Systematic Review

Migrants' Health in Iran from the Perspective of Social Justice: a Systematic Literature Review

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Abstract

This paper presents a systematic literature review of studies that shed light on the health of migrants in Iran from the perspective of social justice.

A systematic search was conducted in PubMed and Iranian databases, including IranMedex, Magiran, and SID, in June 2012. All studies that were published until June 2012 describing the health status of migrants – including refugees – in Iran were included. The search results were categorized according to an adapted version of the six dimensions of well-being in Madison Powers' and Ruth Faden's theory of social justice in health. They consisted of access to health care, health, respect, self-determination and attachment, personal security, and social determinants of health.

The majority of papers mentioned issues related to infectious diseases (100 papers, 60.2%). Only a few papers mentioned socioeconomic status and access to health services, education, and work. Infectious diseases and high population growth among migrants and the problematic image of migrants as "threat" to the Iranian population's health appear to be the most prominent results in our search.

It is imperative to combat the high numbers of infectious diseases among migrants in Iran while simultaneously making efforts to change the public image of migrants as a health and social service threat to Iran. Data concerning social and ethical issues of migrants' health in Iran is scarce, and thus, future research is necessary using other methods and sources.

Keywords: Afghans in Iran, health of migrants, social justice

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Introduction

There is a large number of empirical studies on migrants' health and health care. Studies within groups of migrants are ambiguous as to whether their status has a negative impact on their health, i.e. whether migration is correlated with a specific vulnerability in terms of health.[1] However, in some cases, systematic health inequities can be detected, especially when the status as migrant goes hand in hand with a low socioeconomic status or with a precarious residence state, as e.g., in the case of asylum seekers or undocumented migrants.[2,3,4]

The altogether large body of empirical data on migrants' health and especially the concerns of health inequity has profound ethical relevance, since it stirs normative questions, for example: Which are the moral duties of states, institutions and individual health care workers towards migrants and can differences to the treatment of citizens ever be morally justified? Even though migrants' health and health care raises important ethical concerns, there are only few contributions from an ethical perspective, and these are mainly from high-income countries such as the USA, Australia, the UK or other European countries.[5,6,7] It is a general desideratum to pursue more systematic ethical research in this area in general,[8] and also to conduct research specifically in middle- and low-income countries. In this paper, we focus on migrants' health*[1] in Iran as an upper middle-income country, an issue on which little literature exists altogether from the perspective of ethics and social justice, and to our knowledge, no overview paper.

In order to reach an understanding of whether and which relevant issues are at stake, it is necessary to gather as much factual insight as possible. We therefore chose to pursue a systematic literature research on migrants' health in Iran and evaluate the results from an ethical and social justice perspective.

Migration and health care in Iran

Migration to Iran has a long history. One of the first documented mass migrations refers to the migration of Jews from Babylon to Iran in 539 BC after being freed from captivity by "Cyrus the Great".[9] In the 20th century, many factors led to mass migration to Iran. They included the long-lasting civil war in Afghanistan followed by severe poverty, lack of welfare services, mass migration of the Iraqi *Shi'a* and Kurdish people due to the international military struggle in Iraq since 1990, extended poverty, natural disasters, and political instability in Pakistan.

Today, Iran hosts one of the largest populations of refugees in the world who were forced to leave their countr.[10] Of 10.4 million registered refugees, 8.5% live in Iran.[11] If undocumented refugees are taken into consideration, the estimated number in Iran is 2.5 million.[12] In 2011, about 96% of all registered refugees in Iran were of Afghan origin.[10] Before the Syrian crisis, Iran was the second

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1* If in the following we speak of migrants, the large numbers of refugees in Iran are included in this definition, as it is in many cases difficult to draw a clear distinction between the two categories. If we specifically want to make a distinction between migrants who voluntarily left their countries and refugees who were forcibly displaced, we will do so.

major refugee-hosting country in the world after Pakistan.[13]

The highest number of migrants (including refugees) in Iran are from Afghanistan.[13] Over the last 37 years, a number of push factors – especially those related to security and economic and political circumstances – have motivated more than six million Afghans to leave their country for Iran, Pakistan and other countries. Today, the Afghan population residing in Iran includes refugees who were forcibly displaced but also migrants who voluntarily left to seek work in Iran.[14] Some repatriation programs during these 3 decades, starting in 1993, have not been successful.[15]

