

Evaluation of Health Services in Refugee Camps Using the Responsive Evaluation Model

Roghayeh Mohseni¹, MSc;
Leila Bazrafkan², PhD;
Nasrin Shokrpour^{3,4,5}, PhD

¹Education Development Center,
Shiraz University of Medical Sciences,
Shiraz, Iran

²Clinical Education Research Center
and Medical Education,
Shiraz University of Medical Sciences,
Shiraz, Iran

³English Department, Faculty of
Paramedical Sciences,
Shiraz University of Medical Sciences,
Shiraz, Iran

⁴Center for Interdisciplinary Research
in Islamic Education and Health
Sciences, Shiraz University of Medical
Sciences, Shiraz, Iran

⁵Clinical Research Center,
Shiraz University of Medical Sciences,
Shiraz, Iran

Correspondence:

Nasrin Shokrpour, PhD
English Department, Faculty of
Paramedical Sciences,
Shiraz University of Medical Sciences,
Shiraz, Iran

Email: shokrpourn@gmail.com

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Abstract

Background: The number of asylum seekers is increasing annually due to social, economic, and political challenges. Limited access to quality health services for asylum seekers poses serious risks not only to their own health but also to the public health of host communities. Given the importance of this issue, the present study aimed to evaluate healthcare services for residents of the Commissariat Camp Sarvestan (UHNR) using the responsive evaluation model.

Methods: This quantitative cross-sectional study was conducted in 2023. The study population consisted of Afghans aged 18 years or older residing in the UHNR camp (Shahid Beheshti Hospital, Sarvestan, Fars Province). Due to the limited population size, a census sampling method was employed, resulting in a total sample of 270 participants. Data were collected using a questionnaire designed based on the responsive evaluation model, assessing four key components of health services: healthcare delivery, physician-patient relationships, therapeutic collaboration, and access to services. Data analysis was performed using SPSS version 21.

Results: Among the evaluated components, physician-patient relationships received the highest mean score (17.88 ± 6.91), while therapeutic collaboration received the lowest mean score (14.58 ± 5.80). Overall, 75–90% of participants rated the four dimensions as relatively good to moderate, reflecting general satisfaction with the services, whereas 10–25% reported poor or relatively poor ratings. Quantitative analysis revealed a statistically significant relationship between the total healthcare service score and both age and gender.

Conclusion: Over 75% of participants reported high satisfaction across all components, highlighting the efforts, coordination, and planning of the responsible authorities in delivering healthcare services at the camp.

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Keywords: Refugees, Afghan refugees, Health services research, Responsive evaluation model, Sarvestan camp, Migration

Introduction

As defined by the United Nations, vulnerable groups are those that face structural discrimination, such as women, or groups that have difficulty defending themselves and therefore require special support. The number of asylum seekers is increasing annually due to social, economic,

and political challenges.¹ The Islamic Republic of Iran hosts a large population of Afghan asylum seekers.² The growing number of refugees has posed significant challenges for healthcare systems, particularly during the COVID-19 pandemic in host countries.³ Health is a key factor in the successful integration of immigrants into society and the labor market, as good health is a

fundamental prerequisite for individuals to realize their developmental potential.⁴

Lack of access to quality health services for asylum seekers not only poses a serious threat to their health but also endangers the overall health of the host community.⁵ Therefore, ensuring that asylum seekers have access to appropriate and high-quality health services is essential. The quality of healthcare is a central dimension of health system performance, and evaluation plays a critical role in quality improvement. When conducted effectively, evaluation can help identify and address problems, inform decision-making, and contribute to knowledge development.⁶

The responsive evaluation model, a management-oriented evaluation approach, was developed to assist service providers in making informed decisions and to provide a holistic and systematic review of programs. Stake introduced this model in the 1970s to address the need for evaluations that consider the practical goals of all stakeholders, rather than solely assessing whether predetermined objectives of the intervention were achieved.⁷ Stakeholders can learn how to reduce ambiguity and power differences. In fact, one way to implement effective external projects in the region and carry out a useful evaluation is to consider all stakeholders in the dilemma and address the problems of the target group based on the evaluation criteria.⁸ Evaluators and decision-makers determine the type of evaluation tailored to the needs of the program.^{9,10} The responsive evaluation model includes five stages: research, discovery and identification of problems, discussion, interpretation of findings, provision of a suitable context to facilitate dialogue among stakeholders, and Socratic education and guidance.¹¹ The model is shown in Figure 1.

