

Predisposing, Enabling, and Reinforcing Factors in the Normalization of Intimate Partner Violence: A qualitative study of Afghan Refugee Women's Experiences in Torbat Jam Camp, Iran, 2025

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Abstract

Background

Intimate partner violence against women, especially Afghan migrant women, is a multidimensional phenomenon rooted in historical-cultural structures, gender inequalities, and the challenges of forced migration. This form of violence, reinforced in a context of asymmetric power between spouses and patriarchal norms, is compounded among Afghan migrant women: on the one hand, the experience of war, political instability, and prolonged displacement increase the psychosocial vulnerability of these women, while on the other hand, language barriers, limited access to support services in the host country, and fear of social stigma severely reduce the possibility of reporting or escaping the cycle of violence. The aim of this study is to discover, explain, and categorize predisposing, enabling, and reinforcing factors associated with intimate partner violence against Afghan women residing in Torbat Jam camp, Iran.

Results

In this study, 24 individuals were interviewed. The average age of informants was 35.3 years, most of whom were Housewife. Out of a total of 408 codes extracted in this study, 309 codes were related to predisposing factors, 61 codes were associated with enabling factors, and 10 codes were tied to reinforcing factors. Additionally, 28 codes were categorized as non-behavioral factors.

Conclusion

In situations involving migrants or refugees, violence serves both as a means for individual control and as a way to perpetuate systemic oppression on a larger scale. Addressing this requires interventions focused on gender justice and interdisciplinary strategies, overseen and supported by international organizations and NGOs.

Introduction

Violence against women, particularly intimate partner violence and sexual violence, is a major public health problem and a human rights violation(1). Among the types of violence against women, intimate partner violence (IPV) is the most prevalent(2).and is known as a global epidemic(3). Some consider it as a hidden epidemic of society(4).

Globally, about 1 in 3 women have experienced physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime(1). The United Nations describes violence against women as any act of gender-based violence that causes or is likely to cause physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether

occurring in public or private life(1). Intimate partner violence (IPV) has numerous negative impacts on women (1, 5). Research from various countries indicates a heightened risk of mental health issues, such as depression, post-traumatic stress disorder (PTSD), and suicidal tendencies, along with other health concerns, financial difficulties, and housing instability. Despite the potential for timely and adequate support to significantly reduce these risks, women often encounter obstacles and challenges when seeking help for IPV(5).

Studies have reported high rates of domestic violence against Afghan women (6–8), with approximately 90% of Afghan women admitting to having experienced some form of domestic violence, including physical, sexual, psychological, or forced marriage (9, 10). The violence that affects the lives of a large proportion of Afghan women and girls is rooted in Afghan culture, customs, attitudes, and practices (11). Afghan women have accepted going out without their husbands' permission, arguing with their husbands, neglecting their children, and refusing to have sex as justifications for violence against themselves(10). acceptance of patriarchy and the belief in the inherent aggression of men have led to the justification of men's violence against women, causing women to remain silent about the abuse they face(12). For over seventy years, Afghanistan has experienced various forms of instability. Due to the favorable perspective of Iran's cultural middle class and their empathy towards Afghan immigrants, many Afghans have chosen Iran as their destination for immigration(13). Iran hosts the largest refugee population globally, with most refugees originating from Afghanistan(14). Around 168,000 Afghans, comprising approximately 15,000 families, established their homes in Torbat Jam, Khorasan Province, during the period from 1880–1903(15). Some studies indicate that men's violence is often driven by a need to dominate their sexual partners(16), while around 25% of such violence against spouses is aimed at demonstrating love(17). Education level, employment, marriage age, income level, psychiatric disorders, alcohol and drug addiction, living in a rented house, infertility, and not having a male child are considered the most significant factors influencing all types of violence, according to various studies(12). The reported prevalence of violence in Iran ranges from 17.5 to 93.6 percent, with psychological abuse being the most common and sexual abuse the least common form(12).

The PRECEDE-PROCEED model is among the most commonly utilized frameworks in health education and promotion(18). This model outlines eight phases for planning, implementing, and evaluating health promotion programs. The PRECEDE section (phases 1–4) involves social, epidemiological, behavioral, environmental, educational, administrative, and policy assessments. The PROCEED section (phases 5–8) covers implementation, process evaluation, impact evaluation, and outcome evaluation. The initial part emphasizes planning, while the latter part focuses on implementation and evaluation(4). In the third phase, the elements influencing desired behaviors are divided into three categories: predisposing factors such as knowledge, beliefs, values, and attitudes; reinforcing factors like family, peers, and educators; and enabling factors, including provision, access, laws, and skills (19).