Afghans in Iran have different legal status in the country.[16] Persons who are registered as refugees with the UNHCR receive specific social and health benefits. In 2010, this group was reported to have access to primary health services similar to those available to Iranian citizens.[17] A second group of approximately one million Afghans legally hold resident permits and are thus entitled to receive work authorizations in Iran. This group is offered to purchase health insurance on their own initiative. A third group – said to represent the largest number of Afghans in Iran even though exact numbers are lacking[18] – do not have an official residence permit and thus no official access to health care. However, showing identification cards when seeking medical services in Iran is not mandatory and therefore, there seems to be a possibility even for this group to access public health services.[16]

In Iran, the right to health and health care was established through the Iranian constitution in 1906.[19,20] The health care system in Iran is predominantly public, and services such as emergency care, routine vaccination, and health care for communicable diseases, are free. Other services are highly subsidized for Iranian citizens.[21] Recently, after a national reform of the health system, the government started paying more than 90% of all costs for in-patients cases.[22] During the previous 30 years, improvements have taken place. These include contagious disease control, an internationally-awarded population control program, access to one of the best primary healthcare systems in the East Mediterranean region, and improvements in medical education and research.[23,24] Health indices, including infant and maternal mortality rate, are improving.[25,26]

Methods

We performed a systematic literature review in June 2012. Each step of the review was reassessed by all three team members (for language reasons, the Persian papers were not reassessed by one of the researchers). The search was conducted in PubMed as this is the most important international data base that collects health related literature from different disciplines, including public health and public health ethics. However, since many Iranian publications are not indexed in PubMed,[27,28] we also searched SID, Magiran, and IranMedex databases for papers published in Persian.

Our guiding question for the search was: Which issues have been discussed in relation to migrants' health (including refugees) in Iran? Our search formula in PubMed was thus "migrant", "immigrant", "immigration", "refugee", asylum) "foreigner", "Afghanistan", "afghan", "Pakistan", "Pakistani", "Iraq", "Iraqi", " Iran". Since PubMed only collects papers in relation to health, we did not include a specific search term mentioning health or health-related issues.

To search Persian databases, we used all possible translations for migrants, migration, refugees and health.

The search results were categorized according to an adapted version of the 6 dimensions of well-being from Madison Powers' and Ruth Faden's theory of social justice as the ethical foundations of public health and health policy. These dimensions, that form the core of their theory of public health ethics, include health, personal security, reasoning, respect, attachment and self-determination. Our adapted version consisted of the dimensions: access to health care, health, respect, self-determination and attachment, personal security, and social determinants of health[2*].

We chose this approach as it has become standard in public health ethics research to incorporate aspects related to social determinants of health and to justice-related questions of how to distribute health and related goods.[29–31] In our assumption, Faden's and Powers' theory of social justice in health is especially suitable for our research question as the above-mentioned six dimensions provide a useful tool to capture not only directly health-related issues but also those that are more broadly related to social determinants of health, justice and patterns of systematic disadvantage. Justice, in Faden's and Powers' view, does not only require a sufficient amount of health for everyone, but also of every other dimension.[29]

Our overall aim to better understand social and ethical implications of health of migrants in Iran is to inform researchers, practitioners, and policy makers and ultimately to improve the conditions for migrants.

Results

Of 874 search results on PubMed, we excluded 805 papers (281 on migrants in other countries, and 524 not related to the search subject, e.g., diseases of animals or plants) and included 71 papers. Of the 187 search results in the Iranian databases, we included 102 papers; 7 papers overlapped with the PubMed search. In total, 166 relevant papers were included in our study. Among the search results, 110 papers (66.3%) were related to populations *including* migrants in Iran and 56 papers (33.7%) *specifically addressed* migrants. Despite our literature review aiming at discussing the ethical and social justice related aspects of the health of those who have migrated to Iran from all nationalities, most of the findings where exclusively about Afghan migrants and almost all papers included this population. Therefore, our data set is mainly related to Afghans residing in Iran.

The vast majority of papers (146) thus addressed Afghan populations in Iran, including 10 of Afghan/Pakistani, 3 of Afghan/Iraqi or Kurdish, and 1 of Afghan/Bengali origin. Moreover, 9 papers addressed Pakistani or Iraqi/Kurdish migrants, 10 did not specify nationality, and 1 was specifically related to migrants other than refugees.

The issues addressed were infectious diseases (100 papers, 60.2%), mainly tuberculosis (TB) (48, 28.9%) and malaria (18, 10.8%), non-infectious problems (39, 23.5%), and TB and malaria (3, 1.8%). Among non-infectious aspects were kidney transplantation (5, 3%), reproductive health (5, 3%), mental health (7, 4.2%), and sociocultural and economic aspects (22, 13.2%).

