Afghan refugees’ experience of Iran’s health service delivery

Abbas Heydari, Rana Amiri, Nahid Dehghan Nayeri and Vedadhir AboAli

Abstract
Purpose – The purpose of this paper is to explore experiences of Afghan refugees from health service delivery in Mashhad, Iran.

Design/methodology/approach – This is a descriptive study with contextual and qualitative design. Semi-structured interview conducted with 19 Afghan refugees and their caregivers and a focus group session were held with Afghan medical science students. Purposive sampling technique was used to select participants. Data were analysed by qualitative content analysis of Graneheim and Lundman. Lincoln and Guba’s criteria were implemented to ensure trustworthiness.

Findings – The results with the core concept of “position of immigrants in the health system” were presented at four themes of “perceived discrimination”, “snowed with loneliness”, “feeling inferior”, and “gratitude”.

Research limitations/implications – This study has some implications for researchers and practitioners. The present study is the first study that was done on the health of Afghan refugees in Iran, therefore it can be a ground for further research. In addition, it has valuable results regarding the Afghan immigrants’ experience of health care system of Iran.

Practical implications – It can be useful for improving the condition of immigrants in Iran and for improving Iran’s health system. In order to improve the health system in Iran, authorities should pay much attention to transcultural caring and needs of minorities. Furthermore, health workers should be trained to appropriately take care of all patients, without prejudice.

Originality/value – Overall the study revealed that there is inequity in access to health services among Afghan refugees in Iran. The findings, although not generalized, offer important insights into health care providers in Iran which should be delivering health service without prejudice. The authors recommended that policies of public medical insurance and assistance programme should be implemented for providing affordable health care services for Afghan refugees.

Keywords Race, Human rights, Health care, Public services

Introduction
These days, migration is one of the hot issues, which has raised many discussions in the world. Immigrants may experience stress because of emotional and cultural conflicts in the process of reconfiguring in the new society (Berry, 1980; Hovey, 2001).

Medical health officers have emphasized the special needs of minorities and immigrants; since according to the evidence, health services provided for immigrants in most countries are significantly different from those provided for residents (Balarajan and Raleigh, 1993). Some studies have revealed the feeling of dissatisfaction with health care delivery among immigrants in different countries (Vydelingum, 2000; Omeri, 2006; Balarajan et al., 1991; Jain et al., 1985). Studies have pointed out that immigrants are unhappy with health care services and have the feeling that the personnel do not understand them (Cave et al., 1995; Ferran et al., 1999;
Reiff et al., 1999). The most common problem mentioned in the studies is communication barriers; however, in spite of resolving this problem by translating, the problem still remained (Baarnhielm, 2000; Lin, 1983).

The largest group of immigrants in the world are Afghan people. Ten years of Soviet occupation (1979-1989) and then National conflict between political and ethnic groups in Afghanistan have led to the death of two million, internal displacement of one million, and migration of five million people (Mehraby, 2002). During these three decades, Afghan people immigrated to different countries to reach to their respective diaspora there. Among all selected countries, Iran and Pakistan were the main hosts of Afghan refugees (Otoukesh et al., 2012). Iran has hosted about 40 per cent of all Afghan refugees (Ghods et al., 2005). A survey on Afghan refugees in Iran, conducted in July 2011, revealed that about 1,019,700 refugees are living in Iran (Koepke, 2011).

In spite of the large population of Afghan refugees living in Iran, there are a few studies on Afghan refugees, especially on the issues regarding health. Among the studies conducted on Afghan refugees in Iran, the first group is related to social and economic issues (Koepke, 2011; Squire and Gerami, 1998; Land info, 2011) and the second group involves issues related to health and illness (Ghods et al., 2005; Kalafi et al., 2002; Moradi et al., 2008; Otoukesh et al., 2012; Sadeghipour et al., 2006).

