Predictive Role of Social Security and Psychological Health Literacy on Health Promoting Behaviors among Afghan Immigrant Mothers Aged 30–45

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Background and Objectives: This study aimed to examine the role of social security and psychological health literacy in predicting health-promoting behaviors among Afghan immigrant mothers.

Materials and Methods: The study employed a quantitative, applied, and descriptive-correlational design. The research population consisted of Afghan immigrant mothers living in districts 18 to 20 of Tehran in 2024. A total of 320 mothers aged 30 to 45 years (35.41± 4.41) were recruited through voluntary and convenience sampling. Data were collected using the Social Safeness and Pleasure Scale, the Mental Health Literacy Scale, and the health-Promoting Lifestyle Profile Descriptive statistics (frequency, percentage, mean, and standard deviation) and inferential statistics—including Pearson's correlation coefficient and simultaneous multiple regression—were conducted using SPSS version 25.

Results: Social security demonstrated significant positive correlations with overall health-promoting behaviors (r = 0.66) and with the following subdimensions: nutrition (r = 0.59), exercise (r = 0.50), health responsibility (r = 0.51), stress management (r = 0.46), interpersonal support (r = 0.36), and self-actualization (r = 0.34) (all $p < 0.01$). Similarly, psychological health literacy was significantly correlated with overall health-promoting behaviors (r = 0.66) and with nutrition (r = 0.47), exercise (r = 0.55), health responsibility (r = 0.53), stress management (r = 0.46), interpersonal support (r = 0.42), and self-actualization (r = 0.41) (all $p < 0.01$).

Conclusion: Simultaneous multiple regression analysis revealed that social security and psychological health literacy accounted for 43% and 45% of the variance in health-promoting behaviors, respectively, and together explained 60% of the variance. These findings indicate that higher levels of social security and psychological health literacy are associated with greater engagement in health-promoting behaviors among Afghan immigrant mothers. Recognizing these influential factors can inform the design of targeted educational and support interventions aimed at improving the quality of life in this population.

Keywords: Social security; health literacy; Health-promoting behaviors; Mothers; Migrant

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Introduction

There are currently 36.4 million refugees worldwide, with Afghan refugees constituting the second-largest refugee group globally (1). The number of refugees and undocumented migrants living outside the legal and regulatory frameworks of their host countries has steadily increased over the past few decades. Projections suggest that, due to the impacts of climate change, the number of undocumented migrants could reach 140 to 200 million by 2050. The physical and mental health needs of refugees and undocumented migrants are often substantial, and at present, the financial burden of healthcare services for these populations is largely borne by host countries (2). According to 2024 UNHCR statistics, Iran hosts one of the world's largest migrant and refugee populations, with approximately 3.8 million documented individuals, around 99% of whom are Afghans. However, some unofficial estimates suggest that the total Afghan population in Iran may be as high as 8 million, implying a potentially greater strain on the country's health services than official figures indicate (3). While the primary drivers of Afghan migration have not historically been gender-related, gender issues—such as insecurity for women and the preservation of family honor—have consistently acted as significant deterrent factors (4). As social relationships in contemporary societies grow increasingly complex, the concept of security has evolved beyond its traditional association with military and state-controlled domains. It now encompasses economic, social, environmental, and political dimensions. In this expanded framework, one of the most prominent emerging notions is social security. This concept, shaped in part by the theoretical contributions of Buzan and Wæver, addresses threats to identity and extends the concept of security into the social sphere (5). Social security refers to the protection a society affords to individuals and households to ensure access to healthcare and income security, particularly in circumstances such as old age, unemployment, illness, disability, work-related injury, maternity, or the loss of a primary income earner (6).

Despite the long-standing history of Afghan migration to Iran, few comprehensive studies have examined their health status. Linguistic and cultural differences, coupled with the stressors associated with migration, make the identification and treatment of mental disorders among Afghan migrants particularly challenging, and a substantial proportion of this population is affected. Recent reports indicate that approximately one-third of Afghans in Iran experience mental health problems (7). A key subcategory of health literacy is mental health literacy (MHL), which encompasses the knowledge and beliefs about mental disorders

that facilitate their recognition, management, and prevention (8). As initially defined by Jorm et al. (1997), mental health literacy involves the ability to recognize specific disorders, awareness of how to access mental health information, knowledge of risk factors and causes, familiarity with self-help strategies, understanding of available professional services, and attitudes that promote the recognition of mental health problems and the pursuit of appropriate assistance (9). This multidimensional construct suggests that enhancing mental health literacy—both within societies and among the general public—can contribute to earlier recognition and timelier intervention for mental disorders (10). Conversely, low public understanding of mental disorders can significantly delay the recovery process. In contexts where mental health literacy is generally poor, mental disorders often go unrecognized, treatment is delayed, and individuals may be deprived of years of good quality of life (11).