A) Access to health care

According to Faden and Powers, society has an obligation to ensure universal access to medical care.[29] In their theory, access

2* The reasons for our adaptation are given below in the results section.

to health care falls under the dimension of "health". Since this is such a central issue in relation to migrants' health, we separated it from "health".

As mentioned above, in Iran, free and equal access to primary health services exists for registered migrants. This includes routine vaccination, reproductive health services, and treatment of infectious diseases.[32–36] However, undocumented migrants are rarely refused health services.[37,16] According to our search, some seem to also have access to complex services such as hemodialysis or kidney transplantation.[38–40] Nevertheless, barriers to health care services for migrants have been described.[36] For example, Afghan women do not receive free prenatal care, as do Iranian women.[32] Barriers can result from lack of insurance, status as an undocumented migrant,[40] or delays in treatment.[41] Although most migrants who are Afghans speak Persian (official language of Iran), some differences in accents and a low literacy rate among migrants can function as a barrier to health education programs.[33]

B) Health

According to Faden and Powers, health is understood as physical and mental health, based upon biological functioning of a body.[29]

A large number of papers address higher rates of infectious diseases among migrants. TB, malaria, and drug resistant isolates affecting migrants are a major concern for public health in Iran.[33] The intercommunity transmission of TB to Iranians and the impact of migration on the Iranian TB control program are discussed.[42] A main obstacle for malaria control in Iran is related to continuous migration flows.[43] Other infectious diseases in migrant populations are less frequently discussed, e.g. syphilis, human immune deficiency virus/acquired immune deficiency syndrome (HIV/AIDS), hepatitis B virus (HBV), hepatitis C virus (HCV), measles, cholera, or leprosy.[44,45] Papers argue for better surveillance, collection of behavioral data of migrants or screening at the borders, and measures like quarantine.[45,46]

Regarding non-infectious health problems, high numbers of migrants and lower rates of contraception use are described as factors impacting a problematically high population growth rate in Iran.[32,34] One study shows that the rate of psychiatric problems is higher among migrants than the native population.[47]

C) Respect

Faden and Powers understand respect as the ability to see others as independent sources of moral worth and dignity, and deserving of equal moral concern.[29] However, the high prevalence of infectious diseases among migrants seems to lead to some resentment within the Iranian population. It is not only a certain virus or disease which is seen as a public health threat, but in some cases the migrant population itself. In an ethnographic study (2001–2004), the authors found that "in public opinion, Afghans place a burden on Iran's health, social, and economic systems… This is partially caused by the perception within the Iranian public health system that "too many Afghanis [*sic*]" overburden an already stressed system of care… Afghans are viewed as a potential health threat to Iranians, because of higher rates of infectious disease, such as cholera, TB, and malaria".[32]

D) Self-determination and attachment

Attachment, as one of the most central dimensions of well-being, includes friendship, love, and fellow feeling within one's community.[29] Self-determination involves the opportunity to shape the contours of one's life through one's own choices and efforts.[29] Self-determination and attachment are two separate dimensions in Faden's and Powers' theory. However, regarding the life of migrants in Iran, it is difficult to look at them separately; therefore, we have combined them in one category.

Self-determination and attachment are important dimensions of well-being when looking at repatriation of migrants. In Iran, migrants have the right to live outside of camps. More than 95% have integrated into Iranian communities[32,37,38] and have built strong sociocultural relations. The bonds with the host society result in resistance to repatriation. Thus, 50% of migrants have no intention to return to their country.[48] Papers suggest that an existing pressure of repatriation progressively worsens the migrants' health status. One paper even argues repatriation may result in migrants' deaths, and calls for professional humanitarian assistance and refraining from repatriation.[38] Another paper highlights the moral responsibilities of the host country to provide the migrant population with follow-up facilities, e.g., after organ transplantation.[49] Rajabali *et al.* have reported agreements between the United Nations High Commissioner for Refugees (UNHCR) and the governments of Pakistan and Iran.[46] They have discussed the possible effect of repatriation of AIDS/HIV-infected migrants on countries of origin.[46]

Following cultural rituals in family planning can increase or decrease self-determination and attachment. Ethically challenging questions are, for example, "which cultural traditions influence health, and whether and how the host community might have the right to intervene in certain cultural traditions?" These questions become relevant in the following areas: marriage among close relatives is reported to be more frequent among migrants compared to Iranians, there is a higher fertility rate and higher rate of unwanted pregnancies, patriarchal structures endorse early marriage for girls and early pregnancies, lower cooperation of men in birth control and a higher tendency for having male children.[37,41,48]