There are many studies regarding immigrants’ experience and attitudes about health access and health care delivery in different countries. Most of these studies have been done with quantitative method, using a structured questionnaire and some of them have been done with qualitative approach and interview with participants. Studies with qualitative design have been performed on experience of immigrants in countries such as the UK, Canada, the USA and Israel on china, Asian, Latin and Portuguese immigrants. Among these studies, those, which are more congruent with our design, are mentioned. Vylidingum (2000) has done a qualitative study on experience of South Asian patients in an English hospital. She acquired information with phenomenology approach and deep interview with participants. Her result revealed that patient had different experience ranging from feelings of satisfaction with care, fitting-in strategies, post-discharge coping mechanisms and unhappy about the service (Vylidingum, 2000). Chandler surveyed health care-seeking experiences of undocumented Mexican refugees women with interpretive phenomenological study in California. Participant expressed that there is lack of recognition of their human plight and worth of their personhood. There were structural and social barriers to care for refugees’ women (Chandler et al., 2012). Ho (2004) investigates the health-seeking behaviour patterns of Chinese refugees patients enroled in the directly observed therapy (DOT) programme in New York City based on grounded theory. Result revealed that patients tends to use traditional Chinese practitioners, than other types of health providers so they had the fewest referrals to the DOT programme (Ho, 2004). Campbell et al. (2014) have done a study on comparison of health access between permanent residents, undocumented immigrants, and refugees. Qualitative interviews were conducted with immigrants to identify barriers and facilitators to accessing health care. Result revealed that immigration status was the single most important factor affecting both an individual’s ability to seek out health care and her experiences when trying to access health care. Language barriers are also noted as an impediment to health care access (Campbell et al., 2014).

Despite various studies conducted on the experience of refugees in the world, there are a few studies with regard to the Afghan refugees’ experience of health services. That is to say, only Omeri (2006) in Australia and Lipson et al. (1995) in California have done studies in this regard.

However, as far as the researchers are concerned, there is no study on health service delivery to Afghans or their health-seeking behaviour in Iran. In fact, Afghan population are vulnerable people that are neglected by many societies, especially Iran, because of their situation. Therefore, investigating the issues related to this group and their experience is not only crucial but also would lead to valuable results about the challenges and problems that they are confronted with. On the other hand, the studies, which have been done on the refugees’ health, are, mostly, quantitative studies. However, it is crystal clear that qualitative research enables researchers to get particularly close to the problems under the study and brings out their personal insights and experiences (Patton, 2002). Thereafter, employing a qualitative design in this study, the researchers aimed to explore the experience of Afghan refugees regarding health care delivery in Mashhad, Iran.
Objective

This study aimed at exploring Afghan refugees` experience of health care delivery in Mashhad, Iran.

Methods

Qualitative research was chosen in this study because this approach allows an in-depth exploration of patients’ views in relation to health service delivery in their natural settings. In addition experiences are subjective; and only through qualitative study we can discover real feeling and attitudes of people in the especial context. In terms of qualitative research, the researcher has used content analysis approach.

The study utilized qualitative research methods including semi-structured interviews and focus groups. This study has been done in Mashhad, Iran. Mashhad was chosen as the place of study because most of Afghan refugees live there due to being coterminous with Afghanistan and being pilgrimage. Among Mashhad clinics and hospitals that refugees mostly refer to, Tollab area was chosen. Tollab is an area in Mashhad that most Afghan refugees live there (nearly 70 per cent).

Participants were selected from among a population who referred to hospitals, clinics, and physicians’ office for treatment. They were entered the study if they had the required criteria for inclusion and if they consented to the research. Inclusion criteria consisted of being in Iran for more than five years, living in Mashhad for more than two years, and having an acute or chronic disease.

To gain in-depth knowledge and understand of the factors influencing health care delivery to Afghan refugees, the present study employed purposive sampling method with maximum variation. This strategy was used to ensure that the collected information was rich enough and clearly addressed the issues in question (Patton, 2002). In this regard, Glaser (1978) states that purposive sampling is often used to select people with different backgrounds to enrich the nature of gathered information. The sample size in qualitative research should be determined based on the amount of data required. Thus, a guiding principle for choosing participants is data saturation. In this study, interviews with Afghan refugees have been continued until the data saturation was obtained.

During the data collection procedure, at first the goal of study was explained to the participants, and their understanding of the study was checked to ensure that they were clear about participation. Also, their right to refuse participation, at any time during the study, was stressed. In addition, patients who consented to participate in the study were asked to sign a consent form. Then, the time and place for the interview were determined according to the tendency of participants. Most participants were interviewed in their home. Duration of interviews was about 35-60 minutes, with an average of 45 minute. Permission to use a tape recorder was got at each interview, and the confidentiality and anonymity of the information were guaranteed. Each interview was commenced with open-ended questions. Examples of questions that were asked from participants are as follows: could you please tell me about your experience of referring to health care centres for treatment when you were sick? What problems were there when you referred to health care centres in Mashhad? Participants were encouraged to talk freely about their experiences and feelings. Probing was used as a communication strategy in order to gain an understanding of critical issues (Glaser, 1978).

