and institutional levels. Findings of qualitative studies also indicate that stigma is not only exerted by the environment but also internalized and influences the development of emotional reactions in the form of shame and fear which has a direct negative impact on prompt diagnosis and treatment assistance (Franz et al., 2010).

Migration and displacement have a close relationship with delayed TB treatment-seeking, but the patterns with which migration impacts care-seeking are not well examined. Migrants frequently have unstable accommodation, overcrowding, and lack of familiarity with the healthcare systems of the countries they are staying in, which all pose practical and psychological impediments to prompt care (de Vries et al., 2017). The fear of legal consequences, undocumented status and the mistrust towards the formal institutions further deter the participation in health services. Even though the literature recognizes these limitations, most of them are quantitative in nature as they measure the outcomes without sufficient investigation of the lived experiences of the migrants. Studies of the social support in the displacements have shown that the networks of communities are small and the mobility can further increase the delay in treatment by lowering the chances of sharing information and receiving help (Stewart et al., 2008).

Gender norms are a very significant but under-theorized factor in determining TB treatment seeking behavior. Patriarchal and migrant environments often restrict mobility, and right of choice over these women in terms of their health, which may postpone diagnosis and treatment (Gul et al., 2021). Migration-related insecurity and social surveillance among the migrant communities tend to escalate these limitations. Simultaneously, men can postpone the need to seek healthcare because of the perception of weakness, low productivity, and financial burden which is why gendered obstacles are both different and overlapping. Although these dynamics are acknowledged, gender is still being addressed as a demographic variable as opposed to a social process enshrined in power relations.

Another major barrier to early seeking of TB treatment among migrant populations is the language and communication barriers. Weakness in the host-country language will be limiting communication since it will mean that the individuals lack the capacity to present symptoms, comprehend healthcare guidance, and deal with sophisticated healthcare systems (Suurmond & Schouten, 2025). These obstacles promote embarrassment, mistrust, and fear of misdiagnosis and often result in the postponement or avoidance of formal health services among the migrants. However, most of the available literature is largely dedicated to the side of providers, and little attention is paid to how migrants solve their communication problems in healthcare interactions.

Indirect costs, such as transportation costs and lost wages, as well as economic hardship, also worsen delays in seeking treatment. In the case of people in poverty, healthcare is not a priority and more often than not is pushed to the back taking a back seat to urgent survival necessities, especially where the services are seen as a waste of time or otherwise too expensive (Stanikzai et al., 2025). Socioeconomic disadvantage does not work alone but rather it combines with stigma, low level of health knowledge and displacement stresses to produce cascading effects that enhance obstacles that support delayed care. Nevertheless, the research often divides economic variables out of their social context, which constrains the comprehension of the effects of financial insecurity on health choices in the long run.

Recent articles tend to underline that TB treatment-seeking delay cannot be associated with an individual determinant but arises as a consequence of the

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combination of various vulnerabilities, such as stigma, displacement, gender norms, language barriers, and economic hardship (Yang et al., 2023). Although this intersectional approach has been conceptually recognized, there is still limited empirical research, especially when it comes to the migrant population in cities. Qualitative research that summarizes the convergence of these aspects in real-life scenarios as a determinant of treatment-seeking patterns is notably lacking. The latter weakness is particularly apparent when it comes to the example of the Afghan migrants in Pakistan, which explains why the qualitative research into the social dynamics leading to delayed TB care requires deeper attention.

3. Theoretical Framework

The current research used a combined theoretical framework integrating the Health Belief Model (HBM), the Social Determinants of Health (SDH), and the Gender and Migration Theory to understand why Afghan migrants delay in seeking treatment against tuberculosis. Collectively, these ways of thinking theorize treatment-seeking delay as a socially constructed and contextualized process as opposed to a failure by a person.

At the personal level, the Health Belief Model describes the effects of perceptions in the determination of when to seek care. Low literacy on TB symptoms and access to treatment minimizes perceived severity and perceived benefits of treatment early and maximizes perceived barriers caused by fear of stigma. Without powerful action-related cues, people could postpone the process of seeking care until the symptoms are dangerous. Therefore, personal perceptions are influenced and bounded by the larger social settings.