The issue of family planning is also discussed in the light of religious differences between those Afghans who belong to the Sunni sect of Islam and Iranians that are predominantly *Shi'a* Muslims. It seems to be a religiously motivated suspicion that leads to lower rates of contraception among some Afghans.[34] Tober *et al.* have explained the strategy used to convince Sunni Afghan migrants to accept the *Shi'a* interpretation and use contraception, and thus, to possibly undermine self-determination and attachment, although they found that the issue of religion is not the only factor which affects the Afghan migrants' acceptance of Iranian family planning programs.[32]

E) Personal security and socioeconomic status

Providing personal security is a sign of treating others as a moral equal. It involves prevention of human interest violation in maintaining physical and bodily integrity and psychological inviolability.[29] Socioeconomic status is not one of Faden and Powers' dimensions of well-being. However, it is important within theories of social justice in health when identifying vulnerable groups within a society and is deeply connected with each dimension of well-being. We therefore included it under the dimension of personal security, because of their interrelationship, for example when looking at security at work for someone of a low socioeconomic status.

In the literature we screened, we did not find any indication

for reduced personal safety in terms of rape, assault, or torture. However, altogether the studies provide evidence of less safety in various regards and a lower socioeconomic status of some migrants in Iran with negative effects on health. Registered migrants have the right to work in Iran.[34,35,37,38,48–51] Although only few Afghan migrants remain unemployed,[37] registered refugees and legal migrants workers who come to Iran with a work visa have the right to work based on the present regulations.[35] Nevertheless, difficult and low-paid work is reported among migrants.[48] Compared to Iranian children, migrant children have lower literacy rates, lower age average, and lower income.[52] A high rate of work-related accidental electrocution is reported among Afghans residing in Iran.[50] Sepehrdoost emphasizes the benefit Iran receives from the presence of Afghans as *cheap* labor.[51]

A higher probability of being murdered among Afghan migrants is reported,[53] as well as higher rates of violence and substance abuse in migrant families, and a higher level of aggression among Afghan migrants high school students.[54] A relationship has been observed between TB or malaria and poverty among Afghans residing in Iran.[33,41]

The papers also emphasize the vulnerability of migrants in terms of being suitable targets for organ trafficking. The legal restriction in Iran of organ donation to a recipient from another nationality has been discussed in some studies.[38,40,49] In their paper, Najafizadeh *et al.* explain a special waiting list for foreigners (including migrants), so that transplantation among foreign nationalities (e.g., Afghan to Afghan) can be secured.[40]

F) Reasoning

According to Faden and Powers, reasoning includes "the basic intellectual skills and habits of mind necessary for persons to understand the natural world".[29] In order to achieve reasoning abilities, factors such as adequate brain function, suitable social and physical environment, schooling, and medical care are necessary. Faden and Powers emphasize the first few years of childhood as crucially important for exercising reasoning capabilities.

In our databases, we did not find information on the early years of migrant children and whether the environment is such that reasoning capabilities can be developed. However, they have the right to access education at schools and university education.[35,37] The situation of second-generation Afghan migrants seems to be improving regarding health, literacy, education, and employment mainly because of their closer relationships with the host society.[35,48] The study by Abdizarin *et al.* even shows that Afghan high school students in Iran have a better mental health status and a better education score than Iranians.[55] However, overall literacy rates among Afghan migrants are low,[32,33] and especially near Afghanistan-Iran-Pakistan borders (AIP region), the rate of illiteracy and gender inequality is high.[56]

Discussion

Limitations

Our study was conducted in Pubmed and the mentioned Iranian databases only, thus leaving out possible other literature sources that can help to provide a more accurate picture of migrants' health in Iran. Even if we screened and processed a large amount of data, our review is thus only one small contribution to a much needed more comprehensive understanding of the situation. This review should be understood as a first step and also as a call for more research on the situation of migrants in Iran from a public health ethics point of view that also takes social justice into account. We assume that more literature reviews in more databases will bring other relevant studies to light. Altogether, more research, especially of qualitative nature, is recommended to better reveal the health related topics of migrants in Iran.

Numbers of relevant studies

Regarding the year and source of publications, we found more papers between 2000 and 2011 (12 papers/year) in comparison to 1986 to 1999 (1.6 paper/year). This increase could be interpreted as an emerging attention towards migrants' health or it may be due to the fact that Iran has experienced a dramatic general growth rate in the numbers of medical publications since 2000.[57]

As mentioned above, the high proportion of results on Afghan migrants reflects their high number in Iran.