Individuals with low levels of health literacy are more likely to encounter challenges such as arbitrary and indiscriminate medication use, non-adherence to prescribed treatments, poor disease management, limited health knowledge, inadequate expression of health concerns, and ineffective communication with healthcare providers (3).

Experts assert that health literacy influences individuals' health status and their utilization of healthcare services by enhancing disease awareness, improving health-related behaviors, and encouraging the adoption of preventive services. Consequently, there is a direct relationship between health literacy and health-promoting behaviors—actions and strategies individuals employ to manage and maintain their health (12).

The theoretical definition of health-promoting behavior is that individuals acknowledge the importance of their health and actively engage in preventive practices to improve it. Such behaviors involve modifying lifestyle habits and patterns through changes in attitudes, acquisition of knowledge, and adoption of health-related practices, thereby enhancing one's capacity for health management (13). According to the World Health Organization (WHO), health-promoting behaviors reflect a genuine inclination toward improving and strengthening health and well-being, fostering personal empowerment, and achieving self-actualization (14). More broadly, health-promoting behavior encompasses self-initiated and sustained activities aimed at improving or enhancing both health and subjective well-being (SWB) (15).

For Afghan immigrant mothers in particular, the role of social security and psychological health literacy is especially critical. Mothers often serve as the primary caregivers within

families, meaning their health knowledge, sense of security, and ability to navigate healthcare systems directly influence not only their own well-being but also that of their children and households. Limited social security can heighten economic and emotional stress, while low psychological health literacy may reduce awareness of mental health needs and delay timely care. These intersecting vulnerabilities make Afghan mothers a key population for examining how social security and mental health literacy affect the adoption of health-promoting behaviors.

This study aims to empower Afghan migrant mothers by generating knowledge that directly addresses the barriers they face in adopting and sustaining health-promoting behaviors. Through an investigation of the roles of social security and mental health literacy, the study not only identifies the specific challenges within this population but also highlights resources and strategies that can strengthen their capacity for healthier living. In doing so, the research creates a foundation for policymakers and healthcare organizations to design targeted interventions that reduce social, educational, and psychological barriers, thereby enabling these mothers and their families to more fully engage in health-promoting practices.

Materials and Methods

The present study employed a quantitative, descriptive correlational research. The study population comprised Afghan migrant mothers residing in districts 18 to 20 of Tehran. To recruit participants, visits were made to schools located within these districts. Eligible participants were selected based on the following inclusion and exclusion criteria by convenience sampling.

Inclusion criteria

- Afghan mothers aged between 30 and 45 years
- Completion of at least nine years of formal education (to ensure the ability to independently read and complete the questionnaires)
- Having one or more children

Exclusion criteria

- Divorced or widowed mothers, or those whose husbands were not living with them for any reason
- Mothers with one or more children with disabilities (due to the additional life stress associated with the child's condition)

- Questionnaires that were incomplete or contained invalid responses (e.g., inconsistent or patterned answers that suggest lack of engagement)

The study employed a voluntary, convenience sampling method. As no precise statistics were available on the number of Afghan migrant mothers in these districts, the Cochran formula was applied to estimate the sample size. Based on this formula, a sample of 384 participants was deemed sufficient for a population exceeding 3,000. Following the acquisition of the necessary permissions, data collection commenced. Several schools were visited, and 10 schools were selected based on the proportion of Afghan students enrolled. In addition, school selection was a pragmatic recruitment strategy, not a variable influencing outcomes. Of these, four schools served exclusively Afghan students, while the remaining schools had a substantial number of Afghan children. At each selected school, questionnaires were distributed individually to Afghan mothers. The study's objectives and the procedure for completing the questionnaires were explained clearly, and participants were encouraged to respond honestly. In total, 430 questionnaires were returned, of which 320 were fully and accurately completed; these were subsequently used for statistical analysis. Data were collected using three standardized instruments: the Social Safeness and Pleasure Scale, the Mental Health Literacy Scale, and the health-Promoting Lifestyle Profile. The following **Figure 1)** illustrates the technical and procedural aspects of sampling, including the application of inclusion and exclusion criteria, school selection, questionnaire distribution, and the final number of valid responses analyzed.