Several studies have examined the quality of healthcare services provided to refugees. In a review study, Goetz et al. assessed the quality of health care for refugees and concluded that refugees often lack regular access to health care and face limited availability of services in their host countries.² Similarly, Salim et al. investigated the satisfaction with health care services among refugees in a camp

in Jordan and found that asylum seekers encountered difficulties in accessing health services, obtaining hospital referrals, receiving follow-up care, and accessing dental services; these areas were reported to have the lowest acceptable levels.¹¹

To the best of our knowledge, no previous research has examined the health status or the quality of health care services provided to refugees in Iran. Therefore, the present study was conducted to evaluate the health care services delivered to residents of the UNHR in Sarvestan refugee camp using the responsive evaluation model.

Methods

The present research was conducted as a cross-sectional study. The study population consisted of Afghan refugees residing in the UNHR camp (Shahid Beheshti Hospital, Sarvestan, Fars province) who were over 18 years old. Inclusion criteria were: holding a service certificate from the Sarvestan UNHCR Health and Medical Center, being aged 18 years or older, and willingness to participate in the study. Census sampling was employed, and a total of 270 participants were included in the study.

Data were collected using the Persian version of a 20-item questionnaire, which was developed into two sections: demographic questions (including age, sex, and marital status) and main questions based on the ZAP Questionnaire. The reliability of this instrument was previously established by Grohl et al.¹²⁻¹⁵ The questionnaire evaluates the quality of health services across four domains: medical services, physician–patient relationship, therapeutic collaboration, and access to health services. Each domain contains five questions, resulting in a total of 20 items. The first five questions assess satisfaction with medical services, the next five measure satisfaction with physician–patient communication, the third set evaluates internal coordination among personnel and departments, and the final five questions address access to services, including time, cost, and ease of access.

Responses were scored on a 5-point Likert scale ranging from “good”¹⁵, “relatively good”¹⁴, “moderate”¹³,

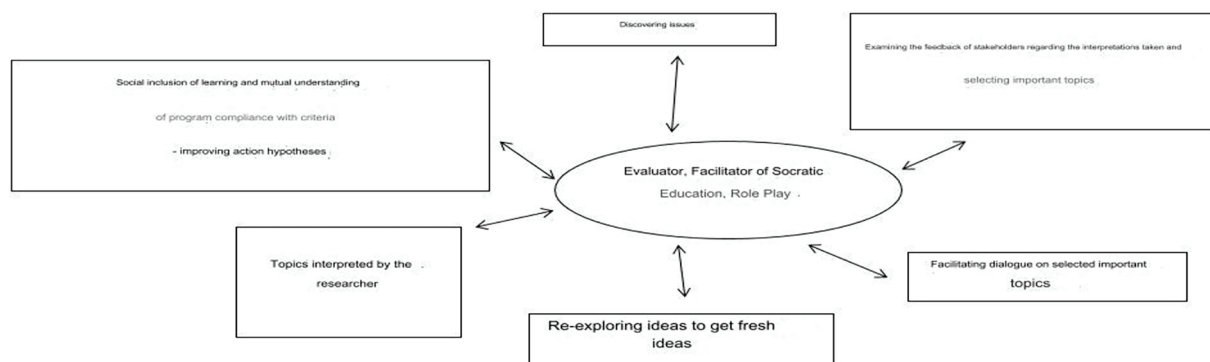


Figure 1: The responsive evaluation model

“relatively poor”², to “poor”¹. The questionnaire’s validity has been confirmed for Middle Eastern populations in the study by Goetz et al.² ($\alpha=0.80$). Additionally, the reliability and validity of the questionnaire were evaluated and confirmed by two experts.

On average, each family in the camp consisted of five members, with two members over 18 years of age. The researcher, accompanied by a trained healthcare worker, conducted the data collection. Due to a high level of illiteracy among participants, the questions were read aloud to those who could understand Persian, and their responses were recorded. For participants who did not understand Persian, questions were translated into Pashto by friends or relatives, and their responses were subsequently recorded.

Data were analyzed using SPSS software version 21. Descriptive statistics, including mean, standard deviation, frequency, and percentage, were used to summarize the data. The Chi-square test was applied to examine the relationship between age and gender and the overall results of healthcare services provided. At the same time, ANOVA was employed to assess associations with the different dimensions of health services.

Ethical Consideration

This study was approved by the Ethics Committee of Shiraz University of Medical Sciences, with the code of SUMS98-477. Participants were fully informed about the research aims, and written informed consent was obtained from all participants. All procedures were conducted in accordance with relevant ethical guidelines. Confidentiality of participants’ information was strictly maintained throughout the study, and documentation of informed consent is available upon request.

Results

Following data collection, the data were first analyzed descriptively. The frequency distribution of participants according to their demographic characteristics is presented in Table 1.