This study aims to identify the factors influencing Afghan women's acceptance of violence in the Torbat Jam camp, Iran.

Methods

The study focused on Afghan women residing in the Torbat Jam camp who had reported experiencing intimate partner violence within the last two months. Participants were selected using purposive sampling to ensure a wide range of variation in age, age difference with their spouse, and duration of stay in Iran. The sample size was determined by the criterion of theoretical saturation, which involves continuing to sample until no new information is obtained(20). In this study, theoretical saturation was reached after interviewing 24 individuals.

The Torbat-e Jam Foreign Immigrants Camp, situated 10 km from Torbat-e Jam city in Iran and 120 km from the center of Khorasan province, has been in operation since 1994 [Persian calendar year 1373]. It houses around 5,000 Afghan refugees, offering accommodation and essential services. Covering an area of 1,000,000 square meters (100 hectares), the camp includes administrative buildings, health clinics, educational facilities, residential units, a commercial market, and self-employment workshops(21, 22).

This qualitative phenomenological study explores individual lived experiences through in-depth, face-to-face, semi-structured interviews conducted at the camp clinic. Key interview questions included:

- - "What personal experiences have you had with your spouse's violent behaviors?"
- - "How do you feel when your spouse acts violently toward you?"
- - "Based on your experience, what circumstances or factors lead to your spouse's violent behaviors?"
- - "What conditions might reduce your spouse's violent behaviors, in your experience?"
- - "Is there anything else important you'd like to share?"

Interviews lasted between 20 to 45 minutes and were audio-recorded, with participants' demographic information collected. Additional questions arose naturally during interviews, guided by initial interview outcomes, emerging thematic patterns, and research objectives.

Data Analysis:

In this study, qualitative data analysis was conducted using the thematic analysis method based on theory (theory-driven). Thematic analysis is a widely used technique in qualitative research for identifying, analyzing, and reporting patterns or themes within data. This method helps researchers understand the main concepts and themes present in the data (23). It is a flexible approach that can be applied using either inductive (data-driven) or deductive (theory-driven) methods (24). For this study, a deductive approach was taken, utilizing the constructs of the PRECEDE-PROCEED model. The analysis was performed using MAXQDA18 software.

During individual interviews with participants, alongside note-taking, conversations were recorded with their consent and transcribed on the same day. The process included typing out interviews, reviewing

transcribed interviews line-by-line, extracting main words and phrases, drafting concise codes, organizing codes within the constructs of the PRECEDE model (subcategories), and arranging subcategories into main categories of the model (predisposing, enabling, and reinforcing factors).

Ensuring the Accuracy and Reliability of Qualitative Findings:

To determine the accuracy and scientific robustness of the findings, Lincoln and Guba's four criteria were used: dependability, credibility, confirmability, and transferability(24).

1. **Dependability:** Refers to the reliability or stability of the data under similar conditions and time, as well as changes in researcher decisions during the research process. To ensure dependability, the duration of data collection (interviews) was kept as short as possible, and all participants were asked the same set of questions on the subject. The methods and procedures of the study were clearly and precisely described, and guiding questions were used during interviews. Additionally, the data were periodically reviewed by the research team members.
2. **Credibility:** Implies conscious effort to ensure the accurate interpretation of the meaning of the data. To achieve this, the interview transcripts and extracted codes were presented to participants for their review and feedback on their accuracy. Sampling for interviews ensured maximum diversity, while ongoing engagement with the data and continuous immersion were prioritized.
3. **Confirmability:** Demonstrates that research findings are not influenced by the hypotheses or prior knowledge of the researcher. The process was shared with colleagues to verify the accuracy of the methodology. Furthermore, a subset of interview transcripts and extracted codes were presented to academic experts familiar with qualitative analysis but uninvolved in the study, requesting their assessment of the coding process's accuracy.
4. **Transferability:** Refers to the extent to which study findings can be applied to other groups or contexts. To facilitate transferability, comprehensive descriptions of participant characteristics, data collection methods, and analysis procedures were provided, along with examples of participants' statements, enabling other researchers to trace the process.