Focus group session

A focus group session was held with Afghan scholars professional in medical science. This session was held for obtaining deep and clear understanding of barriers of health care seeking among Afghan refugees in Iran. There were ten Afghani scholars from different fields of medicine, nursing, midwife, and health. During the 70-minute session, health-seeking barriers facing Afghan refugees were discussed. The focus group meeting took place in an office named union of Afghan students and scholars in Tollab area.

To keep ethical considerations, the researchers obtained ethical approval for the study from Human Research Ethics Committee of Mashhad University of Medical Science. The researchers explained the goal of the study to the participants, and their right to refuse participation, at any
time during the study, was stressed. In addition, the patients who consented to participate in the study were asked to sign a consent form. And, permission to use an audio tape recorder during the interview sessions was obtained from health workers.

Data analysis: data analysis was conducted simultaneously along with data collection; this means that each tape was transcribed and each transcription was checked at the same time. Data were entered to Max QDA software. For data analysis, the researchers used the latent qualitative content analysis by Graneheim and Lundman. All transcriptions were read and reread till familiarity with data was achieved and a sense of the whole was apprehended (De Vos, 1998).

Data were unitized and categorized. Unitizing the data involved coding raw data into distinct meaning units, and categorizing involved grouping these units of meaning or codes into categories and themes on the basis of similarity (Graneheim and Lundman, 2004).

To ensure the trustworthiness of the study, the researchers utilized GABA and Lincoln’s criteria. To increase validity and reliability of data, the study made use of different methods such as allocating sufficient time, in-depth interviews with participants, peer checking, explaining the objectives of the study, and returning codes to participants to verify their accuracy.

Results

In the present study, 19 Afghan refugees participated. They were in the age range of 16-68-year old with an average of 40 years. Among them, 70 per cent were females and the rest were males (see Table I). Each participant was interviewed for about 35-60 minute, with an average of 45 minute.

The results with the core concept of “position of refugees in the health system” were presented at four themes of “perceived discrimination”, “snowed with loneliness”, “feeling inferior”, and “gratitude”, which are presented in Table II. All the themes are discussed in detail.

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<tr>
<th>Table I</th>
<th>Characteristic of participants</th>
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<td>Gender</td>
<td>Level of education</td>
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<tr>
<td>Male</td>
<td>7 (30%) Illiterate</td>
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<td>Female</td>
<td>12 (70%) Primary</td>
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<td>Diploma and higher degrees</td>
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<td>Total</td>
<td>19 (100) Total</td>
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Notes: Min, minimum; Max, maximum

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<tr>
<th>Table II</th>
<th>Themes and subthemes</th>
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<td>Core concept</td>
<td>Them</td>
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<td>Position of Afghan refugees in Iran health system</td>
<td>Perceived discrimination</td>
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<td>feeling inferior</td>
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Perceived discrimination

The first data showing the position of Afghan refugees in Iran’s health system was coded under “Perceived discrimination” with three subthemes of “rejection”, “high treatment cost”, and “Being intentionally ignored”.

Participants felt that there was health discrimination towards refugees in Iran’s health system. They mentioned the three basic points for this discrimination: not being admitted in some hospitals, higher costs, and being ignored.

Some participants pointed out that the hospitals did not accept Afghan people without refugee card or Passport. They emphasized that since they lived illegally in Iran, they had problems with hospital admission. On the other hand, some participants declared that even with legal residency some hospitals did not admit them because of their nationality:

Participant 3, 29 years old who had referred to hospital for childbirth said: “when I refer to hospitals for delivery some hospital did not admit me. I was in bad situation but they did not accept me because I was Afghan. I had resident card and I lived in Iran legally but they told us we did not accept Afghans in our hospital”.