Social Safeness and Pleasure Scale (SSPS)

This self-report instrument, developed by Gilbert and colleagues, consists of 11 items designed to assess an individual's sense of social security. The scale captures the extent to which a person perceives their social environment as safe, intimate, and welcoming. Responses are rated on a five-point Likert scale ranging from 1 (*almost never*) to 5 (*almost always*). The total score is obtained by summing the responses to all 11 items, with higher scores indicating a greater perceived sense of social security (16). Test–retest reliability over a five-week interval was previously reported as 0.75 by Alevi et al. (17), and in their study, Cronbach's alpha was 0.91. In the present study, the Social Safeness and Pleasure Scale demonstrated a Cronbach's alpha of 0.72, indicating acceptable internal consistency.

Mental Health Literacy Scale (MHLS)

The MHLS, developed by O'Connor and Casey in 2015, is designed to assess mental health literacy, encompassing knowledge, attitudes, and help-seeking intentions related to mental health. This self-report instrument is suitable for individuals aged 17 years and older and facilitates the identification of those with lower levels of mental health literacy. The scale comprises 35 items across six subscales. Items 1–15 are rated on a four-point Likert scale (1 = *very low*, 2 = *low*, 3 = *high*, 4 = *very high*), while items 16–35 are rated on a five-point Likert scale (1 = *very low*, 2 = *low*, 3 = *medium*, 4 = *high*, 5 = *very high*). Items 10, 12, 15, 20, 21, 22, 23, 24, 25, 26, 27, and 28 are reverse-scored. The total score ranges from 35 to 160, with higher scores indicating greater mental health literacy. In the original validation study (18), the scale demonstrated good internal consistency, with a Cronbach's alpha of 0.873 and test–retest reliability of 0.797. In a 2021 study by Nejatian et al., the composite reliability for all subscales exceeded 0.59, confirming good reliability. Their findings also reported content validity ratios above 0.62 and a content validity index (CVI) greater than 0.75(19). In this study, the Mental Health Literacy Scale showed acceptable internal consistency, with a Cronbach's alpha of 0.73.

Health-Promoting Lifestyle Profile (HPLP)

The HPLP is a 54-item self-report questionnaire designed to assess health-promoting behaviors across six domains: nutrition, physical activity, health responsibility, stress management, interpersonal relationships, and self-actualization. Responses are recorded on a four-point Likert scale (1 = *never*, 2 = *sometimes*, 3 = *often*, 4 = *always*). The items are distributed across the six subscales as follows: nutrition (items 1–11), physical activity (items 12–24), health responsibility (items 25–32), stress management (items 33–38), interpersonal relationships (items 39–46), and self-actualization (items 47–54). Subscale scores are calculated by summing the relevant item scores, and the total HPLP score is obtained by summing all 54 item scores (20). In the validation study by Mohammadi Zeidi et al., the psychometric properties of the Persian version were confirmed, with Cronbach's alpha coefficients as follows: nutrition = 0.79, physical activity = 0.86, health responsibility = 0.81, stress management = 0.91, interpersonal relationships = 0.79, and self-actualization = 0.81(21). In this study, the questionnaire exhibited good internal consistency, with a Cronbach's alpha of 0.85.