Results

In this study, 24 individuals were interviewed. The average age of informants was 35.3 years, most of whom were Housewife. On average, they had resided in Iran for over 25 years, with the majority holding primary-level education qualifications. (See Table 1 for demographic distribution).

Table 1: Frequency distribution and mean demographic indicators of study participants

Variable(number (%))	
Number of informants	24
Average of age	35.3 ±9.5
Number of children	3.6 ±1.8
Years of residence in Iran	29.5 ± 12.0
Age difference with spouse	6.4 ±4.0
Job	
Housewife	23(95.8)
employed	1 (4.2)
Educate level	
Illiterate	5 (20.8)
Primary school	7 (29.2)
Guidance school	5 (20.8)
Highschool	3 (12.5)
Diploma	4 (16.6)
Academic education	0 (0)

Analysis of Extracted Codes:

Out of a total of 408 codes extracted in this study, 309 codes were related to predisposing factors, 61 codes were associated with enabling factors, and 10 codes were tied to reinforcing factors. Additionally, 28 codes were categorized as non-behavioral factors.

Predisposing Factors

1. **Perceived Norms:** These are individuals' beliefs about what important others approve or disapprove of, or beliefs about what others like them typically do (25).
 - **Witnessing Violence in Parental Family:** Reports from both men and women indicated observation of paternal violence against mothers. Such instances can serve as behavioral patterns for committing or accepting violence.
 - "My parents used to fight all the time; their quarrels often escalated to physical violence." (Informant No. 2)
 - "Even in my mother's life, my father used to beat her with a stick." (Informant No. 16)

- "I told my mother-in-law several times that her son listens to others and beats me. She said, 'All men are like that; even his father used to hit me.'" (Informant No. 7)

- **Interference of Others:** The involvement of others, particularly family members, and their encouragement to engage in violent acts emerged as predisposing factors in this stage of the study.

- "One of the things that causes violence here is the interference of in-laws. For example, my mother-in-law lives in Isfahan but keeps meddling in our lives from afar." (Informant No. 22)
- "I don't understand what my spouse's mother has to do with whether we buy clothes or socialize with my sister. She dislikes me. I have never disrespected her, but she constantly tells my husband to divorce me, which influences him and creates tension." (Informant No. 23)

2. **Self-Efficacy:** Self-efficacy, as a determinant of behavior, emphasizes empowering individuals with a sense of control over their health. It is a core concept of Bandura's social learning theory, describing individuals' cognitive state of control, where they feel capable of influencing their environment and acting upon it (25).

- "Sometimes, maybe I, as a wife, contribute to my husband's misbehavior." (Informant No. 2)
- "But now, no matter what he says or does, I respond back, telling him that it's not the old days when he could boss me around." (Informant No. 7)

3. **Beliefs** Belief refers to the conviction of truth or reality of a phenomenon or object. Health-related belief statements might include "I believe it's important to care for myself so I can care for my family" or "When your time is up, there's nothing you can do about it" (25).

- **Perceived Barriers:** Factors like the stigma of divorce, fear of disgrace, significant age differences with spouses, familial marriages, early-age marriages, fear of worsening situations, lack of mutual understanding, absence of harmony, and child-rearing emerged as obstacles to adopting solutions or countering violence.
 - "I was afraid my father's reputation would be ruined, and I also feared my husband would hear about this and make matters worse." (Informant No. 10)
 - "Reporting to the police station is no good; it's a disgrace." (Informant No. 14)
 - "My father said we have no tradition of women leaving their husband's house to return to their father's; you must leave your husband's house only in your burial shroud." (Informant No. 10)
 - "My husband and I have a significant age gap—he's 34 and I'm 22. I think most of our problems stem from this difference." (Informant No. 15)
 - "Our marriage was traditional; we were first cousins, and from birth, I was considered destined for him." (Informant No. 1)

- **Perceived Benefits:** Aspects like increased self-esteem, mutual respect, reduction in challenges, improved conditions, behavioral impacts on children, reflection of behaviors in the future, inverse outcomes of violent behaviors, and greater marital satisfaction were identified as benefits of controlling and reducing violent behaviors.
 - “After I started working, our situation improved. Sometimes, I stood my ground against him, and my confidence increased.” (Informant No. 11)
 - “I think if women remain silent and patient, they can prevent disputes.” (Informant No. 2)
- **Perceived Threats:** Issues such as fear of being alone, the impact on children’s behavior, financial difficulties, damage to masculine pride, and the influence of parents’ behavior on children were identified as perceived threats.
 - “I’ve endured a lot of hardship in this life, and our fights have made our children aggressive. I’m afraid my children’s future will be ruined.” (Informant No. 16)
 - “My husband loved another woman in the past, and I think he still loves her. Who’s to say he won’t marry her?” (Informant No. 15)
 - “I didn’t dare tell my parents because back then they were authoritative figures and might have beaten my husband to death or caused harm, leaving me and my kids abandoned.” (Informant No. 4)