Afghan refugees had complained about high treatment costs in Iran. Most of them had not any insurance coverage for referring to doctors or hospitals. They mentioned that even in public hospitals, they had to pay as much as private ones. Because the cost of treatment is very expensive, sometimes they cannot afford it, thus they do not refer for treatment. In some cases, they had to sell all their property or borrow money from others to pay for hospital admission. As one participants indicated to this reality:

Participant 14 explained: “My niece was very poor. She was pregnant last year but they had not enough money for hospital admission. They asked everybody for help, but no one helped them. One night her husband called me, when I went to their home she was in a very bad condition. She tolerated the pain to deliver the baby at home, because they had not enough money to refer to hospital. Finally, I borrowed some money and carried her to hospital. Unfortunately, the baby was missed and the mother was in a very bad condition. With emergency surgery they could rescue her”.

Regarding the concept of “being intentionally ignored”, some of the participants believed that when they were admitted in hospital or referred to clinics, they were not given appropriate care as Iranians. They thought that health care providers discriminated between them and Iranians in caring. They declared that when personnel understood they were Afghan, their attention and caring decreased and their behaviour changed:

Participant 8, 30 years old that has epilepsy and her child had monoplegia said: “When I took my son to physiotherapy, they respond me later than others; they were impatient and had bad temper with me. They treated with me in a way as if I didn’t want to pay money; although they get double from us. When my turn came, they devoted less physiotherapy time to my kid compare with others”.

Participant 4, 48 years old that was admitted in hospital because of TB said: “they were very impatient that I thought they hate me. When the nurses injected me they pushed the Syringe hardly that I had pain and when they pulled the IV from my hand they took it with pressure”.

This discrimination may be created because of lack of appropriate therapeutic relationship, but in practice, most of the participants mentioned this discrimination.

Snowed with loneliness

Another theme showing the position of Afghan refugees in Iran’s health system was “snowed with loneliness” with two subthemes of “Being stranger” and “Feeling of being isolated”.

Being alone is a common sense among refugees. Though they speak like Iranians, behave, and wear like them, the society does not accept them because of their nationality. They are stranger and alone; when they refer for treatment or for being admitted in hospitals, they suffer from this loneliness:

Participant 13, 28 years old said t: “I was born in Iran, grew up and educate in Iran and I have never seen my country, so I am like Iranian people. Once I was in NICU ward, my baby was admitted there. At first they thought that I am an Iranian so they behaved me like others. One day I told one of the
nurses that I am Afghan; she got surprised and told me I thought you were an Iranian because you were like Iranian people. After that time, not only that nurse, but also most of the staff, even patients behaved me differently; I mean as a stranger”.

Another subtheme is “feeling of being isolated”. It means that because some contagious diseases are more common among newly arrived Afghan refugees, Iranian people stay away from them. Some Iranians disgusted Afghans and they were afraid of disease that would be transmitted by them. This view is not only towards newly arrived refugees, but also towards refugees who lived there for a long time. Participants declared that they felt being isolated in every situation, especially when they were sick. In fact, although they might be physically in one environment and room with Iranian patients, they were mentally isolated from others. They stated “we are in one hospital, one ward, and one room, but there are red circles around us that separate us from others”. One of the participants mentioned:

Once I was admitted in a ward, there were four Iranians. Assistant nurse behaved with me very badly, when I told her why you behave this way with me, she got angry and said: “you make our country dirty”. And said to other patients: “you must complain to head nurse to transfer this dirty patient to another place; he is Afghan and may have many disease, so he would make your condition worse”.

Participant 15, 35 years old said: “when I referred to health centre for the vaccination of my kid, who is 6 years old, a paper was on the door reading: Afghans should refer only on Tuesdays. I think it is not justice and this kind of behaviour might harm our children mentally; because my kid asked me why they separate us from our friends; he felt unconfident”.

Feeling inferior

This theme and its subthemes reflect an unequal and superior-inferior relation between the staff and the refugees. Some studies in Iran showed that health workers had superior view towards patients (Vasli et al., 2015), not only they looked refugees down but also they insulted them.

Most of the participants stated that when they referred to hospitals or clinics they were insulted. They pointed that their identity and nationality were exchanged with insults between health personnel:

Participant 2, 32 years old, that had been admitted in hospital because of delivery said: “for delivery, I went to […] Hospital. A midwife asked me to sit down on the bed but the bed sheet was dirty. I said the bed sheet is dirty. She replied: you, an Afghan, think that you are human and can recognise dirtiness. When I say sit down, you should sit down”.