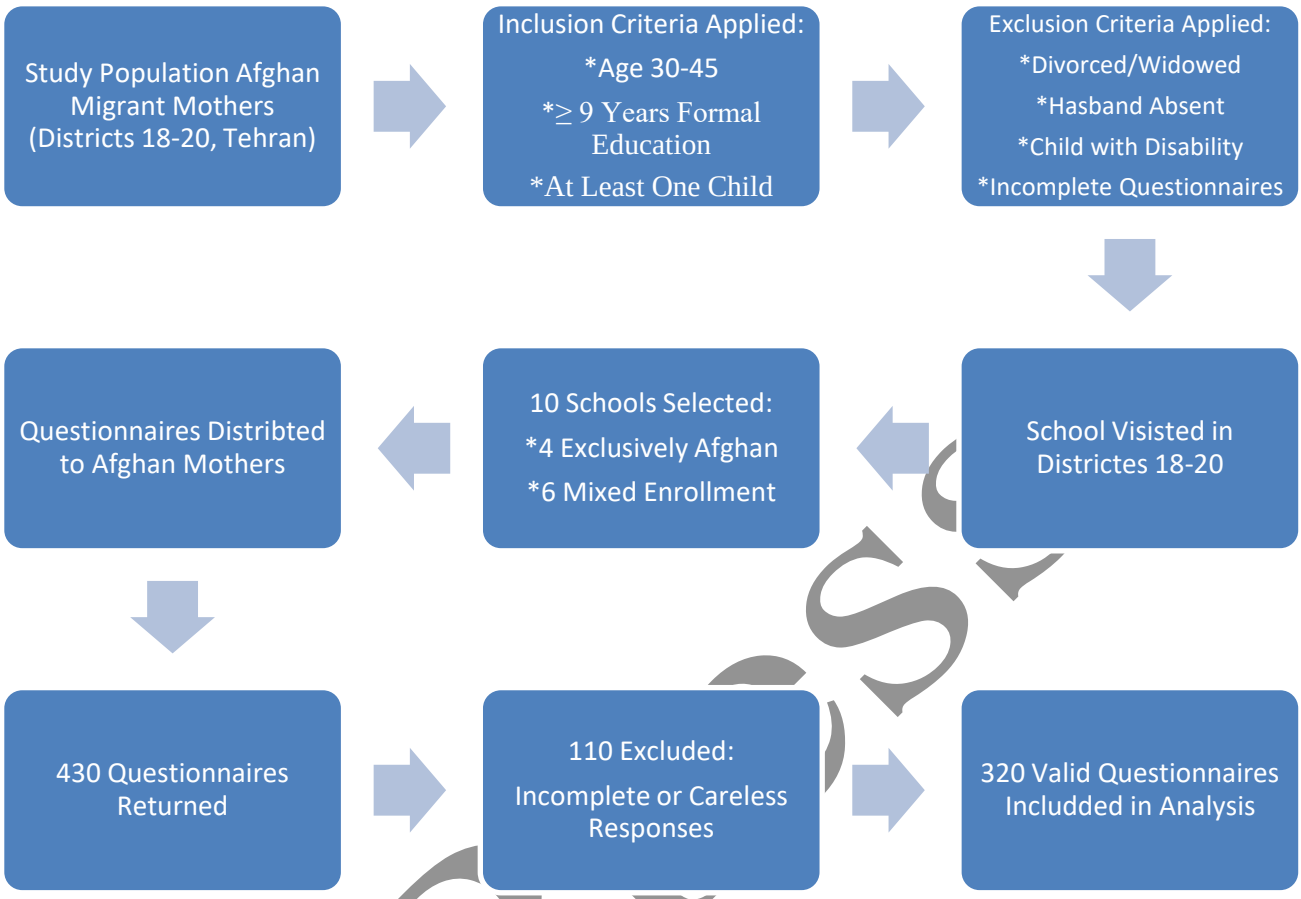

Figure 1. Sampling Flow Diagram

Results

Data analysis was performed at multiple levels. Demographic variables were examined using frequency and percentage, while descriptive statistics (mean and standard deviation) were calculated for the main study variables. Hypothesis testing was conducted using Pearson's correlation coefficient and simultaneous multiple regression analysis. Before performing the statistical tests, the relevant assumptions—including normality of data distribution, independence of errors, and absence of multicollinearity—were evaluated and confirmed. All analyses were conducted using SPSS software, version 25. According to the data presented in **Table 1**, the largest proportion of participants fell within the 30–33 years age range (n = 132), while the smallest proportion was in the 42–45 years age range (n = 39). Regarding educational attainment, the highest frequency was observed at the cycle level (*n* = 241), whereas the lowest frequency was recorded at the bachelor's degree level (*n* = 12). As shown in **Table 2**, the correlation coefficients between social security and the variables of health-promoting behaviors, nutrition, physical activity, health responsibility, stress management, interpersonal support,

and self-actualization were 0.66, 0.59, 0.50, 0.51, 0.46, 0.36, and 0.34, respectively. All correlations were statistically significant at the 0.01 level ($P < 0.01$).