At structural level, Social Determinants of Health model focuses on how health behavior is determined by displacement, poverty, insecure housing, and less access to information. The situations of refugees and migrants place one at structural vulnerability where healthcare access is limited and delays in the process. These determinants are beyond individual control and they systematically impact on the possibilities to receive care in a timely manner.

The Gender and Migration Theory describes the impact of gender norms, power relations, and migration experiences on treatment-seeking decisions at the socio-cultural level. The lack of mobility among the women and dependence on the male family members also hinder access to the health facilities as well as men have social norms in terms of their strength and economic productivity which may make them discourage early seeking of care. Mistrust and hesitation are further encouraged by language barriers and cultural distance between the healthcare provider and the patient. The migration status adds to these constraints by restricting social capital and institutional acquaintance.

This paper can offer a broad prism through which delayed TB treatment-seeking can be interpreted in terms of a meeting of individual perceptions, structural barriers, and socio-cultural values by amalgamating HBM, SDH, and Gender and Migration Theory. Such a framework is used to interpret the results of the qualitative analysis and justifies the necessity of multi-level interventions which can tackle beliefs and social conditions as well as systemic barriers.

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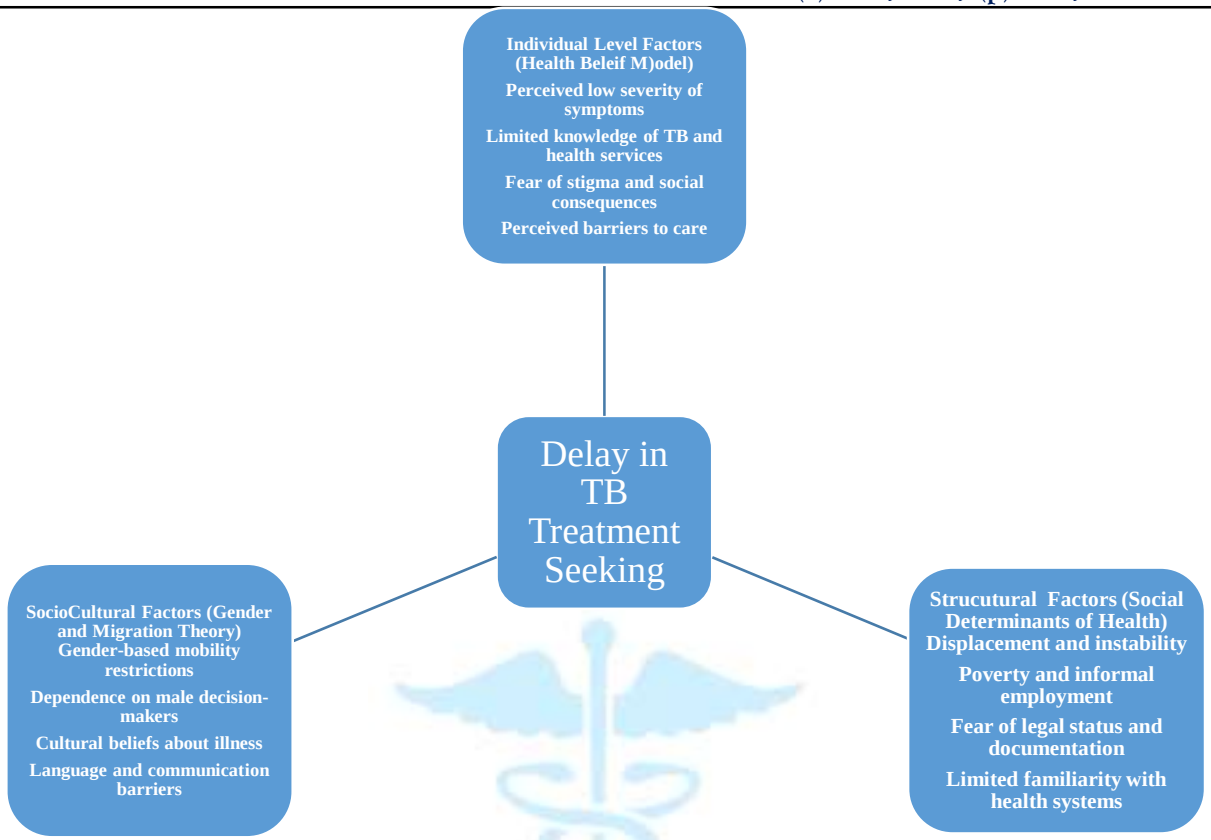