4. **Knowledge:** Knowledge, which is one of the most important components of most theories (26), is acquired over time through exposure to, experience with, and awareness of a subject. Numerous educational studies over decades have demonstrated a positive correlation between knowledge and behavior. However, while knowledge is necessary for personal informed health actions, it is not sufficient. Additional information does not necessarily lead to behavioral change (25). In this study, topics such as awareness of the causes of violence, types of violence, necessary actions during violence, and conditions that foster violence were highlighted as critical areas of knowledge.

- “Now I’m indifferent to his yelling and words; they don’t matter to me anymore—it’s become normal.” (Informant No. 7)
- “Many times, in my life, my husband has been violent, but he never admits it and says, ‘You and the kids are to blame for all the fights.’” (Informant No. 6)

5. **Values:** Values are concepts or ideas that individuals regard as important. They are influenced by gender, culture, social group membership, religion, and life experience. Values become internalized, shaping motivations, thoughts, and behaviors. They can serve as standards that form a part of an individual's identity and guide their actions. Values provide a basis for morally or ethically justifying one's actions (25). This study identified expectations from a spouse, reactions to a spouse's behavior, children’s relationships with their father’s following violence against mothers, prioritization between work and family, and the necessity of the husband’s involvement in family activities as key values.

- “The kids never share their problems with their father.” (Informant No. 1)

- "Because of my husband, we have no peace at home." (Informant No. 1)

6. **Attitudes** In the context of health promotion planning, attitudes are value judgments about a specific behavior or task. Attitudes can range from positive to neutral to negative and are typically derived from internal frameworks of values and beliefs formed over time (25).

- "When my husband argues with me, I completely break down; I feel awful." (Informant No. 12)
- "A few months after our wedding, my husband had an accident, and his family said the bride was unlucky." (Informant No. 1)
- "I'm very scared when my husband gets angry." (Informant No. 1)

Enabling Factors

Enabling factors directly or indirectly influence behaviour through environmental mediators, encompassing skills, plans, and the availability/accessibility of essential resources(27).

Skills: Skills refer to an individual's ability or capacity to perform tasks. Health-promoting skills include: Controlling personal risk factors for diseases, appropriately utilizing medical care, Modifying or managing environmental exposures (28 ,25).

- "I also got married at 16, so I often felt misunderstood" Informant No. 20)
- "When angry, my husband throws whatever is nearby—the remote, phone, teacup... His anger erupts suddenly" (Informant No. 1)
- **Availability of Resources:** Services that are readily available are more likely to be utilized (28).
 - "Here [in the refugee camp], there's no one to share life's problems with" (Informant No. 14)
 - "If there were a court or place to vent their feelings, it would help immensely" (Informant No. 8).
- **Accessibility of Services:** Services lose value if waitlists span years or are physically inaccessible to those in need (28).
 - "Talking to you now has lifted my spirits. Can we do this regularly?" (Informant No. 13)
 - "Addiction drives violent behaviour. Opium and drugs are accessible to everyone here" (Informant No. 13).
- **Community/Government Laws and Policies:** Laws and policies can drive behavioural or environmental changes while emphasizing their significance (28).
 - "If training sessions could clarify laws about interfering in others' lives, it would help" (Informant No. 24).

Reinforcing Factors

Reinforcing Factors are attitudes of individuals and society that support or hinder the adoption of healthy behaviors or the creation of healthy environmental conditions. These are primarily the influential

attitudes of individuals: families, peers, teachers, employers, health or human service providers, media, community leaders, policymakers, and other decision-makers. An intervention may be most effective in reaching the real target group through these individuals and groups - due to their influence(28).

- "Her mother never becomes an intermediary and does not advise her; she always supports her child" (Informant No. 16).
- "Here the elders, instead of helping, mostly ruin lives" (Informant No. 12).