Table 1. Descriptive statistics for participants' age and education (N = 320)

Age Range (years)	Frequency	Percentage	Educational Level	Frequency	Percentage
30–33	132	41.3 %	Secondary education	241	57.3 %
34–37	83	25.9 %	Diploma	67	20.9 %
38–41	66	20.6 %	Bachelor's degree	12	3.8 %
42–45	39	12.2 %			
Total	320	100 %	**Total**	320	100 %
Mean ± SD	**35.41 ± 4.41**				

Table 2. Correlation Matrix of Social Security with Health-Promoting Behaviors and Its Components

Variables	1	2	3	4	5	6	7	8
1 Social Security	1							
2 Health-Promoting Behaviors	0.66**	1						
3 Nutrition	0.59**	0.79**	1					
4 Sport	0.50**	0.80**	0.49**	1				
5 Health Responsibility	0.51**	0.76**	0.56**	0.56**	1			
6 Stress Management	0.46**	0.62**	0.38**	0.45**	0.41**	1		
7 Interpersonal Support	0.36**	0.63**	0.40**	0.42**	0.37**	0.31**	1	
8 Self-Actualization	0.34**	0.59**	0.35**	0.39**	0.32**	0.31**	0.27**	1

**P<0.001

As presented in **Table 3**, the correlation coefficients between mental health literacy and health-promoting behaviors, nutrition, physical activity, health responsibility, stress management, interpersonal support, and self-actualization were 0.66, 0.47, 0.55, 0.53, 0.46, 0.42, and 0.41, respectively. All correlations were statistically significant at the 0.01 level ($P < 0.01$). Table 4 presents the results of the regression model predicting health-promoting behaviors based on social security and mental health literacy.

Table 3. Correlation Matrix of Mental Health Literacy and Its Components with Health-Promoting Behaviors and Their Components

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14
1 Mental Health Literacy	1													
2. Ability to Recognize Disorders	0.76**	1												
3. Awareness of Risk Factors and Causes of Mental Disorders	0.51**	0.28**	1											
4 Knowledge About Oneself	0.5٢**	0.30**	0.26**	1										
5. Knowledge of Reliable Information Sources	0.63**	0.40**	0.30**	0.21**	1									
6 Attitudes Toward Recognition or Help-Seeking and Awareness of Available Professional Help	0.74**	0.40**	0.19**	0.26**	0.27**	1								
7 General Attitudes Toward People with Mental Illnesses	0.49**	0.27**	0.18**	0.26**	0.23**	0.22**	1							
8 Health-Promoting Behaviors	0.66**	0.5٠**	0.46**	0.35**	0.43**	0.44**	0.34**	1						
9 Nutrition	0.47**	0.38**	0.32**	0.19**	0.34**	0.31**	0.20**	0.47**	1					
10 Sport	0.55**	0.38**	0.40**	0.34**	0.34**	0.38**	0.29**	0.55**	0.46**	1				
11 Health Responsibility	0.53**	0.35**	0.35**	0.24**	0.36**	0.40**	0.23**	0.53**	0.55**	0.56**	1			
12 Stress Management	0.46**	0.40**	0.34**	0.26**	0.23**	0.26**	0.27**	0.46**	0.38**	0.45**	0.41**	1		
13 Interpersonal Support	0.42**	0.33**	0.24**	0.27**	0.26**	0.24**	0.29**	0.42**	0.40**	0.42**	0.37**	0.31**	1	
14 Self-Actualization	0.41**	0.30**	0.27**	0.22**	0.26**	0.26**	0.24**	0.41**	0.35**	0.39**	0.32**	0.31**	0.27**	1

**P<0.001

According to the data presented in **Table 4,** social security and mental health literacy, when considered jointly, accounted for 60% of the variance in predicting health-promoting behaviors.

As shown in **Table 5**, the standardized coefficients for social security and mental health literacy in predicting health-promoting behaviors were 0.43 and 0.45, respectively. Since the *t*-statistic values for both variables exceeded ±1.96, these coefficients were statistically significant at the 0.01 level ($p < 0.01$).

According to **Table 6**, the standardized coefficients for the components ability to recognize disorders, awareness of risk factors and causes of disorders, knowledge about reliable sources of information, attitudes facilitating recognition or help-seeking and awareness of available professional help, and general attitude toward individuals with mental illnesses in predicting health-promoting behaviors were 0.43, 0.45, 0.15, 0.20, and 0.12, respectively. These coefficients were statistically significant at the 0.01 level ($P < 0.01$), as the corresponding *t*-values exceeded ±1.96. The standardized coefficient for the component "knowledge about ourselves" was 0.10, which was statistically significant at the 0.05 level ($P < 0.05$), with its *t*-value also exceeding ±1.96.