Figure 1: Theoretical Framework Explaining Delay in Tuberculosis Treatment-Seeking

This framework integrates the Health Belief Model, Social Determinants of Health, and Gender and Migration Theory to illustrate how individual perceptions, socio-cultural norms, and structural constraints interact to produce delays in tuberculosis treatment-seeking among Afghan migrants.

4. Research Methodology

This study adopted a qualitative case study design to explore the socio-cultural and structural factors influencing delays in tuberculosis (TB) treatment-seeking among Afghan migrants in Rawalpindi District, Pakistan. A qualitative approach was considered appropriate as it allows for an in-depth understanding of participants lived experiences, perceptions, and meanings attached to illness and healthcare-seeking behavior. The methodology was carefully aligned with the study objectives and theoretical framework to ensure coherence and rigor.

Philosophical Orientation

This research is supported by the constructivist ontology, which presupposes that reality is socially constructed and perceived by different individuals in different ways basing on their social, cultural and structural settings. In this light, delay in seeking treatment of TB is not considered as an objective or more or less temporal state but a subjective state of displacement, stigma and gender norms, as well as relations to healthcare systems.

Epistemologically, this research is based upon interpretivist approach, which focuses on the co-construction of knowledge between the researcher and the participants. This position acknowledges that the concept of treatment-seeking delay can only be comprehended in terms of migrants having interpretations of illness, risk, and health care instead of using objective time-related assessments.

Study Design

A qualitative case study design was chosen to capture the complexity of TB treatment-seeking behaviors

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within a specific social and geographic context. This design enabled an in-depth examination of how multiple factors intersect to influence delayed healthcare-seeking among Afghan migrants, while remaining sensitive to contextual realities.

Study Setting

The study was conducted at a tuberculosis (TB) center located in Rawalpindi District, Pakistan. Rawalpindi is an urban district that hosts a substantial Afghan migrant population residing in informal and low-income settlements. The setting was selected due to the coexistence of TB diagnostic and treatment facilities alongside migrant communities experiencing economic vulnerability, displacement-related instability, and limited access to health information.

Study Population and Sampling

The study population consisted of Afghan migrants who had experienced symptoms suggestive of tuberculosis and had sought, or eventually sought, TB-related care. A purposive sampling strategy was used to select participants who could provide rich and relevant insights into treatment-seeking experiences and delays.

Fourteen participants (n = 14) were included in the study. Selection criteria included Afghan migrant status, experience of TB-related symptoms, and willingness to discuss treatment-seeking pathways. Interviews were conducted until no new insights relevant to the study began to emerge. By the twelfth interview, participants were repeatedly describing similar experiences related to displacement, limited awareness of TB services, stigma, gender-related restrictions, and language difficulties. Additional interviews largely echoed these accounts rather than introducing new perspectives.

Given the shared living context and migration experiences of the participants, reaching saturation within a relatively small sample was appropriate for this qualitative case study. Two further interviews were carried out to ensure that the emerging themes were stable and well developed, bringing the final sample to fourteen participants.

Data Collection

Data were collected through semi-structured, in-depth interviews conducted between participants and the researcher. An interview guide was developed based on the study objectives and theoretical framework, covering topics such as perceptions of TB symptoms, duration of healthcare-seeking, knowledge of TB services, experiences of stigma, gender norms, language barriers, and displacement-related challenges.

Interviews were conducted in a language familiar to participants to facilitate open communication and comfort. Help of a translator was also taken due to researcher`s poor knowledge of participants language. Each interview lasted approximately 40–60 minutes and was audio-recorded with participants' informed consent. Field notes were taken to capture contextual observations and non-verbal cues that enriched data interpretation.