Other factors:

Other factors that can include specific health-related behaviors or conditions through various mechanisms include personality and sociocultural factors such as economic status, age, gender, ethnicity, genetics, and family size or history. While these types of factors are actually "determinants" of behaviors and health outcomes, we do not classify them as predisposing, reinforcing, or enabling factors because they are not immediately changeable and do not readily lend themselves to health promotion interventions. However, they can help identify groups in need of intervention and whether different interventions should be planned for different groups. This information is crucial in the early stages of the planning process to identify specific priority populations and any need for specific targeting or communications with them(25).

- "All my husband's relatives live in Afghanistan, Kabul. Only we are in Iran and strangers here among all the tribes and families. Only my husband and I are here" (Informant No. 3)
- "The camp environment is not suitable for living in general. I wish they had built the houses in a way that at least there were separate rooms for the children because the children are very vulnerable" (Informant No. 16)

Discussion

One of the factors identified as contributing to violence in this study by informants was early marriage of girls, which is consistent with Akbari et al (29). Early or child marriage before the age of 18 with an adult or another child is defined as marriage at a young age, mostly seen in low- and middle-income countries (30). Therefore, pursuing and implementing gender equality, which is included as one of the 17 Sustainable Development Goals (SDGs) by the United Nations and is one of the axes of this goal, "Eliminating all harmful practices such as child marriage, early and forced marriage" worldwide by 2030 (31) can be a key principle and policy in reducing violence against women.

"Among other facilitating factors of violence identified by informed individuals in this study, the observation of paternal violence within the family was noted, which correlates with Sheikh's study (32). The hypothesis of intergenerational transmission of violence indicates that patterns of perpetrating IPV are a product of initial damage within the family system. Women belonging to families where the father has been violent towards the mother have come to believe that male violence against women and the tolerance of violence by men are natural occurrences (33). Some informed individuals mentioned that

their fathers were violent towards their mothers and likely imitated their parents; these findings are consistent with the results of the study by Azad et al. (34). According to the claims of social learning theory, children who witness parental aggression and learn that violence is an appropriate means of conflict resolution (35, 36), will continue this violence continuously and across generations if left unaddressed.

In this study, the researchers identified unemployment and unfavorable economic conditions as one of the most common factors associated with violence, consistent with Capaldi et al. (37) study where low income and unemployment were shown as strong risk factors for intimate partner violence (IPV). Poverty in society influences individuals' health. In impoverished and marginalized areas, there is a lack of access to healthcare systems and unfair gender interactions. To the extent that women are sometimes perceived as second-class citizens and violence against women is prevalent (33).

Some informants have suggested that with the passage of time and increasing age, the level of violence experienced by a spouse decreases, which is consistent with the findings of several longitudinal studies examined in Capaldi and colleagues' systematic research (37) indicating that IPV decreases with age.

The absence of laws or legal protection for women against male violence in Afghanistan has been identified as a major factor contributing to violence in this country, while the enactment of laws prohibiting violence against women is one of the most important measures that the Afghan government has taken in the past decade to eliminate discrimination and violence against women. However, the situation in Afghanistan is somewhat complex with regard to new conditions (31). According to Article 619 of the Law on Disciplinary Offenses and Penalties approved in 1996, any form of aggression or harassment towards women or acts of verbal or non-verbal violence, such as words and actions contrary to their dignity and well-being, is considered a crime. In Iran as well, despite its shortcomings, the law on prohibiting violence against women was passed and promulgated in 2009 (38). Women's lack of awareness of these laws has led them to either tolerate or remain silent in the face of male violence, which can be addressed through education and awareness-raising efforts for women.

The participants in this study identified the lack of responsibility of a life partner as one of the reasons for the existence of violence in families, as highlighted in the study by Jafari et al. (39) as one of the main causes of violence.

Unfulfilled expectations and demands, such as sexual dissatisfaction and unpreparedness of food, which are prominent examples of male dominance, have been raised as reasons and justifications for the perpetration of violence against women, a phenomenon that has been examined and confirmed in other similar studies (40, 41). In Afghanistan, when women defy gender norms and resist men's demands, physical violence against women is considered an acceptable act. Actions such as leaving without a husband's permission, arguing with a spouse, refusing sexual relations, and burning food are viewed as acceptable justifications for violence against women (10). Patriarchal norms in Muslim societies are strong and may be misused to justify violence against women (9). In various subcultures, women are generally perceived as the secondary or weaker gender, a belief that is ingrained in women

and often leads men to consider themselves superior or above women. This belief alone can enable men to benefit in any circumstances and create an environment conducive to violence against women (42).