Disrespecting Afghan refugees on the part of health workers is the most popular complaint. They indicated that when they referred to clinics or hospitals, personnel treated them very badly with no respect. They, also, stated that health workers paid less attention to them compared with Iranians. Also, they believed that though they may not show it in their behaviour, it is clear from their look. The following participants confirmed these findings:

Participant 7 explained: “when I referred to hospital to visit my uncle, I referred to secretary and asked him about the ward and the room of my uncle. The first contact between us (me and the secretary) was politely and respectfully. But when he realized that I was looking for an Afghan patient, his behaviour changed. Because he realized that I am an Afghan. From that time on, he answered me impatiently and irritability; he did not like to speak with me”.

Gratitude

The last theme, “Gratitude” and its two subthemes, “sympathy” and “helpful”, showed a contradictory and positive view towards health care workers in Iran.

Some participants expressed their thanks to Iran’s medical system for diagnosing and curing their illness. They stated that health system in Afghanistan has many problems and they immigrate to Iran for treatment. In Iran, their disease has been diagnosed and cured:

Participant 14 that lived in Iran because of her son’s disease explained, “I sold all our property in Afghanistan to pay for my son’s treatment. He was admitted in the Herat hospital for a long time,
but they failed to diagnose his illness, they said he has anaemia, and transferred blood to him, and then we went to Kabul. There, they said that he has heart disease; each time he was admitted for 40-50 nights, and without any progress they discharged him. Finally, a doctor advised us to take him to Iran. When we came Iran, they diagnosed my son’s problem, but unfortunately it was very late because his kidneys were failed”.

Some participants expressed their thanks to health care personnel for their honest work and impartial care. They believed some personnel tried over their force just for the sake of all people’s lives.

Some others expressed their thanks to health care personnel for realizing their problems and cooperating with them. Helping people in special circumstances by physicians and nurses, and kindness to them were some of the appreciated behaviours:

Participant 1 who was admitted in hospital for surgery of cataract said: “when I referred to hospital they don’t accept me because my resident card was expired. One of my eyes had glaucoma and my surgery was an urgent one. If I waited for extension of my card, I would be blind. I spoke with the manager of the hospital but he doesn’t accept. Finally I spoke with my surgeon, he did the surgery with his responsibility and asked no money for the surgery. I bless him every time”.

Discussion

This qualitative study investigated Afghan refugees’ experience of health care delivery in the context of Iran. To the best of the researchers’ knowledge, there are a few studies regarding Afghan refugees’ health while they are a vulnerable and helpless population. For instance, in Sun Francesco, Lipson et al. (1995) conducted one of the first studies on the health of Afghan refugees using a qualitative method. Then, Omeri (2006) did a study on the health care of Afghan immigrants in Australia. Although most of the Afghan refugees live in Iran, there is no study on the health care of refugees using qualitative or quantitative methods. Therefore, as far as the authors of the present study are concerned, the present qualitative study was done on Afghan refugees in Iran for the first time and has yielded unique and valuable results.

The analysis showed that health care system in Mashhad, Iran, does not provide equal health services for refugees. Despite the emphasis of medical authorities on this issue, always immigrants and minorities suffer from inequity in delivering health services. Different studies indicated the inequity in the delivery of health services and dissatisfaction of immigrants from health care services in different countries (Vydelingum, 2000; Adamson et al., 2003; Dyhr et al., 2007; Smaje and Grand, 1997; Hjern et al., 2001; Oddone et al., 2002).

Based on health care texts, equity means social justice or fairness; it is an ethical concept, grounded in principles of distributive justice. Equity in health is defined as the absence of socially unjust or unfair health disparities (Braveman and Gruskin, 2003). Meanwhile, the findings of the present study revealed that the participants felt being discriminated, isolated, alone, and inferior. These conditions make the authors conclude that the health care delivery in Iran is not based on equity. The researchers observed high domination of inequity in health care delivery in the present study.