Data Analysis

Data were analyzed using thematic analysis following the six-phase approach proposed by Braun and Clarke (2006). This process involved: (1) familiarization with the data through repeated reading of transcripts, (2) generation of initial codes, (3) searching for patterns and clustering codes into categories, (4) reviewing and refining themes, (5) defining and naming themes, and (6) producing the final analytical narrative.

The analysis was inductive and interpretive, allowing themes to emerge from participants' narratives rather than being imposed a priori. However, interpretation of themes was guided by the integrated theoretical framework, enabling a deeper understanding of how individual perceptions, structural conditions, and socio-cultural norms intersect to produce treatment delays.

Ethical Considerations

Ethical approval for the study was obtained from the relevant institutional review authority. Prior to participation, all respondents were informed about the purpose of the study, the voluntary nature of participation, and their right to withdraw at any stage without consequences. Written or verbal informed consent was obtained from all participants.

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Confidentiality and anonymity were strictly maintained. Pseudonyms were used in transcripts and reporting, and identifying information was removed. Given the vulnerability of migrant populations, interviews were conducted with sensitivity and respect to ensure participants' comfort, safety, and emotional well-being.

Trustworthiness of the Study

To ensure trustworthiness, multiple strategies were employed in line with qualitative rigor criteria. Credibility was enhanced through prolonged engagement with participants and the use of verbatim quotations to support key themes. Dependability was strengthened by maintaining detailed documentation of the research process and analytical decisions. Confirmability was addressed by grounding interpretations in participants' narratives rather than researcher assumptions. Transferability was supported through thick description of the study context and participants, allowing readers to assess relevance to similar settings.

Table 1: Coding Process and Theme Development

Participant Statement	Initial Code	Category	Final Theme
"I kept coughing but thought it was just flu, so I waited."	Misinterpretation of symptoms	Low perceived severity	Limited Knowledge of TB and Health Services
"I didn't know where TB treatment is free."	Lack of awareness of TB services	Knowledge gaps	Limited Knowledge of TB and Health Services
"I tried home remedies first."	Self-treatment	Low perceived severity	Limited Knowledge of TB and Health Services
"People will avoid me if they know I have TB."	Fear of social isolation	TB-related stigma	Fear of Stigma
"I was ashamed to tell anyone about my illness."	Fear of disclosure	TB-related stigma	Fear of Stigma
"Without my husband, I cannot go to hospital."	Restricted female mobility	Gender-based constraints	Gender-Based Mobility Restrictions
"My family decides when I can see a doctor."	Dependence on male decision-making	Gender-based constraints	Gender-Based Mobility Restrictions
"Doctors don't understand our language."	Communication difficulty	Language barriers	Language and Communication Barriers
"I could not explain my problem properly."	Difficulty explaining symptoms	Language barriers	Language and Communication Barriers
"We moved many times, so I didn't know which hospital to visit."	Displacement-related confusion	Structural instability	Displacement and Instability
"I was afraid they might ask about my documents."	Fear of legal consequences	Institutional fear	Displacement and Instability

Table 2: Socioeconomic Profiles of Participants

Sr. No	Respondent No.	Gender	Age	Marital Status	Duration of Disease	Status
1	Participant 1	M	37	Married	2 months	Migrant
2	Participant 2	M	40	Married	3 months	Migrant
3	Participant 3	F	34	Married	5 months	Migrant

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4	Participant 4	M	35	Married	7 months	Migrant
5	Participant 5	F	28	Married	1 year	Migrant
6	Participant 6	M	46	Married	8 months	Migrant
7	Participant 7	M	42	Married	2 years	Migrant
8	Participant 8	F	38	Unmarried	4 months	Migrant
9	Participant 9	F	28	Married	5 months	Migrant
10	Participant 10	F	35	Married	6 months	Migrant
11	Participant 11	M	49	Married	6 months	Migrant
12	Participant 12	F	31	Married	5 months	Migrant
13	Participant 13	F	17	Unmarried	2 months	Migrant
14	Participant 14	F	26	Married	2 months	Migrant

5. Findings

This study explored the factors influencing delayed TB treatment-seeking among Afghan migrants living in Rawalpindi District. Analysis of interview data revealed five major themes: (1) Displacement and Instability, (2) Lack of knowledge about available medical facilities, (3) fear of stigma, (4) Gender-Based mobility restrictions, and (5) Language barriers.