Table 4. The regression model predicting health-promoting behaviors based on social security and mental health literacy

Criterion variable	Predictor variables	R	R^2	A R^2	Std. Error
Health-promoting behaviors	Social security Mental health literacy	0.77	0.60	0.60	11.06

R=Multiple Correlation Coefficient, R^2 =Coefficient of Determination, AR^2 =Adjusted Coefficient of Determination

Table 5. Regression coefficients of predictor variables in predicting the criterion variable

Criterion variable	Predictor variables	Unstandardized Coefficients		Standardized Coefficients (Beta)	t	P
		B	Std. Error			
Health-promoting behaviors	Intercept	34.01	4.8	-	7.08	0.001
	Social security	1.15	0.10	0.43	11.16	0.001
	Mental health literacy	0.66	0.05	0.45	11.27	0.001

B= Unstandardized Coefficient, Beta= Standardized Coefficient , t= t- statistic , P=P-value

Table 6. Regression coefficients of the predictor variables in predicting the criterion variables

Criterion variable	Predictor variables	Unstandardized Coefficients		Standardized Coefficients (Beta)	t	P
		B	Std.Error			
	Intercept	43.31	5.88	-	7.36	0.001
	Ability to recognize disorders	0.92	0.21	0.43	4.4	0.001

Health-promoting behaviors	Awareness of risk factors and causes of mental disorders	2.07	0.36	0.45	5.74	0.001
	Knowledge about oneself	0.84	0.37	0.10	2.26	0.024
	Knowledge about reliable sources of information	0.9	0.27	0.15	3.34	0.001
	Attitudes that facilitate recognition, help-seeking, and awareness of available professional support	0.73	0.16	0.20	4.45	0.004
	General attitude toward people with mental illness	1.11	0.38	0.12	2.86	0.001

B= Unstandardized Coefficient, Beta= Standardized Coefficient, t= t-statistic, P= P-value

Discussion

The findings of the current study, utilizing simultaneous multiple regression analysis, demonstrate that both social security and mental health literacy significantly predict health-promoting behaviors among Afghan migrant mothers. This outcome is consistent with previous research indicating the crucial role of social stability and mental health knowledge in encouraging positive health practices (22-24).

Security is widely recognized as a fundamental human need and a core motivator for behavior. Maslow's hierarchy of needs places security immediately after physiological requirements, emphasizing that the fulfillment of higher-level psychological needs and self-actualization depend on the establishment of a secure environment (25). Similarly, Giddens conceptualized security as a foundational condition for human functioning, arguing that a sense of security is essential for the effective performance of daily life activities and overall development. In this context, social security constitutes a critical prerequisite for survival and holistic growth, especially for vulnerable populations such as migrants (26).

Afghan migration to Iran is primarily driven by ongoing conflict, insecurity, and socio-economic instability in Afghanistan, compelling individuals to seek work, education, and refuge (27-28). Mental health challenges among Afghan migrants are widespread, with studies reporting that nearly one-third experience symptoms such as anxiety, depression, and post-traumatic stress disorder (29-30). Strengthening social security mechanisms can significantly alleviate these mental health burdens by reducing stressors related to social exclusion and perceived threats to personal safety and cultural identity (31-32). Enhanced security fosters psychological well-being, enabling migrants to devote more cognitive and emotional resources toward health maintenance and lifestyle improvement.

Increased feelings of security among Afghan mothers encourage participation in educational programs and counseling services, which in turn elevate mental health literacy. Awareness and understanding of mental health symptoms facilitate early recognition and timely help-seeking, reducing stigma and denial often associated with psychological disorders (33-34). Moreover, knowledge about risk factors and preventive strategies promotes the adoption of healthier behaviors, including balanced nutrition, regular physical activity, and effective stress management (35).

Women hold a central role within families and communities as primary caregivers and influencers of health behaviors (36). Addressing women's health must extend beyond physical well-being to encompass mental health, given its profound impact on overall quality of life. Women's health-promoting behaviors are influenced by multifaceted factors that include socio-cultural norms, access to resources, and psychological empowerment (37). The interplay between physical and mental health is especially salient in women, necessitating comprehensive interventions tailored to their unique needs.