According to the results, of the 270 participants, 145 were female (53.8%) and 125 were male (46.3%). In terms of age distribution, 44 participants were under 20 years (16%), 80 were aged 20–30 years (30%), 48 were 30–40 years old (18%), 52 were 40–50 years old (19%), and 46 were over 50 years (17%). Table 2 presents the mean scores for each of the four dimensions of health services provided to the participants, as reported by the participants themselves.

The total mean score for healthcare services provided to Afghan immigrants was 64.21 out of 100. Among the assessed components, the highest mean score was observed for the physician-patient relationship, whereas the lowest was recorded for therapeutic collaboration. To explore whether age and gender were associated with the overall health services score, a Chi-square test was conducted. The results of this analysis are presented in Table 3.

The results of the quantitative analysis showed a statistically significant relationship between age and gender and the total score of health services ($P=0.003$ and $P=0.001$, respectively). In other words, participants’ age and gender were significantly associated with their overall evaluation of health services. Participants’ opinions on the health services are presented in Table 4.

The analysis revealed that 66.9% of participants had a positive or relatively positive opinion regarding overall health services, 73.7% regarding the physician-patient relationship, 69.7% regarding treatment

Table 1: Frequency distribution of participants by demographic characteristics (n=270)

Variable		Abundance	Percent
Gender	Female	145	53.8
	Male	125	46.3
Age	Under 20 years	44	16
	20-30 years	80	30
	30-4 years	48	18
	40-50 years	52	19
	Over 50 years	46	17

Table 2: Mean scores of health services and their dimensions as reported by Afghan immigrants

Variable	Mean(M)	Standard deviation(S.D)
Health services	15.27	6.02
Physician-patient relationship	17.88	6.91
Therapeutic collaboration	14.58	5.80
Access	16.48	6.13
Total	64.21	23.44

Table 3: Relationship between participants' age and gender and total health services score

Total service score	Mean and standard deviation		Significance level
Age	64/21±23/44		0.003
Gender			0.001

Table 4: Participants' perceptions of the health services provided

Spectrum	Weak		Relatively weak		Medium		Fair		Good	
Title	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Health Services	1	0/4	40	14/6	48	18/1	59	21/8	122	45/1
Staff-patient communication	2	0/7	31	11/4	39	14/4	42	15/8	156	57/7
Therapeutic collaboration	1	0/4	45	16	49	18/9	45	16/6	130	48/1
A	2	0/4	29	10/6	46	17/2	38	14/1	156	57/7

coordination, and 71.8% regarding access to services. Overall, a majority of participants reported good or relatively good opinions across all dimensions.

An ANOVA was performed to examine the relationship between age, gender, and the four dimensions of healthcare services. The results indicated that, in general, females were more satisfied with health services than males (54% vs. 46%). When comparing the mean scores across the four dimensions, females reported higher satisfaction, particularly in the physician-patient relationship (54%), compared with the other dimensions. In comparison, males expressed greater satisfaction with overall health services (41%). Analysis across different age groups revealed that participants under 20 years of age were more satisfied with staff-patient relationships (34%) and access to healthcare (29%). Conversely, participants over 50 years of age showed greater satisfaction with overall health services (32%) and access to healthcare (34%).

Discussion

Refugees and asylum seekers represent a vulnerable and underserved population. Addressing the healthcare needs of immigrants and facilitating access to services in the host country can yield benefits for both the host community and the immigrants themselves. Moreover, considering their current and past circumstances and providing support to improve their lives can have a substantial positive impact.

The present study aimed to evaluate the delivery of healthcare services to residents of the UNHR Sarvestan refugee camp, examining key components including demographic characteristics, health services, physician-patient relationships, therapeutic collaboration, and access to care. The results showed that more than half of the participants were satisfied with the quality of healthcare services provided. Additionally, a significant relationship was found between demographic characteristics, such as age

and gender, and the total healthcare service scores. More than half of the participants reported high satisfaction across all components, reflecting the efforts, coordination, and planning of the responsible authorities in providing healthcare in this camp.

In this study, the highest satisfaction scores were observed for physician-patient communication, while the lowest scores were related to therapeutic collaboration. Consistent with these findings, Durmaz (2023) reported that 95.2% of participants in his study expressed satisfaction with the healthcare services they received.¹⁶

Mahmoudian (2006), in his study on Afghan immigrants and their socio-economic status, concluded that access to educational and health services was greater than to any other component. He further noted that the educational and health-related gap of Afghan immigrants was wider compared to their compatriots in Afghanistan than in any other socio-economic domain. The availability of free education in Iran provided Afghan immigrants with a unique opportunity to improve their situation. At the same time, access to health facilities contributed to a reduction in mortality and improved health outcomes among this population. Immigrants' access to social and health services in Iran has largely been strengthened by their greater and longer-term integration into Iranian society, with adaptation improving among those who have resided in Iran for a longer period.¹⁷