All these themes combine to reveal the intersection of social, cultural and structural issues to determine the accessibility of migrants to timely healthcare.

The thematic analysis was applied to the data to analyze them in accordance with the six-step method described by Braun and Clarke (2006). This was done through an inductive approach that entailed familiarization repeatedly with the interview transcripts, creation of initial codes, clustering of codes into larger categories, and further development of themes to reflect common patterns of meaning in narratives of participants. The analysis was still based on an interpretivist standpoint such that, the themes were not forced on respondents but arose out of their lived experiences. The quotes of interviews are verbatim and are used in the whole part to depict themes and to keep the voices of participants.

Theme 1: Limited Knowledge and Misinterpretation of Tuberculosis Symptoms

The underlying similarity in all interviews was poor information about the symptoms of tuberculosis and existing treatment facilities. The persistent symptoms of coughing, fatigue, and weight loss are some of the symptoms that many participants initially dismissed as minor illnesses and only sought treatment later.

TB was considered to be a temporary, seasonal illness, as opposed to a serious infectious illness that should be treated with a high level of medical concern.

One respondent explained:

I continued to cough several weeks and I thought that it was a part of the flu or weakness. I did not suspect that it was something serious as TB; hence I waited and used home remedies.

(Male participant, 33 years)

This misunderstanding was further aggravated by the fact that they are not aware of free TB diagnostic and treatment centers. Some members did not realize the government hospitals offer free TB treatment which supported the delay of the formal healthcare involvement.

I was not aware that treatment of TB is free in the government hospitals. Had I known, I would have done it sooner and not wait and worry about money.

(Female participant, 29 years)

These testimonies show that low health literacy and access to the correct information were the major factors influencing the late treatment-seeking attitude of Afghan migrants.

The huge lack of awareness of the available TB services was the major one. Majority of the respondents were unaware of the locations of the TB centers and the fact that treatment of TB is completely free in Pakistan. This ignorance was not caused by negligence but was caused by inadequate outreach to the migrant communities.

Most of the migrants resorted to home remedies, local medical practitioners or over-the-counter drugs since they thought formal treatment would be costly

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or unavailable. Participants repeated that they had not been told about TB testing, treatment, and diagnosis process, or free government services. 3 said that we did not know that the treatment of TB was available in our locality. Such a gap in knowledge was a major cause of delay in treatment-seeking. It was the lack of accessible and clear information that many found to be the initial obstacle they faced, even before stigma and fear became factors.

Theme 2: Stigma and Social Isolation Fear.

The major social barrier that affected delay in taking treatment was the fear of stigma. The participants were worried that they were labeled contagious or morally tainted and this discouraged revealing of symptoms in families and communities. TB was linked to stigma, rejection in society and tarnished family image.

One participant shared:

"People begin to shun you when they learn that you have TB. They believe that it is contagious, and nobody wants to be with you. The fear prevented me to inform anyone about my disease".

(Female participant, 35 years)

Internalised stigma was another issue raised by another respondent:

"I felt ashamed. I thought that when others learn about it, they will criticize me or consider me as a weak person. Thus, I kept silent and continued to postpone visiting the hospital.

(Male participant, 40 years)

These stories illustrate the effect of stigma as an externality and internality and its effects on emotional reactions that have a direct impact on health care choices. The fear of being socially excluded decrease the desire of physical wellbeing.

Stigma was a strong and powerful influence on treatment-seeking decisions, although not the only source of emotional and social influence. TB was defined by the participants as a socially sensitive disease, which can be associated with shame, weakness, or impurity. This stigma was both at a community level and at an individual family level.

Women were afraid that TB diagnosis would decrease their marital bond with husband or could induce social isolation in migrant settlement. Men were afraid that they would stop being considered as strong providers and being judged as sick people who were unable to work. There are those participants who took a long time before informing even immediate family members of their symptoms. One of the widely shared interview ideas was that people will talk and this meant that there is a strong sense of apprehension towards gossip and judgment within the communities. Stigma was thus a silencing factor that was postponing the discussion of the symptoms and the use of medical attention.