The results of the present study revealed that Afghan refugees believe that they were discriminated regarding the health care services of Iran. Because they mentioned that they were rejected by health centres and were ignored by them, while they paid more treatment cost. The clearest reason for the rejection of refugees in hospitals is their illegal settlement in Iran and their lack of resident card. However, some participants pointed out that even with resident card, some hospitals did not admit them because of their nationality. On the other hand, cost of treatment is the most problematic barrier to health seeking of Afghan refugees who live in Iran. Most of Afghan refugees do not have insurance coverage. Most of them are unemployed or work with low income. Moreover, because of their illegal settlement, hospitals do not accept them, or charge them more. Hesketh et al. (2008) and Peng et al. (2010) in their studies found that the most challenging issues for immigrants is the cost of treatment which sometimes prevents them from referring to health centres for treatment. Being neglected by health workers is the common experience of immigrants, indicated by the present study, which is in agreement with other studies (Jain et al., 1985; Cave et al., 1995; Ferran et al., 1999).
Another finding of this study is related to the theme of “snowed with loneliness”. Loneliness is a common sense among refugees, but in illness condition it is more irritating and cause suffering. Feeling lonely in clinic, office, ward, hospital, and in every condition and situation suffer refugees. Vydelingum found the theme of “being alone in crowd” that is very similar to the theme of the present study. In her study, some patients expressed that they could not communicate with nurses and had the feeling of being lonely and isolated. They expressed that though they could not speak English, the problem was not only the language, but the real problem was that some of the nurses had not positive view towards them; they could see prejudice and disgust in personnel’s face. In the present study, also, there were similar statements by participants pointing that the personnel behaved them differently and they had the feeling of being isolated (Vydelingum, 2000).

Although many studies pointed to language as a barrier to communication between health providers and immigrants, in the present study, this problem was not very serious; because most refugees could speak Farsi.

Another theme mentioned in this study is “feeling inferior” with two subthemes of insult and disrespect. Insult and disrespect were the main barriers for the health seeking of refugees; as a result of this issue, refugees lost their confidence or hid their identity from Iranians. Insulting and use of offensive words are mostly found among low-level educated staff. According to patients, this kind of behaviour rarely was seen among doctors. Also, Michaelsen et al. (2004) found that doctors and nurses had more positive attitudes towards immigrants compared to assistant nurses; this could be explained regarding their higher level of education. In other studies, there were some phrases such as “not respecting immigrants” or “ignoring them” (Graneheim and Lundman, 2004; Reiff et al., 1999) that are similar to the findings of the present study under the theme of “disrespect”.

The last theme was “feeling grateful of health delivery in Mashhad, Iran”. Other studies, also, pointed to this finding under the theme of “satisfaction” (Jain et al., 1985). In this study like other studies, some refugees were satisfied with health workers and appreciated their efforts. Some Afghan refugees believed that the health system of Iran is more satisfying than that of Afghanistan. They, also, mentioned some of the personnel and physicians’ help and behaviour to Afghan patients in difficult conditions, which were beyond organizational chart.

Conclusion

Overall, the present study revealed that there is inequity in access to health services that is especially noticeable in the case of Afghan refugees in Iran. Since health is the certain right of every person, equity in access to health care services should be assured among Afghan refugees.

While most of refugees in Iran do not have insurance coverage, it is recommended that policies of public medical insurance and assistance programmes should be implemented to provide affordable health care services for Afghan refugees. It is, also, recommended that Médecins sans Frontières, which provided health care for refugees in Mashhad until 2006, should be reconstructed again. In addition, regarding the growing trend of cross-cultural care and respect to different cultures, it is recommended that some transcultural communication courses should be held for health care personnel. Due to the fact that Iran is a ground for different cultures and also due to the pilgrimage of Mashhad and having large numbers of pilgrims annually from neighbouring countries, considering to different cultures is necessitate in this country.

At the end, it is recommended to consider the demand and needs of domestic and foreign cultures in Iran. It can improve the quality of health care services provided.

This study has implication for research and practice. The present study is the first study that was done on the health of Afghan refugees in Iran; therefore it can be a ground for further research. In addition, it has valuable results regarding the Afghan refugees’ experience of health care system of Iran. It can be useful for improving the condition of refugees in Iran and for improving Iran’s health system. In order to improve the health system in Iran, authorities should pay much
attention to transcultural caring and needs of minorities. Furthermore, health workers should be trained to appropriately take care of all patients without prejudice. Pay attention to needs of foreign culture and transcultural caring is very important subject in health area that should be considered by scholars. For improving the condition of refugees in Iran, pay attention to the needs of immigrants is necessary. UN should consider the immigrants’ cost of treatment, also holding some training course to enhance health information of immigrants is recommended. As well as holding transcultural caring course is needed for health care workers.

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Further reading


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