Moreover, in line with our findings, Aghaei Hashjin et al. (2024) evaluated the quality of primary care services from the perspective of refugees and migrants in Iran. They reported that, overall, the quality of services was rated as favorable by the refugees.¹⁸ Similarly, Rakhshani investigated the knowledge, attitudes, and practices of Afghan refugee women residing in Zahedan regarding family planning and concluded that the Iranian health system provides Afghan refugee women with access to health services comparable to those of Iranian women.¹⁹

Refugees and asylum seekers face multiple barriers to accessing healthcare and achieving improved health status. These barriers include language difficulties, financial hardship and unemployment, cultural differences, legal obstacles, and limited awareness among healthcare providers regarding refugee-specific issues. Several studies have examined the health problems of refugees in Iran. For instance, Safari (2013), in a study on the education and healthcare of Afghan citizens in Isfahan, reported that one of the main challenges faced by refugees was the inability to afford education and healthcare costs for Afghan students.²⁰ In addition, unfamiliarity among employees in the Iranian administrative system with laws related to refugees has created further difficulties, leading to dissatisfaction among immigrants with the system.²¹

Khan (2002) investigated the participation of Afghan refugees and non-governmental organizations in reproductive health education. His study concluded that raising awareness among vulnerable groups, particularly immigrants, played an important role in reducing maternal and child mortality—one of the key indicators of national development. The findings suggested that organizing workshops and training courses, particularly through Afghan volunteers and teachers, significantly improved the knowledge and awareness of immigrants about their health.^{17, 22} Similarly, Shams (2022) emphasized that refugees often experience dissatisfaction with the administrative system due to staff members' lack of familiarity with refugee-related regulations.²³

The results of this study across different age groups showed that participants under 20 years of age were more satisfied with staff–patient relationships (34%) and access to healthcare (29%). In line with our findings, Salim et al. (2021) reported a satisfaction rate of 72.5% among 500 participants, with younger individuals and those with a shorter stay in the camp showing higher overall satisfaction.²⁴

In contrast, Riahi et al. (2016) examined the health information needs of immigrants attending health centers affiliated with medical universities in Iran. They found no significant differences in information needs based on demographic factors. This result is inconsistent with our findings. They further highlighted that immigrants' unfamiliarity with traditional health information sources posed a major challenge, with schools and universities being the primary centers for providing health information. According to their study, immigrants' health needs were generally high,^{22, 25} which differs from the findings of the present study.

Similarly, Al-Qadi et al. reported findings that were not aligned with our results. Their study concluded that significant gaps existed in healthcare service utilization among Syrian refugees, largely

due to the healthcare system's lack of preparedness to manage the surge in patient demand and the associated increased costs of care. Despite the Jordanian government's efforts to establish a reliable system for refugee healthcare, the massive influx of refugees from the Syrian crisis strained the system. The authors stressed that both decision-makers and healthcare managers must intensify their efforts to improve access to and utilization of healthcare services for refugee communities.²⁶

Although the present study suggested that healthcare services for refugees were adequate, Afshani et al. (2023) revealed weaknesses in Yazd, Iran, particularly inadequate supervision of Afghan migrants by Iranian health authorities.²⁷

Conclusion

The results of this study demonstrated a significant relationship between participants' age and gender and their overall health service scores. In particular, increases in age were associated with higher scores. Moreover, more than half of the participants reported high satisfaction across all components—health services, physician–patient communication, therapeutic collaboration, and access—reflecting the efforts, cooperation, and planning of the authorities responsible for health services in the camp.

To further improve access to healthcare for immigrants, practical and effective strategies should be implemented. These may include revising and strengthening laws and regulations, expanding programs and authorities, and enhancing the role of international organizations in supporting and protecting migrants. Additional measures include increasing human resource support by health professionals, improving educational programs and university-based initiatives for immigrant health, and ensuring comprehensive collaboration across stakeholders to provide more equitable and sustainable health services.

Limitations

This study, like others, faced several limitations. First, data were collected through a questionnaire administered to residents of the UNHCR Sarvestan refugee camp, which may introduce response bias despite the researcher's presence to guide completion. Second, data collection took place during the COVID-19 pandemic, which made accessing participants challenging and may have influenced their responses. Third, as a cross-sectional study conducted in 2023, the findings reflect a single time point and may differ from results obtained in other periods. Finally, although this research was limited to residents of the UNHCR Sarvestan refugee camp, the findings may not be generalizable to refugee populations in other

provinces or within medical universities nationwide.

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Authors' Contribution

RM, LB, and NSh developed the concept and design of the study; RM collected and analyzed the data; LB and NSh prepared the first draft; all authors read and approved the final version of the manuscript.

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Conflict of Interest

All authors accept that there is no conflict of interest in this study.

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