Theme 3: Constraints of both Gender Mobility and Decision-Making.

Women could not easily find timely TB treatment because of the gender norms and power relations in the household. Women always indicated that they relied on the male family members to move around, be supported financially, and to make decisions concerning their health. The result of this reliance was rapid or no access to medical institutions.

One of the female respondents elaborated as follows:

I could not visit the hospital without my husband or brother. I must wait until somebody would consent to carry me even when I am ill.

(Female participant, 28 years)

Then, another respondent said:

In our family, men make decisions on where and when we will have a treatment. At times they tell them to wait or to first have medicine at home.

(Female participant, 34 years)

The stories emphasize how the structures of male-dominated families and limited movement of women serve as obstacles, especially to migrant women, to perpetuate gendered disparities in healthcare access.

Women were highly affected by gender norms on their access to healthcare. A great number of female participants told that they were not allowed to enter the clinic or hospitals without the permission or the physical presence of a male family member. When men were at work, busy, or away, they left women waiting; sometimes a matter of weeks. There also were cultural demands of modesty and domestic boundaries. Women were not always comfortable to go to public clinics by themselves and some were afraid to be asked or neglected due to them being migrants.

This theme emphasizes the fact that the decision regarding women health is often made at the family level not a personal issue. The restriction of

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movement of the women was a structural limitation, which greatly contributed to the delay of their seeking timely treatment of TB.

Theme 4: Language and Communication Barriers in Healthcare Settings

The language barriers were an important cause of unease, and distrust in the interaction in healthcare. A significant number of Afghan migrants have documented experiences of not being able to communicate symptoms because of poor proficiency in Urdu, which caused them to be afraid of being misunderstood, misdiagnosed or humiliated.

One participant stated:

Physicians communicate in Urdu very rapidly and I am unable to describe my issue in the appropriate manner. In some cases, I am embarrassed and hence I do not go back.

(Male participant, 37 years)

Another respondent added:

Due to language issues, I perceived that doctors did not listen to me. That is why I did not go back as my condition deteriorated.

(Female participant, 31 years)

Through these experiences, we can see that linguistic exclusion causes lack of trust in healthcare institutions and the discouragement of timely treatment-seeking, especially in displaced populations.

Another factor that was significant in the development of treatment-seeking was language. Urdu was a problem to many participants as they were nervous to talk to healthcare providers. This influenced their comprehension skills and symptom description skills. Some of them said that they felt embarrassed to ask a question or seek an explanation. Others were concerned that the healthcare employees could misunderstand them and even criticize them because they did not know how to speak Urdu. Language obstacles brought about some distance between migrants and the health system. Most people simply did not want to enter hospitals at all, and they had to negotiate in stressful situations, which added to postponing diagnosis and treatment.

Combined, all these five themes demonstrate that the delayed TB treatment-seeking behavior of Afghan migrants cannot be attributed to one factor but is a consequence of multiple social, cultural and structural problems interacting with each other. The barriers of displacement and instability, deficiency of knowledge, stigma, and gender restrictions, as well as language challenges, are the additional layers of complexity. These results show that a more encompassing, cultural responsive and migrant-oriented TB response is needed in the Rawalpindi District.

Theme 5: Mobility, Uncertainty, and Institutional Trembling.

Instability by displacement also contributed to delay of treatment. The constant movement, the unstable legal status and the fear of being documented led to uncertainty about the place and the possibility of seeking care or not. Respondents indicated the fear that by doing so they would be exposed to legal actions by formal institutions.

One respondent explained:

I did not know what hospital to attend as we changed residences quite often. I also feared that they could enquire about documents.

(Male participant, 42 years)

Another participant shared:

Due to the fact that we are migrants, we are constantly afraid of government offices. That fear saw me put off treatment even when I was all too unwell.

(Female participant, 38 years)

These results suggest that the delay in treatment is not only an individual decision but rather it is rooted in the structural vulnerability of migrants, legal insecurity, and marginalization experiences.