Whereas we found a substantial number of papers with some relevance to social justice in health in general, we found only two papers specifically discussing bioethical problems. The low number of specifically bioethical papers could be related to the low number of bioethical publications in Iran in general as this is only a newly emerging field.[58] Both bioethical papers are in the field of kidney transplantation,[38,39] an issue that is the most debated aspect of bioethics in Iran.[59]

The image of refugees as a "threat"

Out of 166 papers, the majority (100 papers, 60.2%) addressed infectious diseases, 5 papers were on reproductive health and 22 papers revealed the socioeconomic characteristics of migrants. It is striking that the majority is on infectious diseases and other issues potentially impacting the Iranian population and its public health, especially given that papers explicitly mention the image of Afghans as a "health threat" to Iranians.

In general, the image of a migrant "threat" in Iran is not limited to health, but also includes socioeconomic and cultural issues. For example, some discuss the problem of Afghan migrants threatening job opportunities for Iranians especially for uneducated workers in rural regions.[34] Other studies demonstrate the negative attitude of Iranian citizens towards the influence of migrants on host communities, e.g., when considering the marriage of Afghan men with Iranian women as a sociocultural threat or danger for national identity.[60] The study by Taherpour *et al.* demonstrates opinions that do not endorse equal rights for migrants among university staff and students.[61]

It is paramount for global and national health programs to control infectious diseases. The accessible and wide publication of epidemiological data is of great importance. The evidence illustrates that rates of infectious diseases in Iran are higher among migrants; hence, focus on this specific group is necessary in order to protect migrants and citizens alike. However, this focus also raises the ethical concern of discrimination and stigmatization of the migrant population. If the presentation of epidemiological data perpetuates the image of migrants as "threat" to Iranians, it might be necessary to implement countermeasures, for example, to develop guidelines against discrimination while studying and publishing on infectious diseases among migrants.

Access to health care

Based on UNHCR documents, registered migrants have access to free primary health care similar to Iranian citizens.[10,17,62] We

also found evidence of good access to primary health care for undocumented migrants. Najafizadeh *et al.* have even pointed out that Iran's generous contributions to migrants in relation to organ transplantation have been universally acknowledged.[40] However, the United Nations' (UN) reports and some papers in our review have revealed barriers to health care.[10,33,36,56,17,62]

In contrast to these contributions that purport sufficiently good access to health care, some papers describe barriers to health care services for migrants and refugees. Whereas public health relevant programs like vaccination, family-planning services and treatment for infection are free, Afghan women do not receive free prenatal care, as do Iranian women.[32] Other barriers to health care for refugees can result from lack of insurance,[32] or from delays of treatment.[41] Another barrier to health care and health education results from cultural problems and language or accent barriers. The need for language-adjusted educational instruments to improve health communication is expressed.[3,56]

These results are ambiguous and deserve further enquiry. Questions still remain regarding the regulation of access to health care, existence of barriers, and measures which should be implemented to secure access to health care. Furthermore, the ethical question of whether it might be justified to tolerate some health inequalities (e.g., 60% in-hospital births for migrants compared to 90% for Iranians) if this level is much better compared to the country of origin (14% in Afghanistan) remains unanswered.[35]

Socioeconomic status and social determinants of health

The majority of papers address infectious diseases and high population growth among migrants, issues that affect and possibly "threaten" the Iranian population. Only a striking minority of papers address socioeconomic status and access to health services, education, and work even though we assume that many issues in these areas deserve to be studied. Studies give proof of a lower socioeconomic status and various disadvantages with resulting health-related difficulties for migrants. The study on electrocution-related deaths is revealing in this regard, as the rate of work-related electrocution mortality is reported to be higher among Afghan workers than Iranians.[50] The approach of social justice theories in health is especially interesting here. Since the understanding of health is not reduced to access to health care, biological functioning, and epidemiological data, but expands to the position of a group within a society, possible systematic disadvantages, and possibilities to develop a self-determinant life, while being respected by others.[29] More evidence is needed in order to evaluate how social conditions affect migrants' health and well-being in Iran.

Conclusion

Our literature review identified issues related to migrants' health in Iran from the perspective of social justice in public health ethics.

Infectious diseases, high population growth among migrants, and a possible image of a "threat" on the Iranian population's health appear to be the most prominent results of our search.

From the material we have analyzed, we can conclude that it is imperative to combat the high numbers of infectious diseases among migrants in Iran while simultaneously modifying the public image of migrants as a health and social service threat to Iran. More issues concerning the migrants' health in Iran (such as access to health care, organ transplantation, or social determinants of health) deserve to be examined further and in much more detail.

Future research is necessary in order to consolidate our findings and to identify more issues before developing specific policy recommendations. Future research could examine databases such as Iranian public media or legal documents. Empirical research among non-governmental organizations (NGOs), government workers, or migrant groups is rare and would be highly insightful.

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