International human rights frameworks and global health organizations consistently highlight women's health as a priority, recognizing that improving the well-being of women and girls is essential for sustainable development and intergenerational health equity (38,30). Since women constitute approximately half the population worldwide, safeguarding their health benefits entire communities. Consequently, migrant women represent a critical focus for health policies and programs aimed at reducing health disparities.

In this study, social security and mental health literacy collectively explained 60% of the variance in health-promoting behaviors among Afghan migrant mothers. This substantial explanatory power underscores the vital importance of these factors in fostering healthy lifestyles within migrant populations. These findings suggest that policymakers and healthcare providers should prioritize initiatives that enhance social security—through improved legal protections, community support, and safe living conditions—and bolster mental health literacy via accessible education and culturally sensitive outreach. Such integrated strategies have the potential to significantly improve health outcomes and quality of life for migrant women and their families.

Study Limitations and Strengths: This study has several limitations. First, recruitment through schools was a practical approach to reach Afghan mothers of school-aged children, but it may not represent mothers outside the school system. Second, the age range of 30–45 years restricts the study population and should be reflected in the study title to clearly define the target group. Finally, the use of convenience sampling and the exclusion of divorced or widowed mothers may limit the generalizability of the findings to the broader population of Afghan mothers.

Innovation and Recommendations: This study is the first to concurrently examine the roles of social security and mental health literacy in predicting health-promoting behaviors among Afghan migrant mothers residing in Iran. Unlike prior research, which has typically investigated these variables separately and within general populations, women, or migrant groups, the present study focuses specifically on a vulnerable subgroup: migrant mothers. Implicitly, the study highlights the central role of mothers as a vital link between the individual and society. Mothers are not only responsible for their own physical and mental health but also play a crucial role in shaping the psychological well-being of their families. Therefore, enhancing mental health literacy among migrant mothers may have multilayered effects that extend across generations.

Furthermore, this study conceptualizes social security as a subjective experience rather than merely a collection of objective indicators such as income or legal residency status. This perspective enables a deeper understanding of the dynamic interplay between social context and individual psychological outcomes. Moving beyond a pathology-focused approach that concentrates solely on mental health problems, the study adopts a health-promotion and empowerment framework, emphasizing individuals' internal capacities for psychological well-being and the adoption of positive health behaviors. The findings suggest that strengthening mental health literacy and enhancing the sense of social security are critical factors in improving health-promoting behaviors among migrant mothers.

In light of these findings, the need for tailored educational programs for Afghan migrant mothers becomes evident. These programs should focus on stress management, mental and physical health, and increasing awareness of preventive and therapeutic strategies. Delivery of such education through both in-person workshops and online platforms can help ensure

broader accessibility. Moreover, creating opportunities for social interaction—such as support groups, local associations, or cultural activities—can foster a sense of social belonging and psychological security, which may indirectly promote healthier lifestyles.

Moreover, implementing mechanisms to collect feedback from mothers about their lived experiences and the barriers they face in accessing health services could enhance the quality and effectiveness of these services. Finally, considering the existing gaps in the literature, future studies need to investigate the relationship between traumatic migration experiences and mental health disorders among Afghan migrant mothers. Moreover, examining the impact of social security and mental health literacy on health-promoting behaviors, specifically among Afghan migrant mothers with low educational attainment (less than nine years of schooling) or no formal education, may provide clearer insights into the role of literacy in shaping their health-related behaviors.

Conclusion

The results of the present study revealed a positive and significant relationship between social security and mental health literacy with health-promoting behaviors among Afghan migrant mothers. Both social security and mental health literacy were found to simultaneously predict health-oriented behaviors. The findings further emphasize that, to improve health-promoting behaviors, it is essential to enhance the social security and mental health literacy of these mothers. It is therefore recommended that educational programs and support networks be developed and implemented specifically for this population, enabling them to engage more effectively in health-promoting behaviors.

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Availability of Data and Materials: The data are not publicly available due to ethical restrictions.

Conflict of interest: The authors declared no conflict of interest.

Consent for publication: Not applicable.

Ethics Approval and Consent to Participate: The protocol for this study was approved by the Shahid Beheshti University research committee with code: IR.SBU.REC.1403.092. This research was undertaken in accordance with the ethical principles articulated in the Declaration of Helsinki. To comply with the ethical principles of voluntary participation, written informed consent was obtained from the participants for conducting and recording

the interviews. The participants were also reassured of the confidentiality of their information.

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