The aspect of displacement came out as the key underlying factor that influenced the health seeking behaviors of the participants. Migrant people reported to live in temporary or unstable structures, often changing the place of settlement, and not having the feeling of a long time security. Most of them told them that since they left Afghanistan, they were not concerned about the health, but survival, and adapting to new environment.

Participants indicated that since they moved around a lot, it was hard to acquire knowledge concerning the local healthcare systems. Others shunned hospitals because they feared that because they were

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illegal, they could cause problems. Some of them referred to Rawalpindi as a place that they were not familiar with, thus making them not to pursue formal TB care until symptoms made them sicker. In general, displacement resulted in a way of life in which health had been put second to everyday living. The unsteadiness interfered with continuity of health awareness, access or trust.

Discussion

This paper shows that the fact that Afghan migrants in Rawalpindi do not seek treatment of tuberculosis (TB) early is not caused by the negligence and absence of motivation, but by a socially institutionalized process predetermined by a combination of structural, cultural, and gendered limitations. The results indicate that the instability associated with the displacement, a lack of awareness about TB services, stigma, mobility obstacles based on gender, and language barriers all affect the interpretation, disclosure, and response to the symptoms. These findings echo the literature in the international community on migrant health and point to context-related issues that Afghan populations have to struggle with in Pakistan. Notably, treatment-seeking is a group choice influenced by family relationships, social norms, and structural exclusion and not an individual health choice.

In the view of the Social Determinants of Health, displacement also serves as a structural determinant that supports all the barriers. The experiences of regular movement, unstable housing and lack of familiarity with the host environment compromised the trust of formal healthcare systems among the participants and interrupted continuity of care. In line with SDH theory, these structural insecurities limited the ability of migrants to give emphasis to health in the face of other survival issues like employment, legal security and housing stability. Legal precarity and fear of being taken to immigration also worsened avoidance of public health facilities, which supports the existing literature that migrants tend to, postpone in seeking care despite potential access to these services. In this way, displacement is not just a material state but a psychosocial stressor, which has an influence on the perception of risks and involvement in healthcare.

Health Belief Model gives a valuable perspective of how the lack of knowledge regarding TB facilities led to delayed treatment. The insensitivity of the participants on the existence, free-of-charge, and convenience of TB services diminished the perceived advantages of early care and enhanced the perceived barriers. The risk appraisal was also misrepresented through misconception of TB severity and treatment, and this fact made many people neglect the symptoms at first or use informal care. Without culturally and linguistically specific health education, textual signals to action, e.g., to specific awareness campaigns, were still meager or unavailable. The findings demonstrate how structural exclusion in health information can weaken health beliefs of individuals and strengthen the waiting patterns of treatment among migrant communities.

Stigma turned out to be a potent social factor influencing health behavior and can only be construed by an amalgamation of the Health Belief Model and Social Determinants of Health. Perceptions of social costs of disclosure are increased because of the fear of social labeling, isolation and moral judgment, and are in most cases greater than the perceived health benefits of early diagnosis. Weakness, contamination, and social failure were also linked to TB, which led to secrecy and hiding of symptoms. These anxieties were not just individualistic in nature but a social construct created by the society and their standards. Thus, stigma served as an affective and interpersonal obstacle, which discouraged access to biomedical services, as well as strengthening delays patterns among other migrant and displaced groups.

The results also indicate that stigma is highly gendered which is consistent with Gender and Migration Theory, which underlines the aspects of the mediation of migration experiences by gendered power relations. Women were afraid of the consequences of contracting TB regarding the marriage, and the status of the family, whereas men were concerned with losing the right to provide for the family. These gendered fears influenced the different risk assessment and postponed care-seeking differently. Gender norms therefore affected the interpretation and management of TB in the households thereby supporting unequal health outcomes between men and women.

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Gender-based mobility constraint became a major obstacle to access of TB among women, which can be described best on the Gender and Migration Theory. The reliance of the female participants in the study on their male relatives to get permission, accompaniment, and finances restricted their autonomy when seeking healthcare. These limitations were enhanced by migration that diminished long-run kin organizations that could otherwise be used to access. Even in cases where the women were aware that the symptoms were serious structural dependency and cultural expectations did not allow them to visit the clinic in time. These results emphasize the fact that migration fails to dilute the patriarchal norms, but can instead strengthen it in the circumstances of insecurity, further entrenching the health disparities based on gender.