From other acceptance issues and tolerating violence by the informed, the harsh conditions of migration and migrants, and the feeling of alienation were; immigrant and refugee women cannot maintain their sense of belonging to Afghanistan nor do they have the ability to emotionally attach to Iran; this matter plunges them into a space where due to the freedom from pressures of both the origin and destination cultures, they experience a wandering identity (43). Additionally, isolation and weaker connections with the host community, unfamiliarity with the language, cultural differences, and/or uncertain visa status can make women more vulnerable to violence (9). International organizations and civil society can play the best role in nurturing and healing the cultural well-being of these women.

In this study, neglecting children was also identified as one of the main reasons for men perpetrating violence against women, which is consistent with the findings of Shinwari and colleagues (10).

Conclusion

The empirical findings of this study identify four principal dimensions underlying intimate partner violence (IPV) against women. At the individual level, contributing factors include younger age, limited educational attainment, childhood exposure to abuse, parental violence modeling, substance abuse tendencies, normalization of violent behaviors, and personality disorders. These elements collectively heighten susceptibility to perpetration or victimization in intimate relationships.

On the interpersonal level, critical drivers encompass relational discord, manifestations of hegemonic masculinity, economic stressors, polygamous marital structures, and educational disparities between partners—particularly when women attain higher academic credentials than their male counterparts. Such dynamics create power imbalances that facilitate coercive control.

The socio-structural level reveals how institutionalized gender inequalities, discriminatory social norms, systemic poverty, economic marginalization, and armed conflict environments synergistically exacerbate violence. These macro-level conditions normalize patriarchal dominance while restricting women's access to protective resources.

At the policy level, systemic failures perpetuate violence through inadequate legal safeguards for survivors and inefficient enforcement mechanisms. Legislative gaps and institutional inertia enable cyclical victimization by deterring reporting and limiting accountability.

Strategies for Violence Mitigation

A multipronged approach integrating *education* and *systemic reform* emerges as pivotal. Educational initiatives must prioritize public awareness campaigns to illuminate the structural roots of gender violence while simultaneously fostering women's psychological resilience and intellectual growth.

Implementation should commence in early childhood education and extend through tertiary institutions to cultivate intergenerational cultural shifts.

Concurrently, governmental agencies must leverage cultural, educational, and media infrastructure to deconstruct patriarchal narratives. Civil society organizations—including NGOs, religious institutions, and grassroots movements—should collaborate to amplify advocacy efforts. Mosques, scholars, and community leaders hold particular potential for reframing gender norms within faith-based contexts. This cross-sectoral synergy enables the reconstruction of societal paradigms resistant to violence, ultimately requiring sustained policy alignment and resource allocation

In qualitative studies, ethical considerations have a particular sensitivity due to the profound nature of the study process.

Declarations

Ethics approval and consent to participate

This study was approved by the Research Ethics Committee of Shahid Sadoughi University of Medical Sciences (ethical approval code: IR.SSU.SPH.REC.1402.099) and was conducted in accordance with the principles of the Declaration of Helsinki. Given that the study involved face-to-face interviews with vulnerable participants, particular attention was paid to ethical considerations and the potential for emotional distress during the interviews(44). The informed consent procedure, including the use of fingerprints for participants who were unable to provide a written signature, was reviewed and approved by the Ethics Committee. Participation was voluntary, and informed consent was obtained from all participants before the interviews. For participants who could not read or write, the consent form was read aloud and explained to them in the presence of either a trusted family member or a health worker working in the camp whom the participant trusted. The participants were given time to ask questions and decide whether they wished to participate. For those who could not provide a written signature, consent was documented using their fingerprint. All participants' privacy and confidentiality were maintained throughout the study. Interviews were conducted in private settings, either at the clinic or at the participant's home. Pseudonyms were used in quotations and reports to protect participants' identities. Electronic data were stored on encrypted devices, while documents containing personal information were kept in locked cabinets with restricted access. All personal and identifiable information was securely destroyed after completion of the study.

Consent for publication:

Not applicable.

Data availability:

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

Conflicts of Interest:

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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Author Contributions:

All authors contributed equally to the study's conception, design, data collection and analysis, interpretation of results, and manuscript drafting, and all approved the final version for submission.

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