Their language barrier also increased the treatment delays through the diminishing efficiency of communication between migrants and healthcare professionals, supporting the findings of the Social Determinants of Health framework. Poor English and poor command of Urdu hindered participants to describe the symptoms, comprehending the diagnosis, and adherence to medical orders. Such linguistic exclusion led to the development of shame, dependency, and mistrust and deterred recurrent use of health services. Consequently, migrants usually turned to community intermediaries or they did not seek care at all, which demonstrates how the communication barriers become the structural inequity but not a personal failure.

More importantly, these barriers were not independent of each other but they interacted in complicated and reinforcing manner. The displacement increased legal insecurity and language barriers, absence of knowledge increased stigma, and gender norms increased the impact of mobility and communication restrictions. This interconnectedness makes sociological claims that health behaviors should not be viewed as independent variables but they should be viewed as part of broader lived realities. The paper relies on the theories of Health Belief Model, Social Determinants of Health and Gender and Migration Theory to emphasize that timely seeking of TB treatment among the Afghan migrants is created via the layers of structural vulnerability, social meaning making and gender power relations.

In general, the results demand TB interventions that go beyond individual awareness-raising to structurally and culturally responsive TB interventions. Outreach based on gender sensitivity, health communication in a language that fits the migrant culture, and healthcare policies that are inclusive of the migrants are necessary in curbing delays in treatment. This is because, unless there is a challenge to the social and structural factors influencing the health beliefs and choices of migrants, TB control programs will not be exhaustive enough among the displaced and marginalized communities.

Limitations

There are limitations of this study. The sample size and the qualitative case study design of the study restrict the extrapolation of the research in the context of the whole study. The study was also done in an urban setting which might not be a complete representation of the migrants in the rural or semi-urban setting. The study despite these constraints gives very valuable insights on the socio-cultural and structural processes that affect delays in seeking treatment of TB.

Conclusion

The paper has investigated the reasons behind the delay in seeking treatment of TB among the Afghan migrants in the Rawalpindi District. The results show that delays are defined by a complex of social, cultural, and structural obstacles. Dislocation led to the instability that deteriorated the relationship of migrants with formal healthcare systems and poor understanding of accessible TB facilities further constrained access. The fear of being stigmatized inhibited the openness of discussing the symptoms, and the gender-imposed mobility limitation impacted the access of women to care greatly. The language barriers enhanced a sense of apprehension and distrust in health facilities which added to more delays.

Altogether, the findings prove that the issue of treatment delay is not just a personal decision but a mirror of more general social facts that migrants in Pakistan face. These lessons underscore the importance of TB interventions which should

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acknowledge lived experiences of displaced people. There is a need to have a more culturally responsive, gender-responsive and accessible health system to enhance the outcomes of TB in Afghan migrants. Policymakers and health practitioners can collaborate to ensure that diagnostic delays and TB national response is reinforced by responding to the various layers of vulnerability that this study found.

The article proves that the delay in seeking TB treatment by the Afghan migrants is embedded in a mix of structural, cultural, and social obstacles. The results follow the general study of migrant health and point to context-related issues in Rawalpindi. To combat these obstacles, there is need to address these barriers through a multi-layered approach, which incorporates cultural awareness, gender sensitivity, and structural facilitation in TB programs.

Practical Implication

The research results of this study have significant implications in terms of practice towards the tuberculosis control programs and ultimate healthcare delivery. The slowness in seeking treatment among migrant groups explains the importance of interventions beyond service access to target social and contextual factors affecting the time of care. The TB programs must also include the use of the community based awareness, gender awareness outreach strategies and language support in health facilities to enhance early engagement. Enhancement of coordination of actions among the public health services, community organizations, and representatives of the migrants may assist in developing trust and lessening anxiety towards stigma and discrimination. TB control initiatives can be more responsive, inclusive, and responsive to the promotion of timely diagnosis and treatment by adopting vulnerabilities and communication related to the displacement issue at the service-delivery level.

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